Title of Dissertation:

An investigation into the nature, extent, and experience of collaboration between the Eden District, Western Cape Department of Health and community-based service providers

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Abstract

A major component of the primary health care (PHC) system is the delivery of health services on a community level, at the core of which is the Home and Community Based Care (HCBC) programme.

This study focuses on one element of the HCBC system, namely how those involved in the administration of the community-based health component of primary health care, understand their relationship from the perspective of both the government (WCG - DoH) and the NPO service providers in the Eden District of the Western Cape. Additionally, it analyses the nature and the extent of the collaboration between the two entities. A patient referral tool was facilitated in a collaborative process to assess the ability of the two entities to strengthen their relationship.

The study methodology was undertaken utilising Insider Ethnography with the researcher as a participant observer. Ten semi-structured interviews of the key stakeholders and one focus group were conducted with the staff of four non-profit (NPO) service providers operating in the Eden District and with WCG - DoH staff managing the HCBC programme. The findings reflect a substantial disconnect and imbalance in the relationship between the two entities, highlighting a top-down, transactional process at higher levels of management, in contrast to the operational relationships at the local sub-district level which are more collaborative. This disjuncture often disempowers the NPO service providers involved in the implementation of the programme. A number of recommendations regarding communication, advocacy, and innovation are proposed. Regular meetings of government, from district to provincial levels, with the NPO service providers, to strengthen collaboration by all stakeholders, are crucial.

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1. Introduction

1.1 Research Area and Problem

Chronic poverty and the legacy of apartheid have resulted in many communities lacking basic infrastructure and services. More than twenty years after the onset of democracy in South Africa, the state of basic service provision in the country remains mixed.

Government has made significant strides in the provision of basic services. However, many gaps remain. Debate both within and outside government on their roles and responsibilities continues to grow. There is a wide divergence of thought on the role of government in society (Cullen, 2013; Mhlauli, 2011; Andrews & Pillay, 2005). The Millennium Development Goals, ratified by South Africa, encompassed many basic responsibilities that the government guarantees to implement including: "to end poverty and hunger; universal education; gender equality; child health; maternal health; combating HIV/AIDS; environmental sustainability; and global partnership" (UN, 2015). Consequently, government carries a significant level of responsibility to provide basic services and resources to communities, particularly in the provision of basic health services.

On a macro level, South Africa's health system, based on a framework of primary health care (PHC), faces severe challenges, with a significant gap between effective health policies and implementation of these programmes. The main challenges facing the system are structural and regulatory issues (Naledi, Barron & Schneider, 2011). Service delivery continues to be a major challenge, as staffing and the lack of administrative capacity hamper the effective provision of basic health care. Old infrastructure and a lack of facilities in areas of growing populations have also inhibited the ability of the Department of Health to provide services in high disease burden areas. Finally, considerable pressures on staff and infrastructure, due to an increase in communicable (HIV/AIDS & TB) and non-communicable diseases (hypertension, heart disease, diabetes), have catapulted the Department of Health into a major realignment of policy leading to the piloting of the National Health Insurance (NHI) programme.

Over the last eight years, with the appointment of Dr. Aaron Motsoaledi as Minister of Health, government has responded to the urgent need for a reconstructed health system. The Minister has overseen the development and piloting of the National Health Insurance programme, as the centre-point of the realignment of the national health system. The Department of Health has, therefore, undertaken a major review of the primary health care model in South Africa, in order

to provide a more efficient health system that delivers quality health care to those most in need, within a sustainable costing model.

A major component of this review of the health systems is the delivery of primary health care at a community level. Post-apartheid, government has been able to stop-gap the holes in health care service provision through the use of civil society to provide critical health services they could not provide, because of capacity and/or funding issues. The number of non-governmental organisations entering the system to meet the growing demand from the vacuum left by the gaps in service delivery has risen sharply over the last two decades. This has lead to the need to better understand the various pillars of community-based care in South Africa.

