

8

**DISTRICT HEALTH SYSTEMS DEVELOPMENT:
FUNCTIONAL INTEGRATION AT JOINT PRIMARY
HEALTH CARE FACILITIES IN THE WESTERN CAPE**

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 Date *27 September 2002*

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ABSTRACT

Introduction

South Africa has embarked on a range of health sector reforms since the start of the democratic government in 1994. The Primary Health Care approach has been accepted as a way of delivering cost effective, efficient and accessible comprehensive health care at the primary care level. The district health system has been promoted as the best model for the delivery of primary health care because it decentralizes power to the local, district level and it is able to integrate fragmented primary care services under one management and governance structure. In the absence of a formal, legal district health system, provincial and local government authorities have made efforts towards functional integration in primary health care. The establishment of shared health facilities with the aim of providing integrated, comprehensive health care is part of the effort towards functional integration. This study investigates the level of functional integration in joint health facilities between Local Authority (LA) and the Provincial Administration of the Western Cape (PAWC).

Objectives

The study describes the extent of joint activities, it highlights the successes and obstacles and it makes recommendations about the success factors for functional integration in order to inform policy and implementation.

Design

The study is an observational, descriptive study using both quantitative and qualitative methods and following a health systems research approach.

Methods

The report is based on a sample of eight joint facilities from across several sub-districts in the Metro. A survey questionnaire was used to record objective information on joint activities and interviews provided qualitative data about the experiences of facility managers. A focus group was done in a joint facility with functional integration. Documentation about joint facilities were also studied.

Findings

The main finding of this study is that joint facilities are not necessarily integrated facilities. Functional integration, where the management and core clinical functions of the two services are integrated, only occurs in the minority of cases. The case study of functional integration describes the areas of integrated functioning, benefits and problems and the key success factors.

The level of integration ranges across joint facilities, judging by the type and number of shared activities. In all the joint facilities studied, the building has a shared entrance, waiting room, record room and reception area. Although patient records are integrated through a single filing system, the rest of the patient administration, like the reception and admission service, is not always integrated. There are joint agreements on the sharing of resources, but these are not formally endorsed.

In most of the joint facilities, management systems are not integrated and a dual system operates where managers from both authorities manage the joint facility. Most of the joint facilities did not have integrated clinical service delivery. In only two of the eight joint facilities studied was there integration of both the management and the clinical service delivery.

The study recommends that for the implementation of functional integration to be successful, visible commitment from senior management is required. This should involve a high level of senior and sub-district management planning, monitoring and evaluation as well as active support and guidance of facility staff in the implementation. Staff participation in the planning, preparation and implementation enhances the chances of success. To promote functional integration, a single facility manager should be appointed. Such a person must have good managerial skills, especially to promote co-operative working relations amongst staff. Ongoing in-service training and mentoring are essential to promote crossover clinical functioning. Adequate staffing levels should be maintained in order to facilitate the process of training and crossover functioning.

Conclusion

This study confirms the findings of other studies on health restructuring and integration that planning, monitoring and evaluation are central to the success of any changes in the health system. It demonstrated the importance of consulting with frontline health workers and giving them the opportunity to make recommendations about how to deliver a comprehensive primary health care service in the absence of a formal district health system.

University of Cape Town

TABLE OF CONTENTS

<i>DECLARATION</i>	<i>i</i>
<i>ACKNOWLEDGEMENTS</i>	<i>ii</i>
<i>ABSTRACT</i>	<i>iii</i>
<i>TABLE OF CONTENTS</i>	<i>vi</i>
<i>CHAPTER 1: INTRODUCTION, BACKGROUND LITERATURE, STUDY AIMS</i>	<i>1</i>
Introduction	1
Background Literature	1
Study Aims and Objectives	16
<i>CHAPTER 2: METHODOLOGY: DESIGN AND METHODS</i>	<i>18</i>
Introduction	18
Defining 'joint facility'	18
Sampling	19
Methodological Phases: Design, Instrumentation and Analysis	20
<i>CHAPTER 3: FINDINGS</i>	<i>29</i>
The Functioning Of Joint Facilities	29
Case Study Of Functional Integration At A Joint PHC Facility	44
<i>CHAPTER 4: RECOMMENDATIONS AND CONCLUSION</i>	<i>54</i>
General	54
Planning	55
Facility Management	57
Operational and Staff Management	59
Communication	60
Training	60
Sub-District and Senior Management	61
Information Management	61
Consumer Issues	62
Conclusion	62
<i>BIBLIOGRAPHY</i>	<i>65</i>
<i>APPENDIX A: QUESTIONNAIRE</i>	<i>69</i>
<i>APPENDIX B: CONSENT FORM</i>	<i>74</i>
<i>APPENDIX C: QUANTITATIVE DATA FROM QUESTIONNAIRE</i>	<i>75</i>

CHAPTER 1: INTRODUCTION, BACKGROUND LITERATURE, STUDY AIMS

Introduction

Provincial and Local Government have been jointly involved in the delivery of primary health care services in South Africa for many years, although the focus of each sphere of government has been different and the delivery has taken place through separate management structures. More recently there has been closer co-operation, one example being the establishment of joint health facilities where both provincial and local government health services are delivered from a shared building. This study investigates the functioning of such joint facilities as they have achieved uneven results in terms of providing integrated, comprehensive primary health care. Chapter One of this report will describe primary health care (PHC) and district health systems (DHS), the main health sector reforms that provide the context in which joint facilities operate. Relevant literature on similar efforts at 'functional integration' will be examined and critical factors for success will be highlighted. Chapter Two describes the methodology used in this study. Chapter Three outlines the findings of the study, and describes the range of joint activities in joint facilities as well as providing a case study on functional integration. Chapter Four ends the report with recommendations about the success factors for functional integration.

Background Literature

The Primary Health Care Approach

According to Kutzin (1995), most countries in the world have experienced some form of health sector reform, largely as a result of economic pressures. Although health sector reform has varied across countries, the goals of reforms have mostly remained consistent, aimed at achieving improved health status and client satisfaction, improved efficiency and improved equity of access to care (Kutzin 1995). In January 1978, at the International Conference on Primary Health Care held in Alma Ata, Kazakhstan, Russia, there was a significant change in health sector reform which has been described as "a potential breakthrough in global health rights" (Werner & Sanders 1997, p. 18). Highly placed delegates from 134 nations supported the call for 'Health for All by the Year 2000' and they regarded the Primary Health Care approach as the main vehicle for achieving this goal. The conference delegates subscribed to

a broad definition of health as being “a state of complete physical, mental and social well being” and they outlined the principles and elements of the Primary Health Care approach in the Alma Ata Declaration. The following definition of Primary Health Care is found in the Alma Ata declaration:

Primary Health Care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self determination. It forms an integral part of both of the country’s health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process. (World Health Organisation 1978)

Many of the basic principles of the PHC approach are found in this rather ambitious definition. The model of health in PHC is a holistic one that includes social, educational and economic aspects of health. It further asserts that health care should be accessible, acceptable, appropriate and affordable.

In South Africa, health sector reform since 1994 has aimed to build a unified national health system that could address the inequities of the past and deliver better quality health care in a more efficient and cost-effective way. Part of this health sector reform is the adoption of the Primary Health Care approach. The White Paper on Transformation of Health in South Africa argues that to achieve this, the health service must be both integrated and comprehensive (National Department of Health 1997). The Primary Health Care approach aims for integrated, comprehensive and accessible care at the primary level, which is the first point of access to health services for communities.

District Health Systems

As part of broader governmental reforms, the new democratic government of South Africa adopted decentralization as a model for governance and management for the country. Decentralization implies a shift of power, authority and function away from the centre, towards peripheral or more local levels of governance and administration. The World Bank has regarded the decentralization of public health as an important step for improving efficiency and responding to local health needs (Pillay, McCoy & Asia 2001).

Within the health sector, the District Health System is considered the key mechanism for decentralization as well as the vehicle for the delivery of the primary health care approach.

The White Paper states:

The health system will focus on districts as the major locus of implementation and emphasise the primary health care approach (p.12).

The DHS has been defined as follows:

A DHS based on PHC is a more or less self-contained segment of the national health system. It comprises first and foremost a well-defined population living within a clearly delineated administrative and geographic area. It includes all the relevant health care activities in the area, whether government or otherwise (Tarimo 1991).

In 1995, a 'Policy for the Development of a District Health System for South Africa' was written as a framework for DHS (Owen 1995). The DHS policy aims to improve the quality of health services by improving effectiveness and efficiency and by promoting equity and sustainability. One of the key elements of the DHS model is *inter-sectoral collaboration* between government departments such as welfare, housing, water, and education as well as collaboration between government, non-governmental organizations and the private sector. A second key element is that of *local accountability* which includes community participation in health service decision making (Owen 1995). The DHS therefore aims for integrated planning at a local level that allows for flexibility to local health needs (McCoy & Engelbrecht 2000).

The District Health System is a model for the delivery of health services which aims for district-based management of the primary health care service in ways that will promote effectiveness and efficiency as well as flexibility to district health needs. In the DHS, the governance and management of public sector service delivery is decentralised to the district level which is meant to overcome fragmentation and inequity (Zwarenstein et al. 1993).

The Relationship between PHC and DHS

In order to formalize the marrying of PHC and DHS approaches, an inter-provincial District Health Systems Committee was formed in 1994. This was a sub-committee of the Provincial Health Restructuring Committee, chaired by the Director-General for Health and attended by the heads of provincial health departments. This DHS Committee, which still functions today, focuses on ways to implement district health systems in South Africa. The premise is that a DHS “will enable health services to move from the curative and fragmented approach... (of) the past, to a preventive, health and wellness-oriented approach” (Owen 1995, p.vi). These are also the aims of the Primary Health Care approach and therefore the DHS is considered to be the vehicle for the delivery of comprehensive primary health care.

The Primary Health Care approach and the DHS approach also share other principles including inter-sectoral collaboration, community participation and the focus on accessibility of management and services at the local level, hence the preference for the DHS as the structure for the delivery of PHC services. The DHS policy framework spells this out clearly: “The government structure at the district level... is the structure through which the basic package of Primary Health Care is delivered” (Owen 1995, p.vi).

A range of legislation and policy documents supports the DHS approach. These documents include the South African Constitution of 1996, the National Health Bill of 2001, a 1995 national policy on District Health Systems as well as several Provincial Health Acts. The 2001 draft of the National Health Bill, for example, outlines three options for governance of a district-based health service. In the first two options either the province or the local government governs all health services and in the third option, a statutory body, the District Health Authority, becomes the governing authority (National Department of Health 2001). Several sources indicate that the preferred option for governance of primary health care in a district health system is that of local government or municipal-based governance. The national Ministers of Local Government and of Health discussed the role of local government

in health and indicated a similar preference. In their February 2001 MinMec resolution, the ministers stated:

After conducting an audit of services provided in each municipality, the MEC for Health may delegate the delivery of PHC services to a Metropolitan or a District Council, or a local municipality, or a group of local municipalities, with the appropriate capacity, support and resources... (MinMec 2001).

In other words, where the capacity exists for local government to manage primary health care, they could be delegated the responsibility for governance of the services.

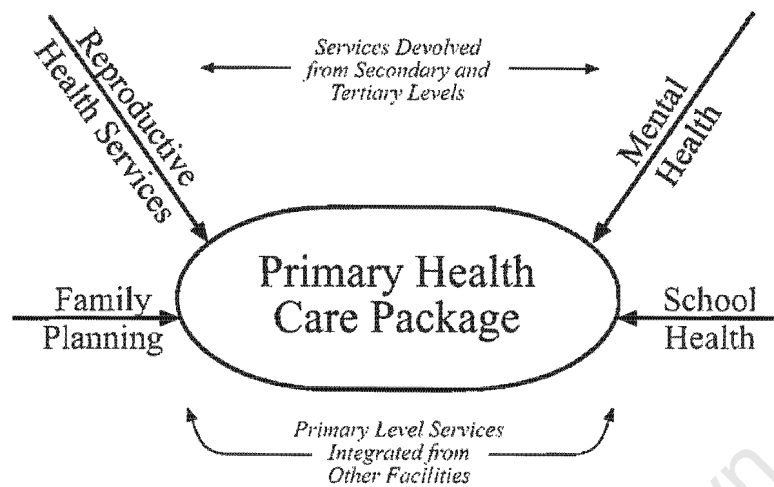
Integration of Primary Health Care Services

Implementing primary health care through a district health systems model involves several forms of integration and transformation. The literature indicates that there are a variety of meanings and uses of the term 'integration'. These include:

1. the vertical and horizontal integration of programs,
2. the organizational integration of PHC management and governance structures, and;
3. comprehensive service delivery (Schierhout & Fonn 1999).

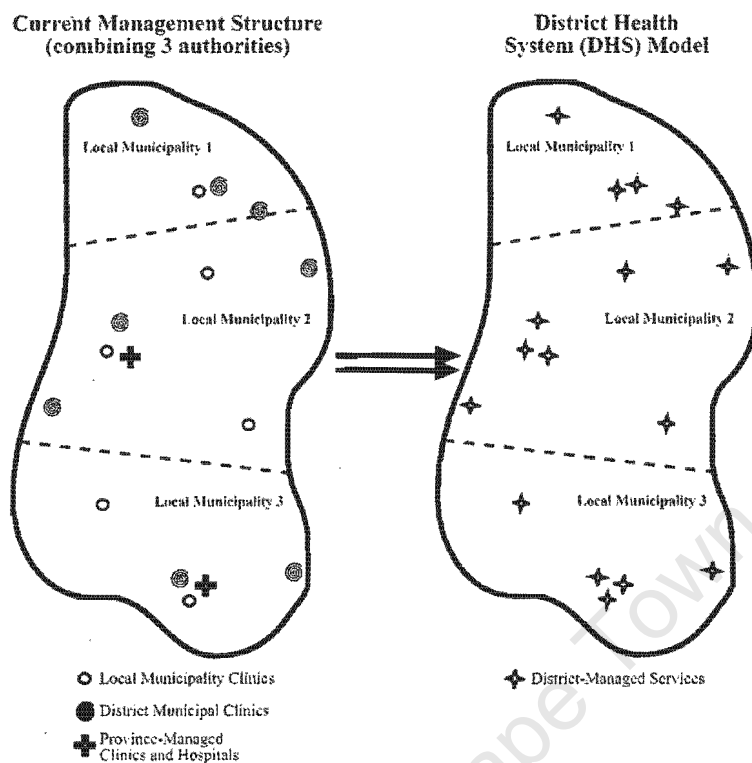
All of these types of integration would be required in a true district health systems model, but the most crucial would be the organizational integration of primary health care management and governance structures. Each of the three aspects of integration is elaborated on below.

Diagram 1: Vertical and Horizontal Integration of Programs in the Primary Health Care Package



Firstly to develop a comprehensive PHC package that offers a range of promotive, preventive, curative and rehabilitative health care requires the rationalization of health programs. For example, to deliver a comprehensive reproductive health service at a primary health care level, reproductive health services previously offered at secondary and tertiary levels (vertical) may now need to be devolved to the primary level. Those services offered in parallel (horizontal), like family planning, would also have to integrate at one service point at the primary level. This is referred to as vertical and horizontal integration of services to create an integrated, comprehensive service. This integration process is meant to allow for a broader range of services to be delivered at first contact. In the case of mental health (previously a vertical program offered from a hospital base), the service would now be offered at the primary care facility as part of an integrated, comprehensive service. The mental health nurse would transfer from the hospital to the clinic level in order to deliver this service, but the other primary health care nurses and doctors would also be expected to take on mental health work to promote integration of the service.