A review of the community based services (CBS) model in the Western Cape, South Africa has been underway for the last several years as part of the review of primary health care and the subsequent PHC Re-Engineering Programme undertaken to support the various aspects of the NHI. It is generally agreed now, that the previous CBS system was highly diverse (loosely structured) and the varied levels of service provision in communities were not sustainable (Schneider, Schaay, Dudley, Goliath and Qukula, 2015). Over the last few years there have been a number of studies on primary health care, and specifically the CBS model (Naledi et al., 2011; Schneider, Hlophe & van Rensburg, 2008; Schneider & Lehmann, 2010). These studies have sought to understand how the CBS system developed, its level of effectiveness in service provision, and recommend a new comprehensive framework for the delivery of health services at a community level.

The research in this study builds on the comprehensive studies already carried out, but with a focus solely on understanding the nature of collaborations between the WCG Department of Health and the non-governmental organisations that actually provide the health services in the community. Other researchers (Schneider & Lehmann, 2010) have looked at this relationship, but not as the sole focus of their research. Rather, it has been one component of either the primary health care system, or specifically reviewing the Home-Based Care (HBC) programme. There is a need for a review of the prior studies into the development of the home and community-based care system and a more in-depth study of how the two entities can work more efficiently through a greater level of collaboration, in order to provide a higher level of impact in health provision.

A practical output and requirement of the UCT - Graduate School of Business, from the current research, was the facilitation of a prototype referral system, between the local clinics and the

NPO service providers in the Eden District, which was developed in order to create a viable model of collaboration. Lessons learnt would provide recommendations on how to strengthen the relationship between the NPOs and the WCG - Department of Health, ultimately leading to more substantive collaboration between the two entities.

Although there has been a significant amount of research on the community-based component of primary health care (Schneider et al, 2008; Schneider & Lehmann, 2010; Schneider et al., 2015; Moshabela et al., 2013; El Ansari & Phillips 2001b), there is less that deals exclusively with the government interactions with non-profit organisations on a daily basis on a community level. In order to provide efficient community-based health interventions, especially in terms of HIV/AIDS & TB treatment, it is vital that there be perceptible collaboration between the two role-players starting on a macro level within management.

1.2 Research Questions and Scope

1. How do those involved in administration of the community-based health component of primary health care, understand their relationship from the perspective of government and the service providers?
    - What is the nature of the collaborative process and extent (scale) of the collaboration between the two entities?
    - What is the current state of the referral system between the Department of Health (clinics) and community-based health service providers who are now assisting patients discharged from the facilities?
    - How can this referral system be modified to provide a higher level of care for patients and build collaborative relationships between government and the NPOs?

The research was limited to the Eden District of the Southern Cape, with semi-structured interviews with the Provincial Department of Health of the Western Cape and regional non-profit service providers.

The research was restricted to the two entities ultimately involved with the delivery of home and community based care (HCBC) services in the Western Cape: herein referred to as the Western Cape Government Department of Health and the Non-Profit Organisations (NPOs) [community-based service providers]. The literature reflects other terminology for these institutions, including: Department of Health, government, non-governmental organisations (NGOs) or non-profit organisations (NPOs), which are the primary service providers for the WCG Department

of Health. For uniformity and clarity the author will use the terms Department of Health to represent the national Department of Health and WCG – Department of Health, or WCG – DoH WCG – Health, or province to identify the Western Cape Government Department of Health.

In South Africa, NGOs have to register as an NPO for certification and tax requirements. The two terms are often used interchangeably, however, the author will use NPO service provider as a standard identifier.

The home and community based care (HCBC) programme is the descendent of the Home-Based Care (HBC) programme developed in the 1980s. Hence, the field-workers have been identified in the past as Home Based Carers (HBCs), Community Care Workers (CCWs) or Community Development Workers (CDWs). With the implementation of *Health Care 2030*, the current identification of staff has been classified as Community Health Workers (CHWs). The author's use of these titles reflects the period of their work as part of community- based services.

The research will focus on the Home and Community based care (HCBC) programme, as part of community based services (CBS) under the primary health care (PHC) framework. The study is limited to the HCBC programme as it is at the centre of the interface between the community and WCG - Health. The local community clinics are usually the first interface with patients and the subsequent referrals to and from the clinic to the NPO service providers reflect the need for each to implement continuity of care. The community-based clinics and NPO service providers are the cornerstone of the PHC system in South Africa, and for the sustainability of the national health system, both have to work efficiently with each other.

1.3 Research Assumptions and Ethics

The research stems from the author's management of a community-based health care programme (the Isisombululo Programme) in the Eden District, over the course of more than a decade. The programme is a partnership between the University of Cape Town's Faculty of Health Sciences, the Western Cape Government Department of Health, and the Hasso Plattner Foundation (funder). As such, the author was embedded in the two distinct entities central to this research, the Department of Health in the Western Cape and local non-profit organisations contracted by the WCG - DoH to render services in the various communities in the Southern Cape.

The author helped establish and develop an NPO, Ithemba Lobomi in Thembalethu, George, which provides HCBC services under a WCG - DoH contract. Therefore, the author has been

able to interact with both major stakeholders in the HCBC Programme over a number of years. This allowed the author to better understand the various agendas (objectives, goals, visions, etc.) pursued by the two entities. The author, as a part his work, managed a funding and implementation programme through the University of Cape Town's Faculty of Health Sciences, which has funded and co-project managed various activities at WCG - DoH and at all the participating NPOs in this study, including the HCBC Programmes. The Isisombululo Programme funded almost every NPO that provided HCBC services in the major centres in the Eden District including: Mossel Bay, George, Knysna, Plettenberg Bay, and Oudtshoorn.

In these daily interactions, the author observed an environment of both collaboration and discord between the WCG - DoH and their service providers, together with an understanding that each needed the other. As the director of Ithemba Lobomi for a period of time, the author also saw the complexities of working with the bureaucracy of such a large organisation as the WCG - Department of Health. Equally, working with other service providers the author came to understand the imbalance in the relationship between the two organisations. While fully appreciating the immense constraints placed on WCG - Health by the disease / chronic health burdens, and staff shortages, the author came into the research with a bias orientated towards the concerns, frustrations of the community-based health service providers. Working on the ground with various NPOs, the author was frequently made aware of the challenges faced by the two organisations in working together efficiently and on an equal footing. Consequently, the assumption was made before the research that NPOs had little or no voice in the planning, tendering, and implementation of the HCBC Programme under a top-down approach, versus the assumption that the WCG - Department of Health held the power in the relationship and could direct the HCBC programme with little regard for the NPO's participation, other than the actual implementation of the Programme.

In order to address this bias, the author has attempted to take a more interrogative approach and better understand through the research the challenges faced by WCG - Health in their implementation of the HCBC Programme as part of primary health care. The author intends to investigate thoroughly the burden of disease that the WCG - Health faces on the ground in the Western Cape, how policy was formulated and how plans were drawn up.

With the primary methodology for the study being insider ethnography, the author was well placed to understand the complex nature of the relationship between the WCG – Department of Health and the NPO service providers. Because the author has been involved in the system for

a long time, he was able to have easier access to the various role-players in order to conduct the research. However, through the use of frequent self-awareness exercises discussed later, the author strove to maintain a level of objectivity and to reduce bias which could develop given his role within the local Home and Community Based Care (HCBC) environment in the Eden District.

As the central theme of the research is collaboration, the author tried to see how the two entities could work together effectively, while understanding that the two parties generally have different and distinct agendas, objectives, and goals, but that they could find certain commonalities of purpose. The goal of the research was to understand the relationship between the two entities and gauge the level of collaboration, as driven by the data arising from the research. The author endeavoured to go where the research results led, and also to mitigate any preconceptions.

Permission for the study was granted through the Western Cape Government Department of Health (reference number: WC_2015RP21_968) and ethical approval through the Graduate School of Business, University of Cape Town (reference number: GSB/MPHIL/108). The interviewees and focus group participants were all professionals and in management / supervisory levels at the WCG – DoH or NPO service providers. All participants signed a consent form prior to the commencement of the interviews. As the interviewees were all at a professional level, there was a clear understanding of the nature of the study and what the interview findings would be used for. Participants also understood that the dissertation would at the end of the study enter the public domain, and as such be open to anyone to read. Anonymity of specific quotes was attained through a coding system and therefore no specific names were linked directly to the quotes. However, because of the relatively small sample size and close-knit nature of the HCBC community in the Eden District, it is impossible to guarantee total anonymity. Despite measures such as coding, it might be possible for names to be linked to quotes. All participants understood this.