Diagram 2: Organisational Integration of PHC Management and Governance in a DHS



Secondly, and more crucial for DHS development, is the amalgamation of the actual health management and governance structures (also referred to as organizational or structural integration). This means that the multiple authorities managing primary care services would have to form one service, governed by one authority. As mentioned earlier, should the local government have the capacity to manage the services, this would be the preferred option. Local government in this case could be a local municipality, a district municipality (which is a combination of several smaller local municipalities) or a Metro municipality, which is a 'mega', urban municipality. For instance, in the Metro municipality (or 'Unicity') of Cape Town, it is planned that local government and the provincial primary health care services would amalgamate into one service which will be a municipal-based primary health care service, governed by the local authority.

Lastly, an "integrated" and comprehensive PHC service refers not only to the structure, but also to the model of health and service delivery. In this model, the health needs of the poor are "recognized and addressed in a coherent way" and "patients are treated as whole persons

with diverse needs” (Schierhout & Fonn 1999, p.34). This refers to the need for primary health care to treat patients holistically. The PHC approach to treating patients would therefore have to go beyond the ‘medical model’ towards a bio-psychosocial model that acknowledges the economic, socio-political and psychological causes of disease.

Organisational Integration and Functional Integration

There are different degrees of integration. The ultimate goal for a DHS is to have full organisational integration. Full organizational integration is only possible with appropriate and adequate legislation, health bills, district boundaries, financial resources and political agreement amongst stakeholders. Organizational integration would mean that there would be one governing authority for primary health care, be it provincial or local government and that personnel would be transferred to this authority. This is referred to as the ‘legal framework approach’ to organisational integration (Department of Health and Social Services 2000; ISDS Technical Report #5 1998).

Instead of waiting for the full legal and political framework of organisational integration to be in place, some health managers have taken a service-driven approach to integration of PHC services. This approach focuses on how to deliver a comprehensive PHC service, even in the absence of the legal and technical framework of a DHS (Department of Health and Social Services 2000). This is often referred to in the literature as ‘functional integration’ (Toomey 2000).

Ultimately, for a District Health System to function effectively and sustainably, the legal approach is required. The legal framework would ensure that there is single, integrated governance and management structure for the primary health care system and it would legislate the finance mechanisms to sustain the structure. In the absence of such a single, legislated structure, the service-driven approach can be a pragmatic response to a fragmented system.

In a service-driven approach, the political and legal pre-requisites for an amalgamated DHS are not finalized, but health management from both authorities seek out opportunities for co-operation. The service-driven approach could involve a wide spectrum of inter-organizational co-operation, ranging from senior management co-ordination to service-delivery integration

at a district and facility level (Department of Health and Social Services 2000; ISDS Technical Report #5 1998).

In the service-driven approach, the term 'functional integration' has been used to describe the strategy used to provide integrated primary care services in the absence of a single authority for PHC governance (Toomey 2000). In other words, where there are still multiple health authorities providing parallel, fragmented and often overlapping services, functional integration is an attempt to move towards a more comprehensive PHC service. Functional integration refers to key authorities involved in delivering primary health care services forming a structure and systems that allow for some degree of joint planning, implementation and monitoring of primary health care services, sharing resources and/or rationalizing services. In the absence of a single, legal framework, functional integration therefore seeks to integrate the services rather than the authorities. In this scenario, the health departments of the provincial authority, the district municipality and the local municipality, would work together to improve services in their district. Collectively, they would assess gaps, strategize and intervene to eliminate duplication and improve efficiency (ISDS Technical Report #5 1998; Toomey 2000). The aim of functional integration remains the same as for the DHS, to deliver an accessible, comprehensive district-based PHC service, but the method used to get there is different. However, it is important to remember that functional integration does anticipate a future legal framework in the form of a district health system so that integration in primary health care can be formalized and developed to its full potential.

Examples of Functional Integration

In most cases, across the country, multiple health authorities provide primary health care services. This involves mainly the provincial health department and the local authorities (or local municipalities) as well as a third authority, the district municipality. Previously, a semi-autonomous service, the district surgeons also provided primary health care, but this function is now integrated into provincial and local authority health services. These multiple sources of health services inevitably lead to the fragmentation and duplication of services. Adult and child services as well as curative and preventive services are split across these health authorities, which makes for an inefficient and ineffective primary health care service.

There are several examples of functional integration across the country where health authorities have developed structures and systems for co-operation. A well-documented case

study is that of the Albany district in Grahamstown in the Eastern Cape. Here three health authorities, the local authority (TLC), the provincial authority and the District Council worked together to improve the delivery of primary health care services. The integration of services at facility level formed part of the functional integration project in the Albany District. Staff from the provincial and the local authority clinics moved into one building, but continued to function separately until the functions of both clinics were integrated. This meant that the curative adult service of the province and the promotive/preventive service of the local authority were combined into a comprehensive 'one-stop' service. The aim was that multiple health needs (curative, preventive, adult and child) would be catered for at one primary health care site. So, for example, instead of splitting the treatment of chronic illnesses such as diabetes and the treatment of infectious diseases such as sexually transmitted disease, these services could now be offered at one facility. The same facility also provided mother and child health preventive services such as family planning and immunization, whereas before integration only the local authority offered this. Other initiatives included the integration of patient records and joint in-service training to support ongoing skills development for staff from both authorities. In this scenario, client access to a comprehensive service was greatly improved. The process of integration was not without problems though. Initially, combining the patient load of both services caused excessively long queues and this required the re-organisation of waiting room space and of patient flow. Management also had to address attitudinal problems, as nursing staff from different authorities did not easily accept direction from each other. Nor were they willing to accept the authority of the facility manager from another authority (Toomey 2000).

In another example, the Brakpan district on the Eastrand in Gauteng started functional integration of their fragmented services as early as 1994, before DHS and PHC integration became part of policy. Before restructuring, there were three different sources of primary care services in the Brakpan district: the provincially-run family planning service, the hospital out-patient curative service and the promotive and preventive services of local authority clinics. Members from the local authority, province and the hospital met regularly to work towards more rational service delivery in the district. A range of joint initiatives was implemented to address the problems of fragmentation and duplication that characterised the primary care service. For instance, two mobile clinics worked in parallel, visiting the same points on a daily basis, each with two professional nurses and two enrolled nurses. The one mobile offered a family planning service and the other a child health service. To rationalise and

optimise the service, the two authorities divided the mobile points between them instead of duplicating the service. To promote integration of service delivery, the local authority provided rent-free space in their clinics for province staff. In turn, province provided free drugs to allow local authority nurses to treat sick babies while provincial staff continued to treat adults. A joint transport and travel policy was also developed to cut costs on both sides (Health Systems Trust 2000).

In the Brakpan district, there are also examples of local government and province sharing one building to deliver a primary health care service. In these shared facilities, they aimed to have some form of functional integration by having a joint management system. Usually there was one facility manager appointed by one of the health authorities and the deputy facility manager appointed by the other authority (Health Systems Trust 2000). Another step towards functional integration, which is more commonly found, is collaboration between district management teams. The district or sub-district managers of both authorities form Integrated District Management Teams (IDMTS) and they use this joint forum to co-ordinate their service planning and management in the district.

Health Service Developments in the Western Cape, Metropole Region

In the Western Cape, as is the case in other provinces of South Africa, primary level health services are delivered in the main by two health authorities. In the Metro, the provincial health authority in charge of primary health care is called the Community Health Services Organization (CHSO). The CHSO has traditionally focussed on providing curative services for acute and chronic illnesses, mainly for adults and children over 6 years. These services are delivered from Community Health Centres, previously known as day hospitals. The local municipality or local authority (LA) has focussed on providing preventive and promotive services such as environmental health, immunization for children, family planning services and treatment of infectious disease such as tuberculosis (TB) and sexually transmitted infections (STI). The TB and STI treatment is delivered by the local authority on behalf of province with province providing the funds for this component of the local authority service. In places in the Metro the local authority also provides curative care to children under 13 years, thus blurring the lines between the two services even more.

This split in the delivery of primary care services makes the management and the delivery of comprehensive primary care difficult because of the fragmentation and duplication that

occurs. Managers of one authority cannot make decisions for the staff of the other authority. The result is fragmented planning. Similarly, lack of co-ordination of service causes fragmented service delivery. A patient with multiple health service needs may have to visit more than one facility to have these needs met. A woman with a history of hypertension, whose infant requires immunization, will have to visit two separate health services, for the baby and for herself. If she happens to have an infectious disease like TB or a sexually transmitted disease, she would still have to visit separate clinics as her chronic illness will be treated by the provincial clinic and the infectious illness at the local authority clinic. This is because adult 'curative' and 'preventive' services are split between the two authorities, with treatment of infectious disease being considered 'preventive'. The result is a non-comprehensive service, which is fragmented, inaccessible and costly for the patient in terms of travel cost, time and inconvenience. It is also costly for the health services due to duplication of resources and lack of continuity of care. In the DHS approach, one health authority will deliver all primary care services, thus addressing these problems of fragmentation and duplication.

In 1997 the Members of the Executive Council (MEC) of Health and of Local Government in the Western Cape met to establish a Bi-Ministerial Task Team (BiMTT) that would investigate the future governance of primary health care in the Western Cape. The task team acknowledged the duplication and inefficiencies in the parallel local and provincial PHC services and they recommended the integration of the two services. More specifically, they recommended that local government should govern the new integrated, municipal PHC service. A target date of July 2001 was set and legislation identified to implement the transfer of provincial staff to local authority (Department of Health and Social Services 2000). The implementation was, however, subject to political and legislative approval from the provincial cabinet.

Three years later, on 10 October 2001, the Western Cape Provincial Cabinet took an 'in-principle' decision to amalgamate the primary care services in the Metro into a single, municipal-based service that would be governed by the local authority (Western Cape Cabinet 2001). This decision is in line with the national level ministerial and political support for municipal governance of primary health care in a district health system. A similar decision for municipal governance of primary health care was expressed in a resolution

issued by a meeting between the provincial MECs and the Minister of Health in their MinMec resolution of February 2001 (MinMec Resolution 2001).

The local government election of December 2000 was an important enabling step towards a district health system. This is because there are two factors that affect district health systems development: health sector transformation and local government restructuring (Barron & Sankar 2001). It is a prerequisite for the DHS to have clearly delineated health districts with a manageable population size of between 50 000 and 500 000 people. These districts should be co-terminous with political and service delivery boundaries of the local and district municipalities in order to facilitate integrated planning and service delivery (National Department of Health 2001). A health district can consist of one or more local municipalities or a district municipality (which is a cluster of local municipalities) or a metro municipality. After the December 2000 local elections, the country was demarcated into 232 local municipalities (category B municipalities), 47 district municipalities (category C municipalities) and 6 Metro municipalities (category A municipalities). In the Western Cape Metro region, this meant the merging of several local authority municipalities into one mega-municipality or Unicity. The Unicity now forms a Metro or Category A municipality named 'The City of Cape Town' (CCT). Should the Cabinet decision be implemented and the two PHC services amalgamate, the City of Cape Town would then become the governing authority for this Metro health district.

Functional Integration in the Metro

Preceding this historic Western Cape Cabinet decision, there were (and still are) many efforts towards developing a district health system. One such example is in the Khayelitsha district where in the early 1990s, initial steps were taken to integrate the activities of the multiple health authorities in the area. In one site, the Nolungile local authority clinic and the adjacent provincial clinic were physically integrated and offered some clinically integrated services. In particular, the child curative services of the provincial clinic and the preventive services of the local authority merged and were then offered by one authority. Inter-sectoral collaboration with a community health worker, non-governmental project led to close co-operation between professional nurses and community health workers. Community participation was also encouraged through the establishment of a local health committee. However, researchers identified several problems that proved difficult to overcome and that eventually led to the suspension of formalized integration efforts. The problems included the

disjointed structure of the health service, hierarchical inter-professional communication, elitist attitudes towards non-professional staff and the lack of a client-centred approach. Poor referral systems and the lack of planning and evaluation skills necessary for an effective health district were further problems (Barron & Fisher 1993). Elsewhere in the City of Cape Town, interpersonal conflicts amongst staff from the different authorities have threatened to disrupt services in some integrated facilities. The lack of clarity around the joint management of these facilities and the disparity in conditions of service have been mentioned as some of the underlying reasons for the conflict (Personal communication with sub-district and senior management of CHSO and City of Cape Town).

On a Metro-wide level in Cape Town, there are various instances of co-operation and integration. Until recently, senior management from both authorities met every two months to address operational and strategic issues of mutual concern. This structure was replaced by a meeting that includes senior management and all the sub-district managers from both authorities, called the Joint Health Services Management meeting. Preceding this, the provincial service put in place an interim system of district managers to start managing the services on a district level in a similar way to local authorities. This enabled the formation of joint sub-district management teams between the provincial and the local authority. In some of the previous 11 sub-health districts (now 8 sub-districts), the district management teams had managed to form Integrated District Management Teams (IDMTs) to collaborate and to attempt co-ordination of the services by both authorities. However, the success of these collaborative efforts varies. In some sub-districts, collaboration efforts are absent or collapsing whilst in others it is doing well (CHSO 2001).

Functional integration efforts in the City of Cape Town, Metro region, are most evident and perhaps most contested at the facility level. More than half of the province's 47 health facilities are shared facilities with the local authority. In the absence of a legal framework for district health systems, attempts have been made to provide a comprehensive and integrated primary care service at facility level. This means that the provincial and local authority health authorities share a clinic building and try to combine and integrate their health services as if they were one service. However, the success of integration at these joint facilities varied widely. Whilst a few have attained a fair degree of functional integration of their management and services, there are also those joint facilities that experienced chronic conflict and a breakdown in the integration of services.

What Makes Integration Work

The integration of primary health care services is dependent on the establishment of a formal, legally framed District Health System. However, there are still many obstacles to the implementation of such a DHS. Barron and Fisher (1993), reporting on their work in Khayelitsha, identified three prerequisites for the development of district health systems. These were: the need for a final definition of municipal health services, the need for parity in conditions of service for the staff of both authorities and the need for local government capacity to manage primary health care services. The definition of 'municipal health services' is still not finalized in the latest draft of the National Health Bill of 2001. The issue of parity of conditions of service remains unresolved, due to the complexities of labour laws and the significant budgetary implications. For most of the country, except for the Metro municipalities, the building of local government capacity for managing primary health care will take many years, so organizational integration of PHC remains a long-term goal. In the Western Cape Metro region, where local government capacity does exist, the process of implementing a district health system has proved a complex one. The transfer of the service to local government has been delayed due to legal, financial and political impediments, some of which can only be resolved on a national level (Organisational Development Africa 2002).

Against this background, the focus of integration at the health facility level has not been on organizational integration, but on functional integration. There are few systematic studies that investigate the impact of the various types of functional integration of health services (Schierhout & Fonn 1999). Some lessons have been documented which point to a few of the success factors for integration. The lessons learnt relate to attempts to integrate vertical programmes such as family planning, into maternal and child health services at a PHC level. The following issues were highlighted: the need to do a local level needs assessment, the need for joint planning and budgeting, the need for clarity about staff roles and responsibilities, the need for appropriate training and supervision and the need for a coherent information and monitoring system (Mitchell 1994). Further lessons are highlighted by the Brakpan case study that pointed to the importance of good working relationships amongst staff from the different authorities. The Brakpan example also argued for a phased approach that could make integration more manageable at a facility level (Health Systems Trust 2000).

In a literature review on the effectiveness of implementing primary care services, several recommendations were made that echo the success factors mentioned above (Scierhout & Fonn 1999). The authors highlighted that effective training, supervision and record-keeping systems should support the integration process. The authors also suggested that the process and outcomes of integration be more closely studied and the lessons documented. More pertinently for this study, they recommended that participatory methods are used to involve health workers in making recommendations about what should happen on the ground in terms of comprehensive service delivery and integration (Schierhout & Fonn 1999).

In summary, this chapter examines the models of health sector reform (district health systems and primary health care) that provide the context in which joint facilities operate. The district health system is a model for the delivery of comprehensive, integrated primary health care. The chapter defines organizational integration as the production of a single management and governance structure for primary health care. It argues that organizational integration is required for a true district health system to develop and in the absence of this, functional integration should be the interim goal. Functional integration is defined as the strategy of providing comprehensive, integrated primary health care services in the current situation where multiple health authorities still exist. Examples of functional integration are given to illustrate efforts made by health management and staff to address the problems of fragmentation and duplication of primary health care services. This is followed by a focus on district health systems development and functional integration in the Metro region of the Western Cape. The chapter ends by reflecting on the prerequisites for successful integration on an organizational and functional level.

Study Aims and Objectives

The aim of the study is to describe the functioning of joint facilities in the Metropolitan area of the Western Cape Province.

The objectives are:

- To describe the range of levels of functional integration that exists in these joint facilities,
- To investigate more closely the functioning of a joint facility where there is functional integration, and;

- To identify the challenges, obstacles and critical success factors to functional integration and to make recommendations regarding the success factors for functional integration in joint facilities. These recommendations will assist health authorities in issues of policy, planning and implementation around joint facilities.

University of Cape Town

CHAPTER 2: METHODOLOGY: DESIGN AND METHODS

Introduction

The study is an observational, descriptive study that combines qualitative and quantitative methods. The primary sources of data consist of a structured survey questionnaire with quantitative and qualitative questions, interviews with facility managers and one focus group discussion. Additional sources of data included qualitative observations made during a visit to each facility, relevant health sector documentation and the researcher's involvement in district and facility management facilitation processes around joint facilities. The researcher did conflict resolution with one district management team, teambuilding with another and was party to discussions in meetings about the problems experienced by some joint facilities.

A Health Systems Research (HSR) framework is followed. This is an approach where applied research in health is closely linked to health service needs. The purpose is to improve functioning of the health system in order to improve health service delivery and consequently improved impact on health status (Katzenellenbogen et al. 1997). Elements of the HSR approach are employed in this research study. These elements include the way the research question was established, consultation with health managers about the process, understanding the context and using multiple research methods. The study also addresses the HSR concern for feeding back findings to health managers who can respond and follow-up with interventions (Health Systems Trust 1998).

Defining 'joint facility'

In this study the term 'joint facility' refers to a health facility where provincial and local government share one building with a view to offering a combined and ultimately functionally integrated service. There are several examples of such shared facilities in various provinces of South Africa. These facilities are sometimes referred to as 'integrated facilities', noting the intention to deliver a functionally integrated service. Using the term 'integrated facilities' as interchangeable with 'shared' and 'joint' facilities creates the erroneous impression that all shared facilities are automatically 'integrated' in their service delivery. This is, of course, not true, as there is a wide range of levels of integration of management and services in these shared facilities.

In this study the researcher uses the term 'joint facilities' to describe the facilities under investigation. Using the term 'joint facilities' means that there is no reference to the level of functional integration present in these facilities. 'Functional integration' in this study, will refer to the integration of management and core clinical functions in a joint facility where there are separate health authorities (Toomey 2000). The importance of using the more neutral term of 'joint facilities' will be explained under the section on **Methodology for data collection**.

This study used two criteria to determine if a particular facility qualified as a joint facility:

- The provincial and the local government primary health care services were located within a single, shared building. The building was not structured or partitioned in any way to indicate that there are two authorities delivering a service.
- The senior management of both authorities set up the joint facility with the intention that the shared facility would deliver a functionally integrated and comprehensive service.

Sampling

The study used purposive sampling, which is a qualitative research sampling method. This is a method (1) of choosing sites to cover a range of characteristics and/or (2) of targeting specific subgroups to represent important sectors of a population (Katzenellenbogen et al. 1997). In this case, the researcher wanted to describe what is typical. For this reason, different types of facilities, that is 8-hour, 24-hour and Midwife Obstetrics Units (MOU) or combinations of these, were included. Before the formation of the Unicity, Cape Town was divided into 5 different local municipalities or sub-structures. To ensure a range of these municipalities were included, the researcher selected facilities from most of the 5 different municipalities. This selection sought to allow a typical picture to emerge across the Metro as well as to ensure that most of the previous municipalities were represented. Lastly, the selection included joint facilities reputed to have a range of levels of functional integration, i.e. those that were functionally integrated and those that were not.

Ten sites were targeted out of a potential 26 that were eligible for inclusion, according to the criteria set out above. Of the 10 sites approached, nine (9) were finally included. The last one, the smallest site, where there is only one staff member from the local authority, could not be included for reasons of time. It was felt that excluding this site would not detract from the general picture that emerged during the data-gathering period.

One of the sites did not strictly fit the criteria of a 'joint facility' as stipulated above. It consists of two adjoining buildings, with separate entrances and a connecting thoroughfare for patients. Integrated service delivery had been piloted in this site and even though the piloting was halted, there were still elements of clinical integration, which will be described in this study. The findings will, however, concentrate only on the eight sites that strictly fit the criteria for a joint facility as set out above. This represents just under one-third (31%) of the total eligible sites, located in 4 of the 5 local municipalities (now called local administrations) in the Metro.

Two sites were actively excluded from the study. The 2 sites are among the largest of the joint facilities and the most complicated in terms of their efforts towards functional integration. The researcher was advised against including these sites in the research because of the problems they were experiencing and because conflict resolution between staff, management and unions was at a sensitive stage. Should the sites have been included in the study, it would have described in greater detail the problems experienced with functional integration in the bigger joint facilities. The exclusion of the sites does not, however, affect the validity of the findings based on the current sample.

Methodological Phases: Design, Instrumentation and Analysis

Phase 1: Study conceptualisation and ethics

The research question arose from the researcher's work with facility, district and senior managers in primary health care. Shared facilities are a widespread phenomena in the Metro and with varying levels of functional integration. Some of these shared facilities have ongoing conflict whilst others reportedly work well (Personal communication with sub-district managers and senior management of the City of Cape Town and CHSO).

The researcher decided to investigate how joint facilities work in practice, to describe the range of functional integration and to explore what makes the facilities work and what causes difficulties. Recommendations could be used to inform policy and planning around joint facilities. This is in line with the Health Systems Research focus on “finding implementable solutions to priority problems” (Katzenellenbogen et al. 1997, p.152).

A research proposal was written for the research project, which is in partial fulfilment of a Masters degree in Public Health. Permission was obtained from the UCT Faculty of Health Sciences where the researcher is registered for a Masters of Public Health. Written permission for the research was obtained from senior management from both health authorities at a joint management forum. Permission to contact facility managers was negotiated via the health sub-district managers and area managers.

Informed consent was obtained by asking facility managers to read and then sign the consent form. A brief explanation was given of the aims, target group and time required. It also stated that written permission was obtained and that a feedback report would be sent to each participating facility. The consent section noted the right to refuse participation without negative repercussions and the confidentiality of the data. Participants were assured that the identity of participants would be protected in reporting of information and only the researcher and her supervisor would see original data where facilities could be identified. Data was stored on a computer with a protected password. Space was provided for both managers to sign and date the consent form. A copy of the Consent form can be found in Appendix B.

Phase 2: Questionnaire design

The researcher met with a provincial health manager to develop the sampling frame and to generate initial questions for the study. A questionnaire with quantitative and qualitative sections was designed to capture the basic functioning of a joint facility in terms of logistical, managerial and service delivery aspects. The questionnaire used the ‘Clinic and CHC Manager’s Checklist’ as a guideline (National Department of Health 2000). The quantitative section was divided into 11 sections each with 1-6 questions requiring a ‘Yes’ or ‘No’ answer only. A copy of the Questionnaire is included as Appendix A.

The 11 sections are listed below.

- A. Types of services (e.g. 8- or 24-hour)

- B. Building (e.g. does the building have a single entrance and waiting room?)
- C. Communication (e.g. does the facility have one telephone system with the same contact number for the reception/exchange?)
- D. Transport (e.g. is the staff transport system separate?)
- E. Supplies and equipment (e.g. is each authority responsible for purchasing and maintaining of their own equipment?)
- F. Patient admission and flow (e.g. do you open separate files for patients of the two authorities?)
- G. Medication (e.g. does the pharmacy do all the dispensing for both authorities?)
- H. Clinical treatment (e.g. can a patient receive his/her LA and CHC service in one site? For example, can a patient receive his STI and hypertension treatment in one visit?)
- I. Recording and reporting of data (e.g. are your daily patient management statistics recorded separately for each authority?)
- J. Centre management (e.g. do you have separate facility management for each facility?)
- K. District management (e.g. do the area managers from both authorities visit the clinic together?)
- L. Community (e.g. were there consultations with the community structures regarding the joining of this facility?)

Each of the 11 sections also had a qualitative open-ended section, asking about how the current arrangements were working. At the end of the questionnaire, respondents were interviewed in more detail about their experiences. The questions included “what worked or did not work”, “what are the difficulties and achievements” and “what recommendations would you make based on your experience of a joint facility?”

Phase 3: Piloting of the questionnaire.

A first draft of the questionnaire was drawn up and piloted at one of the joint facilities. The piloting was meant to assess both the questionnaire and the method of administration. The researcher assessed the following areas:

- Is the Questionnaire comprehensive, understandable and inoffensive?
- Is the YES/NO option adequate for the answers?

- How effective is it to administer the questionnaire and do the interview with both facility managers at the same time?
- Is the allocated time of 90 minutes adequate and feasible?

On the whole the questionnaire was acceptable, but some improvements were made. For example, the integration of clinical functions was explored through a qualitative question in addition to specific illness areas listed in the questionnaire. An additional section on 'Community Involvement' was included to explore the relationship of the joint facility with community structures. To check for the consistency of answers, the researcher asked both managers to fill in the questionnaire separately and to fax through the completed questionnaire. The faxed answers correlated well with those recorded when the questionnaire was administered in the joint face-to-face interview. The managers commented that it was better to have a face-to-face session as it allowed for discussion. Doing the questionnaire and interview with both managers as well as a tour of the facility took between 90 and 120 minutes.

Phase 4: Methodology for data collection

To increase awareness and participation in the study, the researcher addressed a meeting of the provincial facility managers and the heads of health of the 5 municipalities to explain the study.

Once permission was obtained from the health authorities, the researcher obtained a list of all joint facilities and approached the district and facility managers in charge of the sites. (See **Sampling** for the process of selecting sites). District managers were contacted telephonically and by fax, informing them of the study and asking their co-operation and support for contacting the facility managers directly.

After this, the facility managers were contacted telephonically and the researcher explained the study and asked for their participation. It was important to ask both managers individually for their participation. This acknowledged the dual management system that was operating and it avoided impressions of favouritism on the part of the researcher. The researcher asked for both managers to be interviewed together for practical reasons and to ensure that both viewpoints were heard in the interview.

All of the selected facilities agreed to participate. In one case, the researcher adhered to a request from the district management to delay the interviews until the facility was more 'settled', following a difficult period in staff relations. In a few cases, the facility managers expressed reluctance to participate because they felt that their facility was not an integrated one. This reluctance faded when it was explained that the study was describing all types of shared facilities and not just the ones with functional integration. The explanation appeared to allay an apparent concern about being negatively judged for not having an integrated facility.

Of the 8 joint facilities, both managers were interviewed in 6 of the sites. In two of these cases, the managers were interviewed separately at their request. In the two remaining sites, the researcher was unable to secure an interview with the second manager due to practical and logistical constraints on their part.

Once both agreed to participate, an interview date was set two to three weeks in advance. The researcher then followed up with a fax confirming the appointment date, and also included the letter of permission and a one-page information and consent form.

Questionnaire and interviews

Data collection was done during a 3-month period, May to July 2001. At the interview, the researcher reintroduced the study, allowed for questions of clarification and asked both facility managers to sign the consent form.

The questionnaire was administered as part of an interview. Each participant was given a blank copy of the questionnaire to follow the questions. The researcher put the questions to the facility managers and filled in their responses on her own copy of the questionnaire. When the managers were unsure or disagreed about an answer, this was clarified and points of disagreements recorded. The questionnaire and interview with both facility managers present took around 90 minutes to complete. Where the managers were interviewed separately, the interviews were about one (1) hour each.

The questionnaire was structured to record responses for the bulk of the information via a checklist, which required ticking. The researcher chose not to use an audio recorder as the bulk of the responses could be ticked. Also, using a recorder was considered a potential

obstacle to participation in the study, especially where facility managers felt that they would be judged on the level of integration in their facilities. Qualitative information from the interviews was recorded in writing by noting down the key phrases, or where possible, whole sentences.

In the HSR approach, it is important to understand the context and environment in which the research is situated (Health Systems Trust 1998; Katzenellenbogen et al. 1997). Knowledge of the health system and of the expectations and sensitivities around joint facilities helped the researcher to approach the subject cautiously.

In any interview, both the researcher and the subject can introduce bias into the data. The researcher can be over sympathetic or unsympathetic to the topic or the interviewee. On the other hand, those being interviewed can present a skewed picture of things depending on their own agenda or the relationship to the researcher. This introduces problems of both reliability and validity into the research (Russell 2000). Therefore the study approach needed to be as neutral as possible so that participants did not feel obliged to present an exaggerated picture of the level of functional integration at their sites. The following steps were taken to address these potential problems.

- The researcher had to resolve her own expectations of the level of functional integration that is expected at joint facilities and aim to describe the actual functioning of these facilities objectively, as far as this was possible.
- The terms used in the study had to reflect this objective approach and therefore the term 'joint facility' and not 'integrated' facility was used to describe the sites.
- When recruiting participating facilities and during the interviews, the researcher reassured facility managers that the aim was to describe the actual situation with a view to making recommendations based on their experience, rather than judging how well they have functionally integrated.
- A non-judgmental approach is also reflected in the phrasing of the survey questions and the open-ended qualitative questions, for example, questions such as: "How are these arrangements working out?" and "What recommendations would you make?"
- Further more, a quantitative survey was done. The 11 categories in the checklist focused on objective and observable practices within the facility, e.g. whether there

was a single record system or not. This left little room for ambiguous responses or for disagreement.

- The researcher was also able to verify much of the information through taking a tour of the facility.

The researcher administered the questionnaire herself and this allowed her to clarify questions and answers as well as have participants interact with each other around the responses. With both managers present, there was opportunity for equal input and differing views.

Focus group

A focus group was conducted at a facility where functional integration was in place. The aim was to gain an in-depth understanding about how functional integration worked, including what the critical success factors and the challenges were. The focus group was conducted as a final phase of data collection, after all the facility manager interviews were done. The group consisted of four nursing staff. This included the Sister-in-Charge from the local authority and the Deputy Sister-in-Charge from the province as well as two more senior nurses, one from each authority. The interview was recorded and lasted 90 minutes. The interview was transcribed verbatim and the material was content analysed according to the main themes of the study. These included describing the level of functional integration, the challenges, the critical success factors and the recommendations. The findings are described in the form of a case study as well as incorporated into the overall findings and recommendations of the report.

One potential limiting factor is the fact that the focus group did not include more of the facility staff. This may have added a greater diversity of views on how staff were experiencing functional integration.

Tour of the facility

An additional source of information was a tour of the facility. Although this was not part of the original study design the tour proved most useful in concretising and verifying the information supplied by the facility managers. In all of the facilities, the facility management offered a tour of the site without being asked. This was usually done before or after the interview and took between 10 and 30 minutes.