No patients or community members were interviewed, so ethical approval was not sought for staff outside of the WCG – DoH and NPO service providers. The interviews were all conducted in English, after the researcher had ascertained that the interviewee was comfortable answering questions in English.

Finally, the author focused on the Eden District of the Western Cape. This falls under a ‘rural’ setting for the Western Cape Government Department of Health and therefore, any conclusions

reached through this research cannot be ascribed to the Metro, as the relationship between WCG - DoH and the NPOs they contract with there are considerably different.

2. Literature Review

2.1 Community-Based Care

There is an increasingly comprehensive range of literature on the nature of relationships between the Department of Health (national government) and community-based health service providers in South Africa, including the history of the evolution of the partnerships between the two entities (Schneider et al, 2008; Schneider & Lehmann, 2010; Schneider et al., 2015; Moshabela et al., 2013; El Ansari & Phillips 2001b). The literature generally falls into two major categories, one establishing the relationship dynamics from the focus of government, and the other category investigating the issue through the perspective of the community-based service providers. A review of the literature, however, indicates that most of the data on the relationships between the two parties reflects one facet of a larger study focusing on a particular health intervention (Schneider et al, 2008; Schneider & Lehmann, 2010; Schneider et al., 2015; Moshabela et al., 2013; El Ansari & Phillips 2001b; Dawad & Jobson, 2011; Friedman, 2006a). There are fewer studies looking expressly at the relationship between government and their community service providers, and specifically collaboration in the Home and Community Based Care sector.

Access to patient-centred, quality health care in South Africa, is guaranteed in the Constitution / Bill of Rights and codified in various policy documents (Constitution of the Republic of South Africa, 1996; Strategic priorities for the National Health System 2004-2009, 2004; National Health Act, 2004; National Health Bill, 2003; White Paper on National Health Insurance, 2015; Health care 2030: The Road to Wellness, 2015). The Bill of Rights states "everyone has the right to access to health care services, including reproductive health" (Bill of Rights, 1996). While on paper the access to basic, quality health care is assured, in practice this has not been always been available for the vast majority of the population.

In the review of literature as regards the general perception of the health sector in South Africa, the segment of the population that was classified the most "dissatisfied" (General Household Survey), was understandably the black race group (Moller, 2006). Obviously amongst those respondents to the General Household Survey who were living in less favourable conditions, including a lack of access to basic health services, there were those that reported high levels of diabetes, TB, HIV/AIDS, and trauma (Moller, 2006). The post-Apartheid government

attempted to step into the breach, to meet these immense health challenges inherited from the Nationalist Government. Since government did not have sufficient resources to implement health services autonomously in 1994, a partnership between government and community-based service providers was developed.

2.1.1 Primary Health Care and Community Based Services

The evolution of the relationship between the two entities reflects the history of health policy and enactment in South Africa. The view from government has a longevity closely linked with the post-Apartheid history. The overall framework for health provision in South Africa (post-Apartheid) arose from the 1978 Declaration of Alma Ata which motivates for vital health care initiatives structured around scientifically validated and socially proven implementations, including technology, open to all at a cost that is attainable by most, all within the framework of community participation (Hall, Ford-Ngomane & Barron, 2006). This primary health care (PHC) approach was centered on the district level, which it was hoped, would allow for an efficient management and implementation system. Planning would also be accomplished on a district level, which then looked at the particular needs as well as resources for that specific district. The National Health 2003 Act formalised into legislation this district-based, decentralized framework, including the formation of District Health Councils (DHCs) which was designated to support cooperative governance between the various components of government, while also promoting the coordination and integration of services within the particular health district, and finally also assisting the MEC for the Department of Health, through the District Health Councils, on health matters related to that particular health district (Hall et al., 2006).