Phase 5: Data management and data analysis

The data from the questionnaires and interviews was managed in two ways. The quantitative section of the questionnaire was fed into a spreadsheet from which descriptive statistics were derived. The vertical field recorded the name of each facility and the horizontal field covered the following headings as per the questionnaire: demographic information, building, communication, transport, supplies and equipment, patient admission and flow, medication, clinical treatment, recording and reporting of data, centre management, district management and community. The Yes/No responses to each question in the questionnaire were coded as 1 for Yes and 0 for No. Frequency analysis was done for each of these questions. Chart 1 on page 31 graphically displays twelve questions from the questionnaire that illustrate key areas of integration. The specific questions are: E1, F1, F4, H5, J2, G4, C4, K4, I1, I2 and L1. The key areas are: joint buildings, joint agreements, integrated reception, clinical integration management integration, integrated pharmacy, shared tearoom, meetings with IDMT, combined daily statistics, combined monthly report and community consultation. Chart 1 is discussed in the Findings section. Each facility was also scored for level of integration based on eleven of the twelve key areas of integration listed in Chart 1 (see Table 1 on pages 29-30). The table with the raw quantitative data can be found in Appendix C.

Qualitative information from the survey was collated to add value to the descriptive statistics. Data from the interviews were managed by drawing up a qualitative grid to capture information under initial headings that emerged. The headings used were: staff establishment and training, integrated service and management, district management and community role.

Qualitative data was studied and analysed. A thematic analysis was done according to the main questions around what worked well, what did not work well and what recommendations were being made.

Phase 6: Dissemination of results

Health Systems Research has an aim of providing useable, timely information for decision makers at all levels (Health Systems Trust 1998). The results of this study were intended to assist health management and planners to support, develop and understand the challenges of joint facilities trying to provide comprehensive health services. A technical report based on

this research was therefore submitted to senior management of both authorities in January 2002. This report focussed mainly on findings and recommendations.

The timing of research results is also important in HSR (Health Systems Trust 1998; Katzenellenbogen et al. 1997). At the time of completion of the research, a decision to amalgamate the primary health care services in the Metro had been made. The findings would therefore be directly relevant to managers in understanding and intervening in the problems of dual management in these facilities. HSR also questions whether the “answer will be heard” (Katzenellenbogen et al. 1997). The researcher works closely with the various levels of management and can therefore “have the answer heard” by decision-makers as well as assist them to respond to the recommendations.

A draft copy of the research report findings was sent to each of the participating facilities and participants had an opportunity to comment before the main report was finalized. The researcher also made herself available to give verbal presentations of the study to the relevant management forums.

The full research report is for academic purposes and will only be available on request. The researcher intends turning this report into a publishable article within 18 months of completion of the study.

CHAPTER 3: FINDINGS

The Functioning Of Joint Facilities

This chapter is divided into two sections. The first section describes the functioning of the joint facilities in terms of various areas of activity, showing to what extent there is functional integration in these facilities. The second section is an in-depth description of a joint facility where functional integration was clearly evident.

It is assumed that the objective of establishing joint facilities is to offer a comprehensive primary health care service. Combining the resources of the provincial and the local authority health services and housing them in one building is meant to help achieve this objective. This achievement can be measured by whether the joint facility is able to offer a functionally integrated service, which enables the facility to provide comprehensive care, despite being driven by two separate health authorities. In this study, 'functional integration' will refer to the integration of both the management and the clinical service delivery in a joint facility. 'Clinical integration' will refer to the integration of clinical services only.

Demographics

There are 26 joint facilities in the Metro area (personal communication with senior management of CHSO and unpublished internal CHSO and City of Cape Town reports). The sample of 8 joint facilities therefore represents nearly one-third (31%) of the total clinics forming the population and it covers a range of health sub-districts across the Metro. Although not a truly representative or random sample, the high sample number (relative to the population size) means that the findings in this report could be considered a reasonable reflection of the issues surrounding joint facilities in the Metro.

Table 1 below shows the type of joint facilities the overall integration score.

Table 1: Facility Location and Type

Facility	Type	Integration Score
A	8 Hour	50%
B	24 Hour	60%
C	8 Hour	20%
D	8 Hour + MOU (24 hour)	50%

E	8 Hour	100%
F	8 Hour	90%
G	8 Hour	30%
H	8 Hour	20%

General

The main finding is that joint facilities are not necessarily integrated facilities. In other words, the provincial and the local authority service may be offered in a shared building, but this does not mean that the service is managed or delivered in an integrated way. Where joint facilities did have functional integration of their management and core clinical work, this was more the exception than the rule.

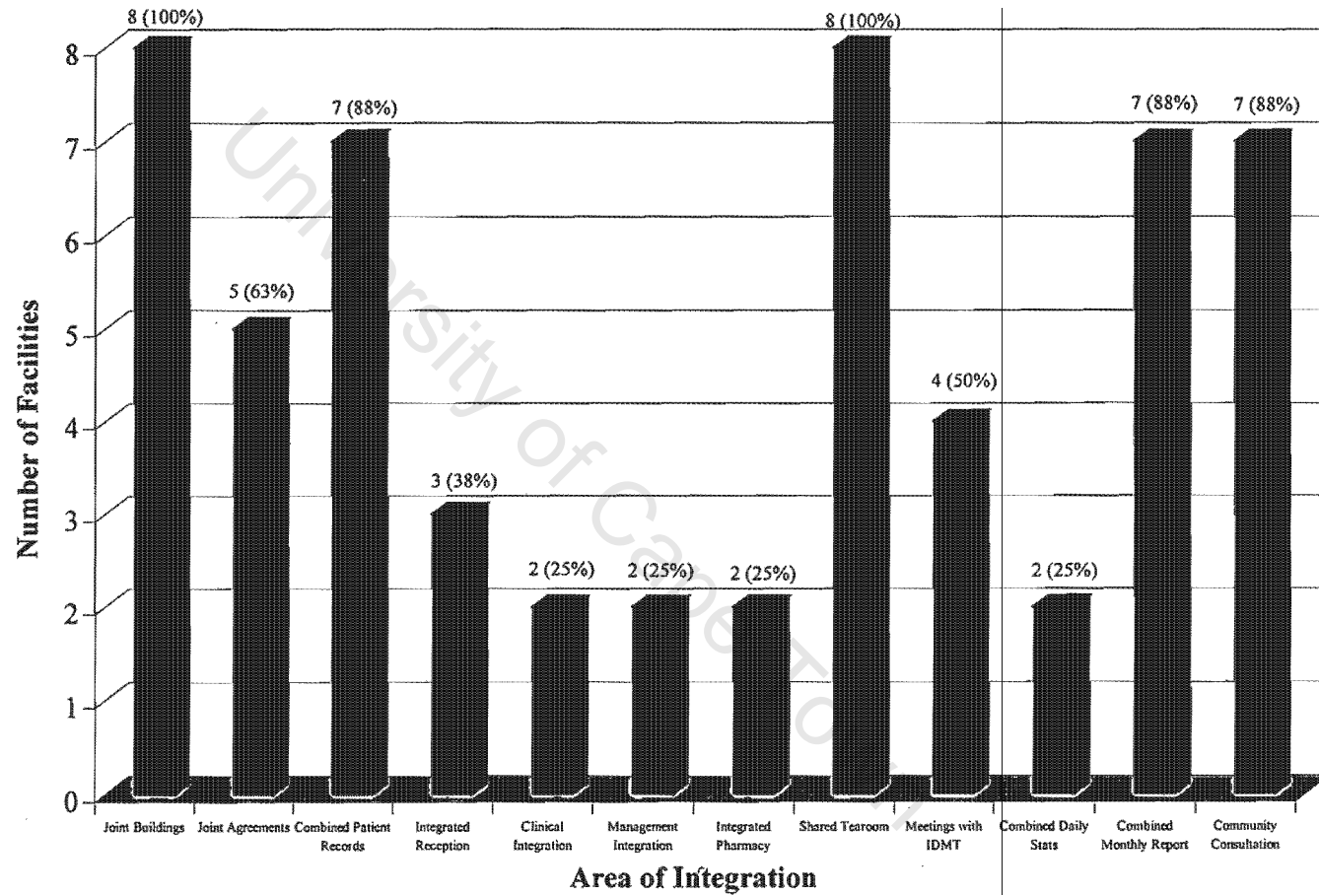
In this study, six of the eight facilities studied did not have functional integration. The facilities had different levels of trying to integrate their services and these will be termed 'joint activities' in this report. The joint activities are described below in terms of infrastructure, service delivery and management. Chart 1 displays many of the key areas of integration at joint facilities discussed below. The key areas identified are the following: joint buildings, joint agreements, combined patient records, integrated reception service, clinical integration, management integration, integrated pharmacy service, shared tea room, combined meetings with the IDMT, combined daily statistics, combined monthly reports and community consultation. The 'integration score' in Table 1 above is based on all of these key areas of integration except for community consultation. This table shows that two of the facilities scored highly for functional integration (facility E & F) and the rest ranged from between 20-60%.

Infrastructure

Building

All of the 8 facilities studied were in buildings that were built with the intention of using them as a joint facility. The earliest of these were established in 1995 and the most recent was completed in 2000. Some of the buildings were newly built for the purpose, whilst others required extensive renovation to accommodate both services. One of the two authorities owns the building and that authority is then responsible for maintenance of the structure.

Chart 1: Areas of Integration at Joint Facilities



The layouts of the joint facilities are fairly similar. At the very least, they all have a single entrance, a common general waiting room, a shared reception counter, a single record room and a shared tearoom. For most of the facilities, this is where the joint use of the building ends. For example, the patients still report to different reception windows for the different authorities and the staff from that authority then serves them. Also, the building is usually divided in such a way that the bulk of local authority and provincial services are done in separate parts of the building.

Joint Agreements

As illustrated in Chart 1, almost two-thirds (5 out of 8, or 63%) of the facilities had written agreements to guide the running of the joint facility. Although several such joint agreements were in use, the senior management of both authorities had not signed any of these agreements. The agreements were, in effect, implemented on the basis of goodwill only.

Although not signed, the joint agreements were the basis on which consumables, equipment and utilities were used in a joint facility. Joint agreements usually covered the following areas: medicines, consumable items, linen, furniture and equipment, utilities, maintenance of buildings, motor vehicles, record system, laboratory services, supervision of nursing and medical services, use of the building by outside organizations and security services.

The unsigned agreements were raised as a source of concern by most of the facility managers. They perceived the lack of official certification as senior management being reluctant to commit to integration at joint facilities. To date, no clear explanation had been given by senior management of province or the local authority as to why these agreements were not signed.

Telephones, Supplies and Equipment

At the time of the survey, all of the 8 joint facilities had a single telephone system. This meant that both authorities could be contacted via the same telephone number rather than two different contact numbers for the two authorities. This had not always been the case. In one facility, despite sharing the same building for years, the two authorities could not be reached via the same telephone number. They could also not transfer calls internally between the two authorities. To locate the correct health service, the clients often had to make more than one telephone call, using different telephone numbers. The separate telephone system also meant

that staff from the two authorities were not easily able to consult telephonically with each other or to transfer a client's call across two authorities. These problems were resolved with the eventual introduction of a single telephone system with one contact number for the joint facility.

Transport

Transport systems, such as the use of government cars for patient and staff transport, remained under the separate management of each authority. On the whole, this did not present problems for the joint facility as they could still transport each other's patients. This is done through completing an indemnity form to allow for the transport of passengers from the other authority. However, while both authorities could transport each other's patients as passengers, the indemnity did not equally apply to staff. As the indemnity from the province side did not extend to drivers, the local authority was not allowed to drive provincial authority cars. This became a problem as it limited their ability to deliver joint services such as home-visits. In one joint facility with functionally integrated services, the provincial district sister was performing both her own and the local authority home visits in an effort to have an integrated district-based health service.

Arrangements between the two authorities also require cost-sharing, but this became problematic if the staff of both authorities could not use the cars equally. To share the cost of petrol equally between the two authorities, the district nurse would use the local authority car on some days and the province car on others. The problem was that because the local authority staff were not indemnified to drive provincial cars, the local authority would be left without patient transport even when the province car was not in use. In this scenario it was clearly also inefficient to duplicate vehicles that were not optimally utilized.

Housekeeping

There appeared to be a fair degree of co-operation among the housekeeping or general assistant staff, even where there was little functional integration in the facility. The general assistants from both authorities made arrangements among themselves to divide the housekeeping tasks of cleaning and maintaining the inside of the building. There was only one example of general assistants dividing the building along the lines of separate authorities and cleaning only the section occupied by the authority that employed them.

Patient administration

Patient records

In all of the 8 joint facilities, there was one record room, which was shared. Chart 1 shows that in terms of combined patient records, all but one facility used a joint filing system where patient records from both authorities were combined. In other words, when a new patient registers, a standard file would be opened for him/her, irrespective of whether they required service from one or the other authority. If it is a baby that is registered, a local authority 'baby clinic' card is opened and merely inserted into the standard folder. This then ensures that there is a unified system for adults and children.

Reception service

In all of the joint facilities, the entrance hall, the main waiting and reception area and the record room were shared between the two authorities. In other words, all patients enter the building through a single entrance, they wait in the same waiting area and their records are stored in the same record room. However, the actual reception service itself was not always shared. In only 3 out of the 8 facilities (38%) was there an integrated reception service. For the rest, (5 out of 8), the personnel in reception did not work as a unit, but concentrated mainly on serving the patients from the authority which employed them. For example, the provincial clerk would serve provincial patients and the local authority clerk the local authority patients.

The facility managers noted that patients were aware that there were different services on offer when they reported to the reception. Those patients seeking a service for their babies would report to the 'baby clinic' hatch and put their cards in a clearly marked box. However, if one was seeking an adult service, the distinction at reception was less clear. For example, new patients seeking tuberculosis (TB) or sexually transmitted infection (STI) treatment would first report to the provincial adult service for an initial diagnosis, even though the follow-up to TB and STI treatment was a local authority service. They are then referred to the local authority service for TB and STI follow-up treatment, for which they have to report to the local authority hatch at reception.

Clinical services

In the majority (75%) of joint facilities (6 out of 8), the patient assessment, preparation, treatment and medication was carried out separately for the two health services. There was little crossover of staff or of functions between the authorities within these joint facilities.

Two of the 8 facilities studied (25%), had gone some way towards integrating their core clinical functions. Although these facilities did not constitute a fully clinically integrated service, they came closest to what an amalgamated service could look like, given that it was still managed by two different authorities. For the purpose of this study, these two joint facilities will be described as 'integrated facilities'. The details of the functional integration at these facilities will be described in the case study section.

Parallel services

The parallel or non-integrated clinical services were run in the following way. The provincial service usually had one or more full-time doctors on their staff. The local authority service used sessional doctors for a weekly tuberculosis and sexually transmitted infection treatment slot. Both the provincial and the local authority services had clinical nurse practitioners (CNPs) on their staff. On the provincial side, the doctors did the bulk of patient diagnosis and treatment, with nurses doing patient preparation, injections and dressings. In the local authority service, however, the clinical nurse practitioner did the diagnosis and treatment of sick babies. Local authority nurses also did immunization, family planning, tuberculosis and sexually transmitted infection treatment. Formally, there is little crossover of staff or functions.

Cross-over functions

Although the clinical treatment of patients remained largely separated in these six of the eight joint facilities, there was, to varying degrees, efforts to share some of the clinical functions. The extent to which the service divisions were crossed differed among the facilities. One example of crossover is when the province nurses did dressings and injections for all patients, irrespective of whether it was a province or local authority patient. In one facility, the clinical nurse practitioner regularly consulted with the province doctor. She would seek a second opinion on a sick baby or refer an adult patient to the provincial doctor. In another facility, the local authority nurses occasionally did adult curative work on the provincial side,

to reduce the doctor's patient load, but this would be a purely voluntary effort on the part of the local authority nurses.

Staff sharing

More active attempts at co-operation were happening where managers from both sides provided staff to relieve in times of staff shortages. In one facility, the province service regularly provided a staff member to assist the local authority service with their staff shortage in their family planning service. Whilst this was an example of active co-operation towards clinical integration, it highlighted another dilemma facing joint facilities. When releasing a staff member to assist with services on the local authority side, this in turn put strain on the provincial services. However, failing to assist also has negative implications for the health service as a whole. The province facility manager explained that if they ignored the staff shortage on the local authority side and the clients did not receive a satisfactory family planning service, these same clients could be returning to the provincial service with complications such as teenage pregnancies, termination of pregnancies or with sexually transmitted infections or even HIV/AIDS. This situation demonstrated how important it was to have a shared vision of the service and how interdependent the two authorities are in trying to deliver an integrated, comprehensive health service. However, although helping out seemed the sensible thing to do in this situation, it also became a source of conflict. In this case, resentment set in when one authority had to relieve for the other on a regular basis.

There were other forms of informal co-operation between the staff of both services, but these also sometimes lead to tension. In one facility, the provincial manager complained that the provincial service was expected to do pap smears (for cervical cancer screening) while local authority staff were trained and had the time to perform this service themselves. On the other side, some local authority staff complained that they had difficulty accessing provincial doctors within the same facility. This difficulty was particularly acute in the mornings when the bulk of the local authority and the province patients were being seen and doctors were unavailable due to their heavy patient loads.

Pharmacy and medicines

All of the facilities sampled had pharmacies of their own and all had at least one pharmacist in attendance as well as a pharmacy assistant. The pharmacy staffs were provincial employees and the pharmacy service was provided by province.

A partially integrated service

The pharmacy service in most of the facilities (6 out of 8) was not an integrated service in that it did not serve the same function for both the health authorities. As a rule, in the provincial community health centres (CHCs) the pharmacy dispensed all of the medication required for patients, usually on prescription from the doctor. Provincial nurses did not dispense medication from their rooms. By contrast, in the local authority clinics, nurses dispensed a limited range of medication from their consulting rooms. In joint facilities this scenario was not much different. The pharmacy dispensed largely for the provincial service and local authority nurses dispensed from their rooms. The main difference in the joint facilities was that the pharmacy would dispense for a small portion of local authority clients as well. The pharmacy also sometimes replenished the local authority medicines when they ran out of stock of specific drugs like medication for sexually transmitted infections.

The main reason given for this dual system of dispensing at integrated facilities is that pharmacies were too overloaded to take on a full local authority service as well. Given that most of the provincial pharmacy services have staff shortages and long waiting times for patients, this seems reasonable. It is difficult to imagine how the pharmacy would manage an expansion of their services in a joint facility, without an increase in resources as well as a restructuring of the service delivery and the financial arrangements. Another reason given for maintaining the system is that the local authority practice of dispensing from the consultation room was much more beneficial to patients. Patients then got a quicker, one-stop service from the nurse's consultation room.

Even in the two facilities with functional integration, where the pharmacy was largely integrated, nurses still provided a limited dispensing service from their consultation rooms. This dual situation appeared to work well in that mothers and babies did not have to queue for medication and the pharmacist's load was not unduly increased.

"Borrowing" of medication

In some facilities, there was flexibility around access to the pharmacy stock. The local authority service was able to "borrow" certain medications that they had run out of in their consultation rooms. However, since the arrangement was not formalized, the borrowing was not controlled and sometimes caused problems. In at least one facility, informal accessing of

medication from the pharmacy reportedly contributed to the provincial pharmacy budget being significantly overspent for that year.

Integrated pharmacy service

It is worth mentioning that there was one integrated pharmacy service in the Metro region. Although not part of the sample of 8 joint facilities, this facility was studied because it was a unique case of where the pharmacy service was integrated, but not the rest of the services between the two authorities. The facility could be described as a 'semi-joint' facility because the two services were housed in separate buildings, joined together by a corridor, which acts as a thoroughfare for patients. Functional integration had been piloted at this site a few years back, but after a while the integration efforts stopped due to a number of difficulties. However, some of the efforts at integration were still evident. For example, the local authority clinic had extended their services to provide a curative service for children under 6 years. As part of this service, they had employed a pharmacist. When the neighbouring provincial health service could not find a replacement pharmacist, they negotiated for the local authority pharmacist to be in charge of the provincial pharmacy, in exchange for the pharmacy serving both patient populations. So whilst the province provided the pharmacy service, including the pharmacy stock, the local authority employed the pharmacist and one of the pharmacy assistants to work in the pharmacy. The effect of this was that in the local authority clinic, the nurses did not dispense from their rooms like in other local authority clinics, but instead referred their clients to the pharmacy next door. Patients from both the provincial and the local authority services, child and adult, were therefore all served by the one pharmacy. Local authority employed sessional doctors and a pharmacist especially for this purpose.

The effectiveness of this system was not explored. It is not known if the integrated service is able to offer a better service to all patients from both services or whether all patients, including mothers with babies, now have to wait equally long at the pharmacy.

Facility management

The standard joint agreements referred to earlier, did not address how and by whom the joint facility would be managed. In practice, different models were used across the various joint facilities. These are described below.

Dual or parallel management

In most of the 8 joint facilities (6/8), there was a system of dual or parallel management. The provincial and the local authority service each had a facility manager and a deputy facility manager who was responsible only for their own service and staff. Only in 2 cases (25%) was there some form of integration of the management of the facility.

Single facility manager, semi-formal

In one of the facilities with integrated clinical services, there was a single facility manager who held this position informally. In this case, the province and the local authority facility manager had agreed to focus on what they each did best. With the support of the sub-district management and the facility staff, the two managers arranged that one of them would fulfil the managerial role for both services, whilst the other would act as deputy. This allowed the deputy to be more involved with her clinical work, which she loved to do. The facility manager did the operational, administrative and staff management for both services. She shared these tasks with her deputy, so in effect, they acted as a joint management team.

Single facility manager, formal

In another facility where an integrated service was offered, there was a single facility manager who was employed by one of the authorities. This was a formalized position in that this specific joint agreement made provision for a single manager. The present incumbent had had to formally apply for the post. Although the local authority employed her, both authorities formally accepted her as the facility manager and she was expected to manage both services, including administrative matters relating to personnel.

In general, the degree of co-operation and integration within the joint facility was mainly left to the facility managers. The facility managers were the ones who decided whether there would be any joint activities beyond the minimum of administrative services or whether there would be any form of joint management or any crossover in service delivery. Some facility managers shared an office and this was usually only when they chose to do so. Apart from the two functionally integrated facilities, only two of the other joint facilities had a shared management office. It should be noted that where the facility managers shared an office, there also appeared to be more efforts towards functional integration.

Staff management

Staff management was reported as one of the key challenges in attempting functional integration. Correspondingly, when examining staff management issues, the study revealed how much or how little functional integration was happening in a particular facility. The following comments pertain to six of the eight joint facilities where there is little or no functional integration.

Utilization of staff/Line management

There was usually a system of dual or parallel line management where each Sister -in-Charge was responsible for the line management of the nurses from their own authority. Staff utilization and staff rotation within the facility remained along the lines of a parallel service. In times of shortages or absenteeism, both authorities would draw staff from their own authority, elsewhere in the health sub-district. In other words, staff within the same facility were not utilized as relief staff between the two health authorities.

Training

Facility managers generally agreed that functional integration could only happen if all staff were trained in all the functions of both services. In practice, however, staff training remained a separate activity for the two authorities. Joint training on core clinical skills such as Integrated Management of Childhood Illnesses (IMCI) training was the exception, rather than the rule. Usually the training was offered outside of the facility and each authority only sent their staff to the training relevant for their service, e.g. local authority nurses go on TB training and province nurse go on trauma training. This makes it difficult for staff to acquire crossover skills that will enable them to perform a comprehensive service. It is also a missed opportunity for team building.

All the facility managers (even those in functionally integrated service) noted the negative effect that low staffing levels had on integration. They indicated that inadequate staffing levels made it hard to release staff from their normal duties to spend time learning new skills in the other service. Opportunities for crossover functioning therefore became more limited when both or one of the two services were short staffed.

Communication & Team building

Regular, formal communication between staff of the two authorities and team building efforts were few and far between. Despite working in the same building, there was an absence of joint facility management and joint staff meetings between the two authorities. Occasionally, formal meetings would be called to discuss an operational matter of mutual concern or to address conflicts that arose from sharing a building and working in parallel.

Informal communication was more common and this largely centred on tea and lunch times. The tearoom was a shared room in all of the joint facilities and it was also the main area of informal contact. The way that the tearoom was laid out and utilized often reflected the degree to which the facility was trying to integrate. This room was usually jointly furnished. For example, one facility would provide the tables and chairs and another the refrigerator. Tea and lunch breaks were staggered to ensure that staff from the two authorities were able to meet. In one of the joint facilities the tea breaks were not staggered and staff did not have this opportunity for informal interaction. Interestingly, in this same facility there were two refrigerators in the tearoom, one for each authority, reflecting how separately the two authorities were functioning in this facility.

Decisions about how to share the consumables such as tea, coffee, milk and sugar were usually taken jointly. Staff would usually work out a system that benefited both parties such as using the better quality coffee from the one authority and the fresh rather than powder milk from the other. Although this appeared to work well in most instances, sometimes conflicts arose. For example, it was difficult for the facility management to ensure that both parties stuck to the rules about how to utilize the consumables when the line management was separate and joint decisions could not easily be enforced.

In the absence of formal meetings, the tearoom became the only place where staff could consult each other on clinical matters. It would be in the tearoom where they discussed their daily work with each other, sought second opinions from one another and made informal referrals between the two authorities. There were few team-building activities between the staff of both authorities at these facilities. Social events like birthdays or the Christmas party were sometimes used as an opportunity for the staff to socialize.

Dispute resolution

There was no formal mechanism for resolving disputes between the staffs of the two authorities in the 6 facilities that were not integrated. This made it difficult to deal with conflict that arose between staff of the two authorities, especially in the absence of regular joint staff meetings. This meant that small problems could easily escalate into bigger ones before the facility management was able to intervene to resolve matters.

Sub-District management and support

In the majority of the facilities (6 out of 8 facilities) examined, the facility managers were expected to report to their seniors about their efforts towards integration at the facility level. Facility managers were sometimes expected to include this in their formal monthly report. The requirement to report on integration was not equal for both authorities, as not all the province facility managers were expected to report on integration. In other words, in such a facility, there was not an equal focus from both authorities, on the need to report on progress towards integration.

Sub-district management teams in each of the authorities were overseeing the joint facilities. The two sub-district management teams in a sub-district usually worked together as an integrated district management team (IDMT), but the success of these IDMTs varied across the sub-districts. Despite being part of an integrated sub-district management team, managers still had their separate line accountability for services and staff of their own authority. So, for instance, the local authority sub-district manager supervised the local authority facility manager. Similarly, the province sub-district manager supervised the province facility manager. Very seldom was there any co-ordination of these activities. This created potential difficulties for joint facilities. For example, they sometimes received mixed messages and contradicting advice from the two sub-district managers. On the odd occasion, joint meetings were held between the sub-district management of both authorities and the full staff of a joint facility.

Information management

In the majority of cases the joint facilities (6 out of 8) recorded their daily service data separately, although both authorities used a revised Routine Monthly Report (RMR) that makes allowance for joint daily recording. Although their daily statistics were usually

recorded separately, most of these facilities (7 out of 8, or 88%) did submit a joint monthly report that combined the statistics of both the authorities.

The monthly reports follow different paths for different authorities. For example, the local authority data go to the local district health officer, whilst the province data go to the CHSO central office in Woodstock and then to the provincial Head Office. This complicated process makes the co-ordination and validation of the data difficult. It is not unusual for joint facility data to be inconsistent and confusing (personal communication in senior management meetings of both authorities). The data gathered was seldom used for joint reflection and planning at a facility level.

In the two instances (25%) where there was clinical integration, the routine service data was completely integrated using the revised RMR. The data could not easily be dis-aggregated to reflect the separate service loads of each authority. Again, because of different requirements for data, the joint service data posed problems for the two different authorities. For instance, one or both authorities still wanted to monitor their part of the services separately, even when the clinical service was functionally integrated.

Consumer issues

In all except one of the cases studied, the community was consulted via a local health committee about the process of establishing a joint facility. There appeared to be an appreciation for and openness to community participation on the part of the facility managers in joint facilities. Each of the joint facilities had either attended in the past or was still attending their local community health committee meetings, even though some of these committees were small or inactive.

There was no formal mechanism for managing patient complaints in a joint facility. One facility manager noted that this was frustrating for patients who did not know who to lodge their complaints with. For example, a patient would ask to speak to the Sister-in-Charge to lay a complaint, only to be told that he/she was speaking to the wrong Sister-in-Charge. In one facility, despite the lack of functional integration, the two facility managers agreed on a joint method of dealing with patient complaints.

Case Study Of Functional Integration At A Joint PHC Facility

This case study was based on data from a survey questionnaire on integration, an interview with two members of the facility management and a focus group discussion with four members, two from each authority (facility manager, acting deputy and two nurses). The facility is a medium size, eight-hour facility with a joint staff of approximately twenty, including one full-time and one part-time medical officer.

The joint facility was newly established in 1997 when both the provincial and the local authority needed to upgrade their separate clinics. The senior management of the provincial health service and of the local authority health service agreed to build a single facility to accommodate both services. The objective was for the two health authorities to join together in order to offer a comprehensive service in an integrated way.

Planning and preparation

Senior and district management promoted integration as part of preparing for a district health system where comprehensive primary health care services would be offered. They were active in the planning and preparation, but less so with the implementation of the integration of the facility. Preliminary steps involved a needs assessment and several preparatory workshops, including one on the *Batho Pele* principles of client-centred service. After moving into the new building, staff at first worked separately, with separate facility management and then gradually integrated the service.

“For 3 months we worked separately to see how it works. Then slowly we started to buddy each other. But to do full integration it was about a year, because it took time to train staff.”

The facility managers noted that they needed support in the planning and implementation of integration. Support and guidance from their immediate supervisors in the sub-district management team was regarded as particularly important for the success of integration.

Facility management

After a few months in the same building, a process of review resulted in the staff from both authorities electing to have a single facility manager. The deputy facility manager was then

appointed from the other authority. The two facility managers at the time agreed between themselves, that the local authority Sister-in-charge would be the facility manager and the provincial Sister-in-charge would be the deputy. The decision was based on the skills and preference of the two nursing sisters, the one being more administratively skilled and the other more clinically skilled. This allowed both to do what they were good at and what they enjoyed most. Staff from both authorities were consulted and they agreed to the arrangement.

The group highlighted the importance of having one facility manager in charge of the facility.

“Why it also worked...there was not an ‘In-charge’ of province and one of local authority. [Before] province people complained to province and local authority to local authority and so, in the end, you don’t know who is saying what, [and] then there are clashes. So we voted for one facility manager, so everyone’s complaints came to one person.”

The facility manager, who was from the local authority, was largely responsible for management, with only 5% of her duties being clinical. She was responsible for all the administrative and staff management matters pertaining to the facility. The facility manager took responsibility for doing duty rosters, daily rotation and staff leave for the combined staff although the task could also be delegated. For example, duty rosters and other tasks like ordering supplies for both the services were rotated monthly with the deputy facility manager. Administration tasks were also delegated to other staff when necessary. The facility manager stressed the importance of having a good working relationship between the managers.