In addition to the focus on a decentralised, district-based health system, a concentration on primary health care became central to the re-engineered health plan. While providing basic health care, PHC also encompasses social development of the community in a holistic manner, including the supplying of clean water, a strong nutritional component, as well a safe and clean place to live and an approach to the prevention and treatment of mental health issues (Friedman, 2006b). The PHC approach, however, is more than the implementation of 'primary' level services, that are usually found in the health facilities and their mobile resources. It foresees a continuous referral system from the community all the way to the specialised care in tertiary health care facilities. (WHO, 1978). As the various plans were developed in South Africa, including the 1994 National Health Plan for South Africa and the 1997 White Paper for

the Transformation of Health Services in South Africa, the various underlying themes were included as the central components of these documents (Hall et al., 2006).

As widely recognised during the Apartheid era prior to 1994, there was a considerable disparity between the health system for whites and non-whites. In many areas lacking basic health services, non-governmental organisations (NGOs) stepped in to provide these vital health services for communities. In the period after 1994, a priority for the newly installed democratic government was the provision of basic health care to the general population. Government understood from the beginning, that because of the dire lack of trained health professionals, it was vital that the NGOs continue to be a core component in health service provision. There had been, however, no real attempt to "formalise" this sector and therefore numerous distinct community-based interventions, centred around some type of field worker strategy, arose organically throughout South Africa, filling the need for health-related services. It will be discussed in greater detail later, but it must be noted that the literature generally shows that government continues to prefer contracting health services for many of its health interventions, instead of providing them directing in the community (Rafter, 2008), but this varies significantly within the different provinces.

The Reconstruction and Development Programme (RDP) drawn up by the ANC-led alliance in the early 1990s discussed the provision of basic health care to the South African population as part of the overall development framework for the country. It focused on "meeting basic needs; developing our human resources; building the economy; democratising the state and society; and implementing the RDP" (ANCs vision for the future, 1994, p. 25). Under the framework of meeting the basic needs of the people, health care, was high up on the list. So as well as planning to build over one million new homes, the newly elected democratic government looked to provide affordable health care for all.

At the heart of this government initiative, was the development of a comprehensive national health system which would provide "free medical care to children under 6 years and to homeless children; improve maternity care for women; provide free services to disabled people, aged people and unemployed people within five years; organise programmes to prevent and treat major diseases like TB and AIDS; expand counselling services (for victims of rape, child abuse, and other kinds of violence); give women the right to choose whether to have an early termination of pregnancy; improve and expand mental health care; run special education programmes on health aimed particularly at young people; improve occupational health in the

workplace; and involve the fullest participation of communities" (Friedman, 2006b, p.171).

Given these requirements for the health system, in 1992 the [national] Department of Health commenced with a set of workshops centred around the role of the newly designated Community Health Workers (CHWs), also categorised as Community Based Health Workers (CBHWs), in developing health services in the community (Friedman, 2006a). By 1995 the Health Systems Trust had funded a national task force with the responsibility to develop a report evaluating the viability of larger government support to community-based health programmes (CBHP). This report recommended that government on a national level and civil society work to assist in its implementation to support the CBHP model. (Friedman, 2006a). Since then, little has changed in formal legislation on a national level, although at a provincial level, the WCG - Department of Health has put into place a framework for CBHPs. The model for this type of programme continues to be a vertical structure with the Western Cape Government Department of Health at the top and the CBHPs at the bottom. In the middle are the nonprofit service providers, which are funded to provide the services for the WCG - DoH. The NGOs do the actual hiring of the CHWs and Professional Nurses to manage the programmes.

The level of quality of these numerous programmes remains uneven, however, and Friedman (2006a) argues this has led to many challenges within the programmes including: "fragmented roles of many different kinds of community based health workers, large variations in incentives and payments, [a] disconcerting range in the amount and quality of training, inconsistent support and supervision, inadequate linkages to the district health system, poor integration, and the potential for developing conflict between different groups of CBHWs, [which] is great if vertical programmes do not agree on working together jointly on a community level" (Friedman, 2006a, pp. 167 – 168). Friedman (2006a) also contends that given that the CBHWs are accountable to the NGOs, and the NGOs are accountable to the DoH (district, primary health care system), this sets up an arrangement that is inherently destabilising at times.