“Integration can only work if the two Sisters-in-charge understand each other. We were big enough to say, she was a practical person and hundred percent good at her work. I am more for admin...so we complemented each other. If we two did not have that understanding...never [would integration have worked].”

Staff meetings are held at least once a month where information from both authorities is shared. The meeting deals with operational functioning and addresses problems, including difficulties around integration.

Key elements of planning, preparation and management are:

- *Senior, middle and facility level involvement in planning is essential.*
- *The integration process was phased in, with an initial period of working separately.*
- *There was a process of preparation, which involved needs assessments and client-centred training.*
- *There was allowance for ongoing review of the process.*
- *There was one facility manager in charge of both services.*
- *The facility manager and the deputy had good working relationships.*

Service delivery/operational functioning

The facility officially opened at 07.30 when the provincial staff came on duty and closed at 17.15 when the LA staff went off duty. One of the province nurses who usually starts early, would open at 06.30 and start the sorting and preparation of patients. Baby cards were taken out and babies weighed while the patients are waiting for the local authority staff to start at 08.15. Province nurses would see tuberculosis patients who need an early morning injection so that they did not have to wait for the local authority staff to arrive.

Nurses from both authorities perform services that have traditionally been performed by one or the other service. As the facility manager puts it:

“Everything here is shared, there is nothing that is exclusive to one service.”

Listed below are examples of service integration in the facility.

- Local authority nurses worked in the preparation room and did dressings and injections.
- A province nurse who had been doing a primary paediatrics course worked primarily with babies.
- Local authority nurses worked in the emergency room, especially after 16.00 when the province staff left.

- Province nurses did family planning and nutrition services.
- A clinical nurse practitioner from LA shared the adult curative load of the provincial doctors.
- The district nurse from province included the local authority home-based services in her work, for example recalling patients for immunization and TB treatment.
- Local authority nurses helped out in the pharmacy when needed.
- Local authority provided the X-ray service, but made the service available for all the patients.
- The provincial mental health nurse referred stable mental health patients to be treated by both provincial and local authority primary health care nurses.
- A local authority nurse-counsellor saw patients for HIV counselling who were referred from both local authority and province staff.
- Province and local authority staff jointly provided the termination of pregnancy (TOP) counselling and referral service.
- Although the TB service had a dedicated local authority staff member, she was in the process of training an assistant who is a province nurse.
- In the reception and house keeping section, the staff worked as a team.

Staff utilization

The facility manager did the weekly or monthly duty allocations, allowing most staff members to work at most of the workstations. This was then rotated every 6 months. Apart from most of the staff being able to perform most of the functions, there was also crossover in duties in the course of the day, as the need arose. “Helping out” and getting the work done for the benefit of the patients was a strong theme amongst the staff. One participant gave an example:

“In family planning, if you are done with your patients, then you must help out elsewhere.”

Training

The group felt that training was a critical element in the process of integration. Nursing staff should be trained to perform all the clinical duties required in the health facility. This may require “bending” of admission criteria to ensure that staff attended each other’s courses.

Training was guided by the SWOT needs analysis that was done during the preparation phase. Another important tool was the 'buddy system', which was a form of skills sharing, used for on-the-job training. A nurse explained:

“You start with a buddy system. The province nurse teaches the local authority nurse to do dressings because her [the LA nurse's] turn will come to work in the dressing room. Then the province nurse moves elsewhere [in the facility].”

The group noted that training and opportunity to practice new skills appeared to change negative attitudes towards integration into positive and enthusiastic attitudes. It also contributed to the “paradigm shift” that is required to integrate a system that is doctor-driven towards one that is more nurse-driven.

Communication and team work

Participants stressed the importance of staff getting along with one another and working as a team. Team spirit included the willingness to “help each other out”. Asked what enables staff to be so flexible and co-operative, members responded in a similar fashion:

“Team work, good working relationships we have with each other. Lots to do with personalities also...Do they get along with each other? Can they work in a team?...”

Keeping the focus on the needs of patients also motivates staff to co-operate “for the sake of the patient”.

“If you don't have work in your room, you go and look for work somewhere else.... It is also to reduce the waiting time for the patient.”

One participant pointed out that peer pressure helps to make everybody pull his or her weight because if one person does not work, the others have to work harder.

“You help out because everybody wants to leave at the end of the day. For instance, if I didn't have work, I'll go to learn how to fill in the register with babies or do the TB totals.”

The team spirit illustrated by these quotes, was according to the facility manager, built through a 'buddy system'. Staff were proud to teach their work to one another and they became friends in the process. It was particularly important to involve those who were more negative as their participation was important for success. There was regular social contact through the staggered tea and lunchtimes. Friday lunchtime was reserved for the whole team to get together. Social events such as birthday celebrations are held on Fridays. A 'kitty' was started to cater for birthdays and parties, but this was not maintained.

Conflict resolution

There are several ways in which conflict was managed in the facility. Perhaps the most important way was that conflict was prevented and reduced due to the good working relationships and ongoing team building. The teamwork between the facility manager and deputy had been particularly important in unifying staff. The facility manager had an open-door policy, maintained strict confidentiality and applied rules and regulations even-handedly. She noted that she particularly guarded against staff attitudes of superiority of one service over the other. For instance, the local authority staff might have negative perceptions of the nursing scope of the province nurses and the province nurses similarly of the local authority nurses. The facility manager tried to limit the negative effects of such perceptions and she used crossover training to dispel these negative perceptions. She also tried to involve those staff that appeared to be negative about integration, by allowing them to express their reservations and by valuing their opinions on how to improve the situation. The facility had drawn up a document that highlighted the lessons learnt in the process of integrating the facility. On the issue of conflict management, the document pointed to the need to be proactive in dealing with conflict and not to wait till conflict escalated. The document stated rather crisply:

“As soon as you see smoke, kill the potential fire.”

Another mechanism for managing conflict was the monthly staff meetings where staff and facility management met to share information. These meetings provided an ongoing, formal mechanism for dealing with operational difficulties that might have arisen. The integration process was reviewed at regular intervals to ascertain whether the team was happy to continue and to plan how to improve where needed.

Community relations

The Sister-in-charge and the deputy attended Police Forum and health committee meetings. Asked if the health committee was aware that this was a joint facility, one sister responded:

“They are aware and very active. They are proud of us.”

Another group member added:

“Because it is a one-stop service, so people don’t moan about having to go to two facilities.”

Members of the health committee offered a weekly soup kitchen to waiting patients. They also helped to mediate communication and difficulties between the health facility and patients. In the group, staff from both authorities appeared to appreciate the importance of community involvement.

Key elements of operational management, training, communication and community relations are:

- *All staff should train in all clinical functions required for PHC.*
- *Use mentoring in the form of a buddy system to train staff in different functions, especially in the emergency room.*
- *Good working relations and a team spirit is critical to successful integration.*
- *Good conflict resolution mechanisms are key to the integration process.*
- *A patient-centred approach motivates staff to co-operate for the benefit of patients.*
- *Staff experience the benefits of skills sharing such as diversity of work and this motivates them further.*
- *An adequate and stable staff complement facilitates the mentoring and integration process.*
- *Staff involvement in decision-making about integration improves their ownership and participation.*

- *A good working relationship with the health committee can be supportive and an asset to the service.*

Problems

There are several problems that the facility experienced in operating as an integrated service. Having to manage two different administrations was burdensome and sometimes confusing. For example having two ordering systems meant double the administrative load. Sharing transport continued to be difficult because of different rules of indemnity.

Differences in conditions of service between the local authority and the provincial health services were raised as an issue that presents problems for functional integration. Although staff were not sure about the range and magnitude of differences in conditions of service, they were aware that there were differences in the salaries as well as in leave, pension and other benefits. The general perception was that the local authority conditions of service were more favourable than the provincial conditions of service. The staff of this integrated facility acknowledged that disparity in conditions of service was a problem when staff were trying to work together as one unit, but they tried to limit the potential negative effects of this situation. They regarded it as an issue that was beyond the control of the staff or management and did not use this as reason not to co-operate with each other.

Initially, there were also negative perceptions amongst staff of each other's work, but this dissipated with training and crossover work. The facility had found creative, informal ways to share some of the benefits (and limitations) of the differing service conditions such as sharing holiday concessions and consumables. Tasks such as stocktaking on a Saturday were also shared. Training and crossover functioning had changed preconceived perceptions of the work on the part of both the staffs.

There were other systems and operational issues that could create problems for functional integration in service delivery. One example is the fact that the local authority service is a nurse-driven service and the provincial service is doctor-driven. One way that the facility had dealt with this was to get more of the provincial nurses trained as clinical nurse practitioners (CNP) to allow them to take a more active role in the diagnosis and treatment of patients. However, as the facility manager explained, it would take more than skills training to change

the different way the two services operate, it would also need an attitude shift on the part of all staff and management.

The difference in nursing ranks was also a problem. For example a nurse working on a similar level of seniority would be called a Senior Professional Nurse (SPN) in the local authority and a Chief Professional Nurse (CPN) in the provincial service. This, together with the fact that their job descriptions differ, made it difficult to compare and contrast the work of nurses in the two different services. A related issue was that in the local authority, facility managers are appointed in a management position with a rank position appropriate to a management level position. Local authority facility managers are also not required to perform clinical work (except for a small portion of their time, when needed). On the provincial side, the opposite is true. A senior Chief Professional Nurse takes on the position of a facility manager, but her rank is no different from that of other CPNs on her staff. She usually has a dual management and clinical role that makes it difficult for her to focus exclusively on her management responsibilities.

The issue of management, is one that the facility manager mentioned could bedevil efforts towards functional integration. The group elaborated that when staff from elsewhere relieved at this facility, they often did not understand or appreciate the integrated functioning. For instance, the provincial staff relieving at the facility were not always comfortable with accepting instructions from the local authority facility manager. Their negative reactions would then have a negative ripple effect on the rest of the staff.

There was a feeling that sub-district and senior management from both authorities did not fully appreciate the efforts it took to integrate a facility. Facility staff also felt that senior management were not always aware that some of their decisions and policies had a potentially negative impact on the level of managing the facility. For example, cost-saving measures or protocol changes suggested by one authority, if not sensitively handled, could upset the delicate balance of co-operation in an integrated facility. In the recent past, senior management from one of the authorities had wanted to reduce the staff number at this facility, based on general workload indicators. This was suggested without taking into account the integrated nature of the work. It became apparent that integrated facilities might be at a disadvantage when assessing workload, as their routine statistics could not easily be disaggregated.

Benefits

In the opinion of this group, the benefits outweighed the problems. Despite duplication of some administrative functions, there was some rationalization of administrative duties in an integrated facility. The facility was able to offer a comprehensive service for patients, including extended opening hours. This meant that patients did not have to go to two separate facilities and they did not have undue delays in having different needs met at the single facility. In contrast, at some non-integrated joint facilities, patients would have to come twice if they wanted services from the two different authorities, even though they operate from the same building.

The integration of patient records and patient care meant that there is continuity of care for adult and child services and patients “do not fall through the cracks”. The fact that most staff are trained to perform most of the required functions allows the facility to work more productively. Staff shortages can be also be more easily absorbed with multi-skilled staff. It was noted that for most staff, the diversity of the work brought more job satisfaction. The positive response from the community via the health committee was a further source of encouragement.

When asked what would change if the two services were formally amalgamated, the group was unanimous in their initial response. They felt that amalgamation would not cause disruption as the service was already integrated. As expressed by one of the group members:

“It is not going to change one thing, except for the letterheads.”

However, when asked about improvements that could result from becoming a municipal-based service, they indicated that some of the problems, like dual administration would be solved. The management of routine statistics would also be easier. Furthermore, there is an expectation of similar conditions of service, a different and improved management style and a more nurse-driven service.

CHAPTER 4: RECOMMENDATIONS AND CONCLUSION

General

The main finding of this study is that functional integration does not happen in joint facilities unless there is a concerted effort from all levels of management. In particular, the commitment of senior management to actual implementation would have to be more visible. For example, joint agreements or memos of understanding have not been signed and senior and district management have had a largely 'hands-off' approach to the implementation of functional integration. Only in the two cases where a single facility manager was appointed, did functional integration occur. In a situation where the management authorities remain separate, the sustainability of these isolated cases of functional integration is questioned. Given the complexity of integrating joint facilities, it will require a huge effort to maintain integration and to prevent conflicts.

It would seem logical therefore, that functional integration in primary health care can best be done if there is a single management and governance authority, be this local authority or provincial, as recommended in the National Health Bill (National Department of Health 2001). This will provide a platform from which to address issues of fragmentation and duplication. This study therefore lends support to several other reports, which made the same recommendation about the need for amalgamation (Ramotsamai et al. 1997; Department of Health and Social Services 2000; Western Cape Cabinet 2001).

The recommendations in this report are relevant in the following scenarios:

- Establishing new joint facilities where there are no immediate plans for an amalgamated municipal system.

In establishing new joint facilities, the management of the separate authorities should pay attention to all the recommendations in this report, but especially the importance of detailed operational planning, consultations with staff and ongoing guidance from sub-district and senior management in the implementation and monitoring phase.

- Where joint facilities already exist, but are not functionally integrated.

In this case, the recommendations about the importance of having a single facility manager who is pro-integration and who has good people management skills should be

heeded. There is also a need for senior and sub-district management to actively demonstrate their commitment to functional integration and for them to co-ordinate their activities in relation to the joint facility.

- Joint facilities in areas where a single governance authority, for example a local authority based system, is in the process of being implemented.

The City of Cape Town in the Western Cape falls into this category as a municipal-based primary health care system has been agreed upon in principle and initial steps have been taken towards implementation. About half of the provincial facilities are shared, but very few have achieved functional integration. In moving to a single, primary health care system, the success factors and the problems of the integrated facility would provide useful guidelines for the new municipal managers in planning for the integration of all the facilities. The recommendation about the importance of planning is of particular relevance.

The history of the development of District Health Systems in South Africa indicates that it is a complex process with many uncertainties and delays. In some areas, the amalgamation of services is not yet feasible for various reasons such as a lack of capacity to manage the services, the absence of a proper legal framework or the lack of political will. Where health authorities remain separate entities, in the absence of a formal District Health System, the need for active collaboration to promote comprehensive primary health care becomes even more urgent. In other words, functional integration, in the absence of a single management system, remains a realistic goal to strive for. Joint facilities present such an opportunity for functional integration. Efforts to understand their challenges and obstacles in order to enhance their level of functional integration are important for laying the foundations for a District Health System. These recommendations are therefore particularly relevant as they point to the important ingredients for success of functional integration at facility level.

Planning

It has been noted that decentralization requires sound planning principles to avoid the common pitfalls. In 'Myths and Realities about the Decentralization of Health Systems', the authors outline several important principles and steps in the planning of decentralization (Bryant 1999). The researcher would argue that many of these principles also apply to the planning of functional integration in joint facilities. Currently, planning is often limited to the

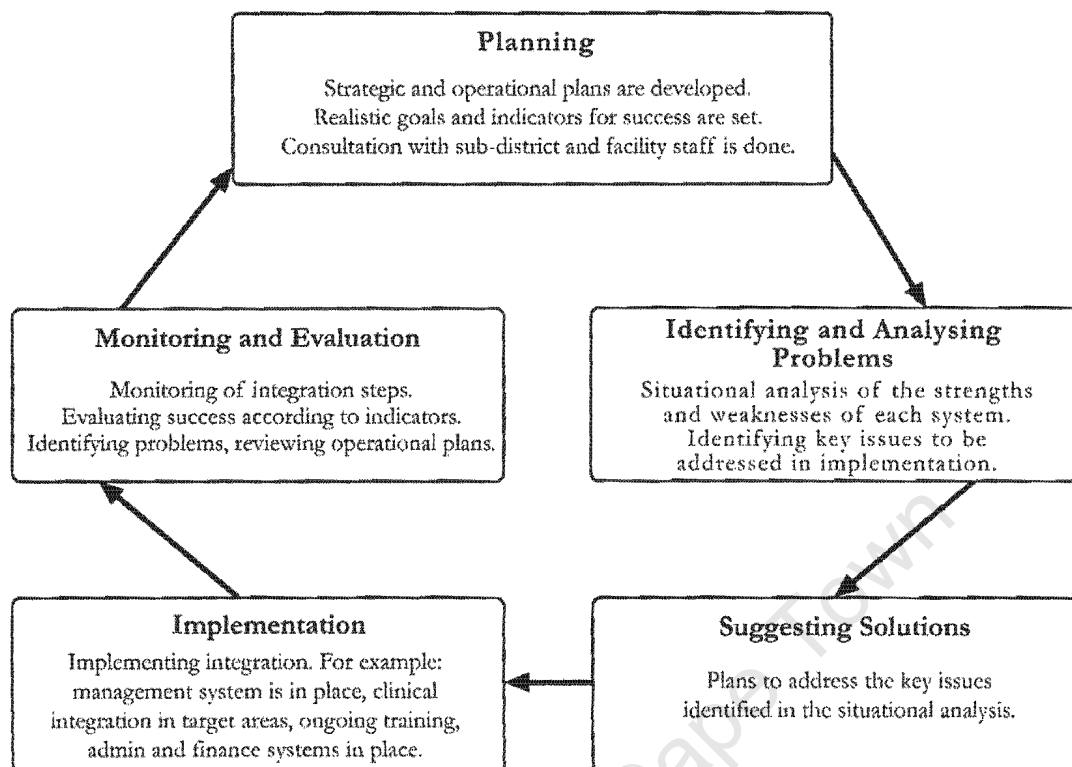
technical aspects of having a joint building and infrastructure. Planning for functional integration in joint facilities should require detailed planning on a strategic and operational level. The purpose and goals of functional integration should be clear and realistic expectations should be set. A situational analysis could provide an assessment of the strengths and weaknesses of both services and identify the key issues. The planning should include education of the health workers and it should actively involve them in decision making.

Planning should consider the financial, human resource, administrative and management issues required for functional integration. A situational analysis should guide the implementation process. For instance, it may be desirable to have a stepwise implementation of functional integration. This might involve the two authorities initially working separately within a joint facility in order to become familiar with each other. Incremental steps towards clinical integration could then be taken, based on a plan that prioritises areas for integration. The emphasis should be to strengthen those services that are working well and to reform those that are not working well.

The management of joint facilities will bring new demands on existing management systems. Operational plans would have to pay attention to financial management systems and budgeting, human resource management and training, logistics of transport, equipment and medications as well as information management systems. The roles and responsibilities of each level of management should be defined as well as how the joint facility will relate to the rest of the health services in the district.

Planning should involve the development of systems for the monitoring and evaluation of functional integration. Clear indicators for progress should be set as well as the ways in which these indicators will be monitored and measured. The diagram below illustrates the different stages of the planning and implementation cycle required for integration.

Diagram 3: The Planning and Implementation Cycle



Adapted from Lucy Gilson et al (1997)

Facility Management

Establishment of a joint facility will make new demands on existing management systems. Joining facilities should not be regarded as a way to fix bad management practices. The need for leadership and good management becomes even more imperative in a joint facility.

The choice of management system may be different for different services, depending on the size and the complexity of the service at a joint facility. The model for how to manage the joint facility should be addressed formally in an agreement and through negotiations with district and facility management, as well as with the staff.

Dual management of joint facilities is not ideal to promote clinical integration as this system supports the continuation of parallel services. However, in the absence of a single governing authority for primary health care, the following factors should be considered:

- If senior and middle management do not have an operational plan for promoting functional integration, then it may be necessary to have dual management to ensure that services continue even if in parallel.
- When there is dual management, there can still be progress towards integration and comprehensive care. However, a lot depends on good working relations between the two Sisters-in-charge, their management skills, their support for integration and their ability to motivate staff.

In smaller facilities, a system of appointing one of the Sisters-in-Charge as the overall facility manager and the other as her deputy can still promote integration. Factors influencing the success of such an arrangement are:

- The two managers would have to agree to the arrangement and the staff should be satisfied with it.
- The arrangement should be monitored and reviewed to ensure that it is satisfactory.
- There should be an option to rotate the facility management position, but service continuity should not be compromised in the process. For example, frequent and short rotations may lead to poor management.
- The facility manager should attend district management meetings for both authorities to ensure that he/she communicates effectively with both services.

The bigger, multi-purpose facilities that are joint (combining 24 hour and MOU services) may require a co-ordinator as an additional, higher level position to do the overall management. This co-ordinator would still require the guidance and support of senior management on both sides, including an operational plan for integration. This has already been implemented in one of the larger joint facilities in the City of Cape Town (one of the two joint facilities actively excluded from this study). Here a co-ordinator was appointed, in addition to the line managers of each authority. The co-ordinator was in charge of the overall management of the joint facility. Although logistically, one of the authorities had employed the co-ordinator, she was expected to assume a neutral position in managing the combined service.

The facility managers would have to have a fair level of understanding of functional integration and they would have to receive a fair level of support from the sub-district management if they were to co-operate with each other on a facility level. Whatever the model of facility management, it is important that management staff have knowledge of the administration, human resource management and labour relations processes in both health authorities. This will provide a more effective knowledge base for managing a joint facility.

Operational and Staff Management

In a clinically integrated facility, staff should be managed as one pool of resources. For example, duty allocations should be done according to training, experience and service needs, not according to which authority delivers what service. Further, the role of nurses and doctors should be reviewed in a functionally integrated service. For instance, medical doctors as well as clinical nurse practitioners should be effectively utilized across both the adult and paediatric services. Adequate staffing levels on both sides of the services are a requirement for developing clinical integration. This makes collaboration, training and crossover functioning easier.

Facility management should develop operational rules that should be applied even-handedly, to both sets of staff. These include operational procedures and cost-saving measures.

The disparity in conditions of service between local authority and province has been noted as an important issue to address in planning for the integration of PHC services. In the absence of a formal DHS where this issue can be addressed, conditions of service, although a legitimate concern, should not be considered a prohibitive factor in working towards functional integration. A few joint facilities have found creative ways to deal with this by sharing some of the benefits and the limitations of their conditions of service.

Conflict at some of the bigger, multi-purpose joint facilities had escalated to the point where the continuity of service delivery was threatened (Personal communication with senior management from both authorities). This, together with union involvement, alerted senior management to the need for dispute resolution measures for joint facilities. Staff unions from LA and from Province have had several meetings with senior management of both authorities in order to address the conflicts in these joint facilities. Unions have gone as far as making a

firm proposal about how these facilities should be managed and how disputes should be resolved (Personal communication with senior management from both authorities).

Communication

Building and maintaining good communication is particularly important for developing good working relations among staff at joint facilities. There should be opportunities for staff to share their problems and achievements with functional integration. For example, joint staff meetings are useful to share information and to promote participation in decisions about integration. Mechanisms and procedures should be developed to build and maintain a team approach and to resolve conflicts that may arise. There should be clear communication channels between the facility management and the two health authorities. Communication between the facility management and the sub-district management team should also reflect on the lessons learnt and ways to improve functional integration.

In addition, the experiences of facility managers and staff of successfully integrated facilities should be shared with others. These facility managers could become advocates for functional integration as well as provide mentorship for other facility managers in Cape Town.

Training

Training is an important tool in changing negative attitudes towards integration into positive, enthusiastic attitudes. Nursing staff should ideally be trained to do all clinical functions required by a comprehensive service and they should be given the appropriate skills before taking responsibility for the new role. Where possible, there should also be scope to accommodate staff preferences (i.e. for adult, child or trauma work).

A skills audit should be done to assess the training needs in relation to the needs of a functionally integrated service. Training of nurses from both authorities should be carried out together to develop comprehensive skills. This is also a good opportunity for team building. Rotation of staff can be used as a form of on-the-job training for crossover skills. Mentoring in the form of a 'buddy system' is a useful method to support staff who are learning crossover skills. Staff may have to be re-deployed from other facilities to ensure that the correct skills profile exists to deliver a functionally integrated service.

Sub-District and Senior Management

Sub-district management

Health sub-district managers have an important role to play in terms of setting an example of good teamwork in an integrated district management team. They also need to support and guide the facility manager in the task of functional integration. This involves understanding difficulties, helping managers deal with problems and affirming their achievements. With the two health authorities remaining separated, there is a danger of sub-district management not working together as a team and this could be undermining the efforts towards functional integration. In order to support functional integration at joint facilities it will be essential that the sub-district management teams work closely together and that they jointly plan and monitor their interventions for functional integration.

Senior management

Senior management should show a high profile presence and a commitment to integration by, for example, signing the agreements that are made between the two authorities. As mentioned earlier, they need to develop operational plans about how joint facilities can work in an integrated way. Facility managers should be involved in developing the detail of the operational plan, keeping in mind different job descriptions for the different authorities.

Support and guidance of the district and facility management in the implementation of operational plans and in conflict management is another important role. Finally, senior management need to be a role model for co-operation by showing that they work closely with their senior counterparts from the other authority. This should involve joint planning and monitoring as well as effective conflict resolution at senior levels.

Information Management

The management of information is a key area in joint facilities. Both authorities should have clear guidelines for the collection and management of routine service data at joint facilities. Where the facility is offering a clinically integrated service, the routine service data should reflect this and the information systems should support the functional integration. Management should therefore be cautious about dis-aggregating this data when trying to determine service loads for the two separate services. Health information should be analysed

and used at facility level to improve functional integration and to promote service improvements.

Consumer Issues

Community participation is a principle of the primary health care approach and opportunities should therefore be created for the community to participate in the planning and implementation of functional integration in joint facilities. This should involve educating the community about the primary health care approach and about the objectives of functional integration in the joint facility. This study showed that community health committees could be a source of support for a joint facility. In one case, the community health committee advocated for services to be expanded to meet community needs and in another, there was active support for functional integration. Members of one health committee provided services like soup kitchens and have assisted with mediating problems between the facility and patients.

Conclusion

What this study has shown is that functional integration in the Metro, Western Cape, is more fiction than fact. Of the twenty-six shared facilities between province and local authority in the Metro only ten (38%) have some form of joint management and only half of those (19% of the total number of joint facilities) have a fair degree of functional integration, where both management and clinical services are integrated. In some of the facilities where integration does occur, there have been chronic conflicts and occasional crises that have threatened not only the integration process, but also the continuation of services. In most instances, integration was left up to facility managers without enough planning and guidance from district and senior management levels. The result has been an absence of or minimal steps towards integration and in places, chronic conflicts that jeopardised the integration efforts.

In this study, the two joint facilities with functional integration appear to work relatively well, largely due to the efforts of the facility management and staff. It would seem that maintaining the functional integration at these facilities requires a high level of people management skill, particularly in motivating staff, problem solving and conflict management. It also requires a balancing act between managing the many changes and crises in both authorities in such a

way as to minimize the negative effects on the integrated service. In a situation where organizational integration and a formal district health system is still far in the future, it will require a clear framework for functional integration and a high level of maintenance and support from all levels of the health system to ensure that functionally integrated facilities are sustained and developed.

This investigation shows that where integration is working well, having one manager in charge of both services appears to be the key to success. Good quality facility managers who are pro-integration, foster good staff relations and provide appropriate training is critical in these facilities. The planning, guidance and support of the district and senior management, especially in the early stages, are also critical. The two functionally integrated facilities in this study were small, 8-hour units and they were relatively conflict free. This might be an indication that it may be easier, at least initially, to facilitate functional integration in smaller facilities as opposed to the larger, more complex, multi-purpose facilities. A separate study about functional integration in multi-purpose, 24-hour units in the Metro would have to be carried out to explore the challenges and success factors of these joint facilities.

In general, there appears to be an acceptance of the concept of integrated primary health care service at all levels of the health service, but the implementation is a contested area. The responsibility for this lies at all levels of the system, but particularly with senior management who have not been visible enough in their commitment to integration. Facility-based staff have expressed feelings of having joint facilities and integration forced upon them. This they find particularly difficult because of their sense that facility staff are expected to integrate whilst senior management of the two authorities are not integrated themselves. The lack of visible commitment is perhaps most evident in that senior management has not paved the way for a formal, jointly agreed upon memorandum and they do not have an operational plan for functional integration.

Planning, monitoring and evaluation of implementation are amongst the most critical elements of the success of any restructuring in the health sector (Gilson et al. 1997). The implementation of functional integration is no exception. There is a need for an operational plan at senior level as well as for active guidance and support in the implementation. Evaluation is essential to determine if there is progress towards functional integration as well as whether functional integration has the desired positive impact on improving accessibility

and quality of care. In a recent study on vertical and horizontal integration of health programs, Magwaza and her co-authors also highlighted these critical success factors (Magwaza et al. 2002). The authors assessed the obstacles and critical success factors of integrating reproductive health services in Cape Town in order to inform health managers about policy implementation in this area. They found that there was a lack of preparation for the integration and that staff felt pressurized by top management to integrate. Further, there were no plans to address operational issues and no monitoring and evaluation to assess whether integration had been successful or not (Magwaza et al. 2002).

It has been noted that health restructuring such as decentralization and integration should be closely tied to quality of care improvements (Gilson et al. 1997; Magwaza et al. 2002). As argued in this report, evaluation of integration is therefore critical. Such evaluation should include both staff and community involvement in assessing the level of satisfaction with the service as well as the progress and level of satisfaction with the integration efforts. This report supports the recommendations of Magwaza et al. (2002) and others such as Schierhout and Fonn (1999) that if implementation of policy is to succeed, the voices of the implementers, the frontline health workers, should be heard. As pointed out by Magwaza et al. (2002):

Clinic staff fears, anxieties, concerns and complaints should be taken seriously and addressed promptly for successful progress.

This study has set out to do just that. Health workers themselves were asked to make recommendations about what should happen on the ground in terms of comprehensive service delivery and integration strategies. It would be helpful to explore the viewpoints of all frontline staff and not just of facility managers as this study has done. Policy planners, managers and implementers should be seeking out these recommendations and acting on them, in consultation with sub-district managers, facility managers, frontline health workers and consumers.

BIBLIOGRAPHY

Barron P. and Fisher S. A District Health Service in Khayelitsha—Panacea or Pipe Dream? South African Medical Journal, vol. 83, pgs. 569-572, August 1993.

Barron P. and Sankar U. Developments Towards a District Health System. South African Health Review 2001. Health Systems Trust: Durban, RSA, 2001.

Bryant M. Planning For and Within Decentralized Health Systems. Myths and Realities about the Decentralization of Health Systems, Kolehmainen-Aitken R, ed. Management Sciences for Health, Boston, 1999.

CHSO. Unpublished Report on Evaluation of CHSO District Management Teams. CHSO: Western Cape, RSA, 2001.

Department of Health and Social Services. Report on Delivery of a Core Package of PHC in the DHS. Department of Health and Social Services, Provincial Administration: Western Cape, RSA, February 2000.

Department of Health and Social Services. Report of the Bi-Ministerial Task Team on the Implementation of a Municipal-Based District Health System in the Western Cape. Department of Health and Social Services, Provincial Administration: Western Cape, RSA, April 2000.