With the advent of the development of the National Health Insurance (NHI) plan and the Primary Health Care (PHC) Re-engineering Programme, the role of CBHWs continues to evolve and has the potential to be more formalised. The Home-Based Care (HBC) programme has been at the forefront of the Community Based Health Programme for some time, and as the NHI planning devolves, this core function is now at the forefront of Community-Based Services (CBS). The plan calls for a multi-disciplinary team based approach centered from a hub at the local health facility. The team would be composed of a professional nurse and community

health workers (CHWs), but could potentially be increased to include other health professionals. Again, these teams would be housed within local community based NPOs. While this plan has yet to be fully implemented, Bam, Marcus, Hugo and Kinkel (2013) argue that the connection of health posts to NPOs operating in the community brings about a set of serious challenges to each of the parties, including possible doubts about their ability to set their programme focus, funding streams, who is responsible for what, and ultimately their overall autonomy.

In an informative study on community health workers in the Free State, South Africa, Schneider et al. (2008) looked at the history of the CBHW Programme and evaluates its progress in the fight against HIV/AIDS. Their pivotal research focused on the role of the CBHW as a dichotomy of technical practitioner versus an agent for change in the community. These contrasting roles have placed the CBHW as being either a source of empowerment in the community or a lackey of the Department of Health (Schneider et al., 2008). Their research traces similar community caregiver programmes within the Department of Social Development where there are approximately nine distinct classes of community worker categories. By 2006, the Department of Health had registered four community worker categories. These were based on proven programmes in Brazil, *Programa Agente Comunitario de Saude* and *Mitanin* in India (Schneider et al., 2008).

The conclusions reached in the study (Schneider et al., 2008) reveal community-based workers as not only generalists as commonly thought, but are actually focused on care and supporting the health professionals in WCG - DoH facilities. They serve as a link between patients/community and the WCG - Department of Health. The fundamental challenge, however, remains that they are a state-sponsored labour cohort, operating on the fringes of the health system, occupying an equivocal position somewhere between a volunteer and a worker. The government, intentionally has failed to incorporate them as part of the formal health system, but relies on the NPOs to act as intermediaries (Schneider et al., 2008). This puts them in the no-mans land where they are employed by a NPO, but work for government. Ultimately, the study recommends that government improve their working conditions and entitlements; expand and enhance their training; develop more defined roles and scope of practice; and create a mid-level of counsellors where more skilled community health workers could enter (Schneider et al., 2008).

Stemming from Schneider's research [and recommendations] in the Western Cape, a strategic framework document has been developed to give direction in terms of primary health care in

the Western Cape. *Health Care 2030 – The Road to Health* (Western Cape Government Health Department, 2015, p. ix) provides the strategic plan for the Department of Health in the province, including key priority areas which comprise: "reducing infectious diseases such as HIV/TB, improving healthy lifestyles, improving maternal and child health, and strengthening women's health." This document serves to provide a context for what the WCG - Department of Health is calling "patient-centred care [with a] life course perspective and integrated care provisioning" (pp. 24 – 25), which will be the cornerstone for health services in the coming decades. The research conducted for WCG - DoH for this new framework by Schneider, Schaay, Dudley, Goliath and Qukula (2015) is the most comprehensive study of the situation on the ground currently, but it is not yet assured that the Western Cape Department of Health has "assimilated" all the findings, especially on inclusive policy formulation. At the heart of this new strategic plan are two service delivery platforms: community-based services (CBS) and primary care services (PCS) – (Figure 1). At the core of the CBS platform are two further service elements: home and community-based care (HCBC) and intermediate care (Western Cape Government, 2015, pp. x - xi).