Gilson L, Balfour T, and Goosen V. Towards Well-Functioning Health Districts in South Africa: A Vision and Indicators for Assessing Progress. Centre for Health Policy, Department of Community Health, University of Witwatersrand: Johannesburg, RSA, 1997.

Gilson L, Morar R, Pillay Y, Rispel L, Shaw V, Tollman S and Woodward C. (eds.). Decentralization and Health Systems Change in South Africa: National Report. Health Policy Coordinating Unit: Johannesburg, RSA, 1996.

Health Systems Trust. Health Systems Research: A Manual. Health Systems Trust: Durban, RSA, April 1998.

Health Systems Trust. Kwik Skwiz #26: The Story of Integration in the Brakpan District. Health Systems Trust: Durban, RSA, June 2000.

Initiative for Sub-District Support (ISDS). Technical Report #5: The Development of the District Health System in South Africa: Lessons Learnt from the Experience of ISDS. Health Systems Trust: Durban, RSA, 1998.

Katzenellenbogen JM, Joubert G, and Abdool Karim SS. (eds.). Epidemiology: A Manual for South Africa. Oxford University Press, Southern Africa: Cape Town, 1997.

Kutzin J. Experience with Organisational and Financing Reform of the Health Sector. World Health Organization: Geneva, 1995.

Magwaza S, Cooper D and Hoffman M. The Delivery of Integrated Reproductive Health Services at District Level. Health Systems Trust: Durban, RSA, 2002.

McCoy D and Engelbrecht B. Establishing the District Health System. South African Health Review 2000. Health Systems Trust: Durban, RSA, 2000.

Mitchell M. (ed.). Managing Integrated Services. The Family Planning Manager, vol. 3, no. 3, Family Planning Management Development: Newton, MA, May/June 1994.

National Department of Health. Handbook for Clinic/CHC Managers. National Department of Health: Pretoria, RSA, October 2000.

National Department of Health. Policy for the Development of a District Health System for South Africa. National Department of Health: Pretoria, RSA, 1996

National Department of Health. White Paper for the Transformation of the Health System in South Africa. Government Gazette, no. 17910, vol. 382, National Department of Health: Pretoria, RSA, 1997.

National Department of Health. National Health Bill. National Department of Health: Pretoria, RSA, November 2001.

Organisational Development Africa. Vital Signs Newsletter. Primary Health Care News. Published in consultation with the Technical Steering Committee, PGWC, WECLOGA and the City of Cape Town: Cape Town, May 2002.

Owen CP. A Policy for the Development of a District Health System for South Africa. Health Policy Coordinating Unit, District Health Systems Committee, Department of Health: Pretoria, RSA, 1995.

Pillay Y, McCoy D and Asia B. The District Health System in South Africa: Progress Made and Next Steps. National Department of Health: Pretoria, RSA, 2001.

Ramotsamai M, Brown L, Urgoiti G and Frankish J. Report to the MEC for Health and Social Services on the Circumstances Surrounding the Death of Ms Thobeka Madayi in Site C, Khayelitsha on Wednesday, 7 May 1997. Provincial Administration: Western Cape, RSA, 1997.

Russell, HB. Social Research Methods: Qualitative and Quantitative Approaches. Sage Publications: Thousand Oaks, CA, USA, 2000.

Schierhout G and Fonn S. The Integration of Primary Health Care Services: A Systematic Literature Review. Health Systems Trust: Durban, RSA, May 1999.

Tarimo E. Towards a Health District: Organising and Managing District Health Systems based on Primary Health Care. WHO: Geneva, 1991.

Toomey L. Functional Integration of Primary Health Care Within the District Health Care System. Equity Project: East London, RSA, 2000.

Werner D and Sanders D, with Weston J, Babo S and Rodriquez B. Questioning the Solution: The Politics of Primary Health Care and Child Survival, with An In-Depth Critique of Oral Rehydration Therapy. Healthwrights: Palo Alto, CA, USA, 1997.

Western Cape Cabinet. Western Cape Cabinet Resolution of October 2001, Provincial Cabinet: Western Cape, RSA, October 2001.

World Health Organisation. The Declaration of Alma Ata, International Conference on Primary Health Care jointly sponsored by WHO and UNICEF. WHO: Geneva, September 12, 1978.

Zwarenstein M, Barron P, Tollman S, Crisp N, Frankish J, Toms I, Harrison D and Solarsh G. Primary Health Care Depends on the District Health System (Editorial). South African Medical Journal, vol. 83. Johannesburg, RSA, August 1993.

University of Cape Town

APPENDIX A: QUESTIONNAIRE

District Health Systems Study: Exploring joint primary health care facilities

JOINT PHC FACILITIES CHECKLIST

Health Systems Trust: N. H. Leon (4476330, fax 4476302 or 083-2706614)

Introduction:

- Your facility has been identified as one where the two health authorities are sharing a single premise.
- This questionnaire aims to describe practically whether there are areas of joint activity and what these are. The study aims to elicit recommendations for the functioning of joint facilities as part of the development of a district health system.
- Permission for the study has been obtained from the relevant authorities (HAM, district management). A feedback report will be sent to participating facilities and to health managers.
- Please could you kindly assist us with the information below. If you have any queries, please contact the researcher at the above telephone numbers.

Demographics

1. Facility name:.....
2. District:.....
3. Name of person(s) filling in checklist;.....
.....
4. When (month & year) did this facility become a joint facility?.....
5. Was the facility newly built as a joint facility? **YES/NO**

Please explain:

Please tick the Yes or No box and comment where appropriate.

A: Type of facility	Yes	No
1. This facility is an 8 hour facility only		
2. This facility is a 24 hour facility		
3. This facility has a Maternal Obstetric Unit (MOU).		
4. This facility is a combination of the above: Plse explain		

<p>B: Building</p> <ol style="list-style-type: none"> 1. Does the building have a single entrance for all patients? 2. Is there a shared waiting/reception area for all patients? 3. Is there a shared reception counter(s) for all patients? 4. Is there a shared record room where all files are kept? 5. Is the inside cleaning of the building done as a shared activity? 6. Is the maintenance of the grounds a shared activity? 7. Does one authority own & maintain the building? Who does? 8. Does one authority provide the security of the building? Who? <p>How are the above arrangements working out?/recommendations</p>	Yes	No
<p>C: Communication</p> <ol style="list-style-type: none"> 1. Does the facility have one telephone system with the same contact telephone numbers for the reception/exchange? 2. Do you have a single telephone bill, paid by one authority? Who? 3. Does the facility have a computer (s) <ul style="list-style-type: none"> i) For use by both authorities ii) With e-mail access 4. Do you have a shared tearoom? 5. If yes, do you have staggered tea and lunchtimes where LA and PAWC staffs meet? <p>How does the above arrangements work out?/ recommendations</p>	Yes	No
<p>D: Transport</p> <ol style="list-style-type: none"> 1. Is the staff transport system separate? 2. Is there a system to access each other's transport if required? <p>Recommendations</p>	Yes	No
<p>E: Supplies and equipment</p> <ol style="list-style-type: none"> 1. Is there an agreement between the two authorities on how consumables, utilities and equipment will be paid for? 2. Is each authority responsible for purchasing and maintaining of their own equipment? 	Yes	No

<p>3. Is there a joint process of assessing equipment needs for the facility?</p> <p>1. Is medical and other equipment shared? Please give examples.</p> <p>How are the above arrangements working out?/recommendations</p>		
<p>F: Patient admission and flow</p> <p>1. Do you open separate files for patients of the two authorities?</p> <p>2. Does a patient have one folder number whether they are LA or PAWC?</p> <p>3. Does a CHC & LA patient have a different type of patient card?</p> <p>4. Does the LA reception clerk serve LA patients and the PAWC clerk serve CHC patients.</p> <p>5. Where there is a computer in reception, is it used to locate LA and CHC files?</p> <p>6. Do patients know that there are two health authorities operating in one building? Plse explain:</p> <p>How are these arrangements working out?/recommendations</p>	Yes	No
<p>G: Medication</p> <p>1. Do you have a pharmacy in this facility?</p> <p>2. Do you have a pharmacist?</p> <p>3. Do you have a pharmacy assistant?</p> <p>4. Does the pharmacy do all the dispensing for both authorities?</p> <p>Medication(continued)</p> <p>5. Does the LA staff dispense medicine from their rooms as well?</p> <p>6. Does the pharmacy dispense medicine if LA staff issue the patient with a prescription?</p> <p>7. Is the procurement of medicine done separately for each authority? How are the above arrangements working?/recommendations</p>	Yes	No
<p>H: Clinical treatment</p> <p>1. Do you have a doctor(s) in the facility? Number:</p> <p>2. Are there staff who are trained to do both adult curative and pediatric work?</p>	Yes	No

<p>3. In terms of patient admission, does the CHC staff first see all new adult patients before they are referred to the LA staff for eg. STD, TB treatment?</p> <p>4. Can a patient receive his/her LA and CHC service in one visit? For eg. STD and Hypertension treatment for the same patient in one visit.</p> <p>5. Is patient assessment, preparation and treatment is largely done separately for the two authorities?</p> <p>6. Are there any crossover of clinical personnel and/or clinical duties between the different authorities? Plse give examples.</p> <p>How are these arrangements are working out?/ recommendations</p>		
<p>I: Recording and reporting of data</p> <p>1. Is your daily patient management statistics recorded separately for each authority?</p> <p>2. Is there a joint monthly report on the facility statistics?</p> <p>3. Is the joint report submitted to a single information officer?</p> <p>4. Is the facility statistics jointly discussed and analyzed?</p> <p>How is it working?/recommendations</p>	Yes	No
<p>J: Center management</p> <p>1. Do you have a facility co-ordinator responsible for managing both the services?</p> <p>2. Do you have a separate facility manager for each authority?</p> <p>3. Is there a system of rotating managers between the two authorities?</p> <p>4. Are there joint centre- management meetings with</p> <p>4.1 facility management</p> <p>4.2 staff from both authorities and management</p> <p>5. If you have one facility manager, is he/she employed by PAWC or LA (circle one)</p> <p>6. Does PAWC or LA employ the deputy facility manager?</p> <p>How are these arrangements working out?/ recommendations</p>	Yes	No
<p>K: District management</p> <p>1. Is LA and CHC facility management expected to report on progress</p>	Yes	No

regarding integration of the facility? 2. Do the area managers for both authorities visit the clinic together? 3. Does the LA & CHC district managers visit the clinic together? 3. Do you have joint facility meetings with the integrated district management team (IDMT)? Recommendations		
L: Community 1. Were their consultations with community structures regarding the joining of this facility? 2. Is there a community health committee or forum in your area? 3. Is the clinic represented on this committee? Recommendations		

General

Your comments are valued and can make a contribution to the development of the health services.

M: Which of the joint activities work well and which do not work well? Why do you think this is the case?

Well	Not so well

N: What recommendations would you make to ease the functioning of current and future joint facilities?

APPENDIX B: CONSENT FORM

District Health Systems Study: Exploring joint PHC facilities : Information & Consent
Health Systems Trust: N. H. Leon (4476330, fax 4476302 or 083-2706614)

Information

- Your facility has been identified as one where the two health authorities are sharing a single premise.
- This survey aims to describe practically what the areas of joint activity are and to elicit recommendations for the functioning of joint facilities. This information is useful in the development of the district primary health care system.
- The study requires facility managers or a deputy from both authorities to participate in a structured questionnaire with closed and open ended questions on joint activities such and recommendations. The researcher will administer the questionnaire at the facility and it will require approximately one hour.
- Permission for the study has been obtained from the relevant authorities such as senior management from both the City of Cape Town and CHSO as well as from district managers.
- A feedback report will be sent to participating facilities and to health managers.

District Health Systems Study of Joint facilities

CONSENT

- a) I agree to participate in the survey & interview .
- b) I understand that I have the right to refuse participation. I further understand that my refusal will not hold any negative repercussions.
- c) Confidentiality: No names will be used in reporting results. Additional efforts will be made to protect identities in reporting and feedback..

Name: _____ Name _____

Signature: _____ Signature: _____

Date: _____

APPENDIX C: QUANTITATIVE DATA FROM QUESTIONNAIRE

		Type of facility				Building								Communication					Transport		Supplies/Equipment				Patient admission & flow					
Facility	Score	A1	A2	A3	A4	B1	B2	B3	B4	B5	B6	B7	B8	C1	C2	C3	C4	C5	D1	D2	E1	E2	E3	E4	F1	F2	F3	F4	F5	F6
A	50%	1	0	0	0	1	1	1	1	1	0	1	1	1	1	0	1	1	1	1	1	1	0	1	0	1	1	1	0	0
B	60%	1	0	0	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	0	1	0	0	0	0
C	20%	1	0	0	0	1	1	1	1	0	0	1	1	1	1	1	0	1	0	0	1	1	0	1	0	1	1	0	0	
D	50%	0	1	0	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	0	0	0	1	0	0	0	1	
E	100%	1	0	0	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0	1	0	0	0	0	
F	90%	1	0	0	0	1	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	0	1	0	1	1	0	
G	30%	1	0	0	0	1	1	1	1	1	0	1	1	1	1	0	1	1	0	1	0	1	0	1	0	1	0	1	1	
H	20%	1	0	0	0	1	1	0	1	1	1	1	1	1	0	0	1	1	1	1	0	1	1	0	1	0	1	0	1	
Subtotal		7	1	0	2	8	8	7	8	7	3	8	7	8	7	6	8	6	8	7	5	8	5	6	1	7	2	5	2	3
Percentage		88	13	0	25	100	100	88	100	88	38	100	88	100	88	75	100	75	100	88	63	100	63	75	13	88	25	63	25	38

Facility Name	Medication							Clinical Treatment							Recording/reporting				Centre management						District mgmt.				Community				
	G1	G2	G3	G4	G5	G6	G7	H1	H1a	H2	H3	H4	H5	H6	I1	I2	I3	I4	J1	J2	J3	J4a	J4b	J5	J6	K1	K2	K3	K4	L1	L2	L3	
A	1	1	1	0	1	1	0	1	1	1	0	1	1	0	1	1	0	0	0	1	0	0	1	0	0	1	0	0	1	1	1	1	
B	1	0	1	0	1	1	0	1	5	1	1	1	1	1	1	1	0	1	0	1	0	0	1	0	0	1	0	0	1	1	1	1	
C	1	1	1	0	1	1	1	1	2	1	0	1	1	0	1	1	1	0	0	1	0	0	0	0	0	0	0	0	1	1	1		
D	1	0	0	0	1	1	1	1	2	1	0	1	1	0	1	1	0	0	0	1	0	0	0	0	0	1	0	0	0	1	0	0	
E	1	1	1	1	1	1	1	1	2.5	1	1	1	0	1	0	1	1	1	1	0	0	1	1	1	1	1	0	0	1	1	1		
F	1	1	1	0	1	1	1	1	1.5	1	0	1	0	1	0	1	1	1	1	0	0	1	1	1	1	1	0	1	1	1	1		
G	1	0	1	1	0	1	1	1	2	1	1	1	1	0	1	1	0	0	0	1	0	1	1	0	0	1	0	0	0	1	1	1	
H	1	1	0	0	1	1	1	1	1	1	0	1	0	1	0	0	0	0	0	1	0	0	0	0	0	1	1	0	0	0	0	0	
Subtotal		8	5	6	2	7	8	6	8	17	8	4	7	6	3	6	7	3	3	2	6	0	3	5	2	2	7	1	1	4	7	6	6
Percentage		100	71	75	25	88	100	75	100	**	100	50	88	75	38	75	88	38	38	25	86	0	38	63	25	25	88	14	13	50	88	75	75

** These figures refer to the number of doctors per facility.