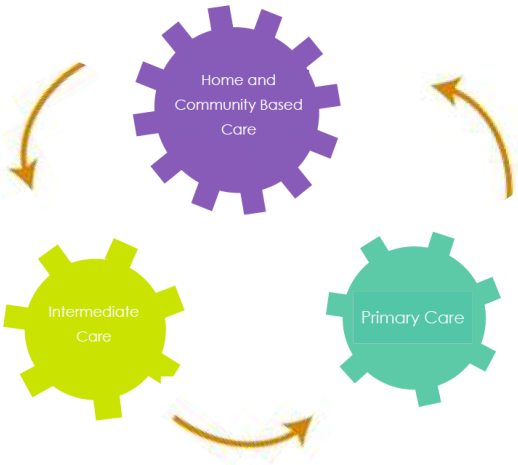

Figure 1: HCBC and PHC Integration (source: WCG: Health / 2014)

The community-based services will be geared "towards prevention and health promotion… through long-term personal relationships with households. [The focus will be on] proactive steps to strengthen the capability for early detection and treatment, reduction of risky behaviour… [in order to enhance] coping abilities [and] prevent illnesses and accidents." (Western Cape Government, 2015, pp. 39 - 40). The document is a considerable change from previous policy plans in that it places much of the responsibility for health on the individuals in the community. Proactive, preventative, and self-supporting aspects are the focus of the service

configuration, with "support" from the CHWs. Those with severe illnesses, chronic diseases, or trauma would be seen in the health facilities; however, their families would be tasked with many of the day-to-day caring burdens.

The model for the HCBC Programme is centred on community health workers (CHWs) and a nurse practitioner, working in a specific sub-district (population based). "Continuity of care… in a seamless manner" (Western Cape Government, 2015, p. x) is a paramount aim of the new plan. The goal is provide services in the household, within a community, with a referral process back to a central health facility based in that particular area. This spoke and wheel approach will focus on the management of the day-to-day operations of the HCBC Programme directed through the local health facility in partnership with the local non-profit service provider. Ultimately, WCG - DoH will be looking at the impact gained through indicators within the local health facilities. The referral and discharge process then becomes a key aspect of the overall procedure (Western Cape Government Health Department, 2015).

The *Health Care 2030* strategic plan document serves as the template going forward for the provision of community-based services in the Western Cape. It has already had an impact, which should be reflected in the research being conducted for this study. While the *Health Care 2030* document and its implementation are both in their infancy, its affects have already reached the sub-districts and local NPO service providers.

Stemming from the *Health Care 2030* document, WCG - DoH has issued further documentation setting out in greater detail the specifics of home and community based care as the new strategic framework came on-line in 2016. *The Home and Community Based Care Service Design Framework* (Western Cape Government, 2016) and *Western Cape Government Standard Operating Procedures for NPO Funding* (Western Cape Government, 2015) documents reflect the procedures for WCG - DoH and the NPO service providers in terms of service provision. The documents also provide the context for the HCBC Programme going forward.

In order to fulfil this new mandate, the strategic framework documents look to the 90 non-profit organisations operating in the Western Cape, with approximately 3,600 Community Health Workers, who are supervised by Professional Nurses, linked to a particular local health facility (Western Cape Government, 2016). As revealed in the literature, this new model has evolved with the participation of the various stakeholders, although what level of collaboration the various participants have reached is part of the work of this study. The documents (Western

Cape Government, 2015; Western Cape Government Health Department, 2016) reveal a need for inter-sectorial collaboration by tapping into the institutional knowledge gained by the NPOs over many years. The literature indicates that the consultation process for the new strategic plan commenced in 2012 through dialogue sessions with external stakeholders and special meetings set up in the districts (Western Cape Government, 2015). The literature also specifies that there were 42 written submissions raised during these sessions and that WCG - Health has "recognized the high levels of uncertainty and complexity associated with planning for the medium to long term…. [and therefore] the approach will allow flexibility [within a specific context]" (Western Cape Government, 2015, p. 2). The various papers are indicative of government documents, and while being descriptive of the overall programme, do not completely reflect the participation of non-governmental stakeholders in policy formulation.

Figure 2 – Wheel of Wellness (source: WCG: Health / 2014)

Recently, however, the various policy documents, including the Primary Health Care (PHC) Re-Engineering plan and the National Health Insurance White Paper have proposed the creation of a community-based service that takes a more gradual approach for individuals in the community by shifting the responsibility from solely that of the health system, to a partnership between WCG - Health and the individuals residing in the specific community. Therefore, strategic frameworks developed by WCG - Health, indicate that HCBC's objectives now reside in "increasing wellness (Figure 2) as not a state of being, but a proactive process of increasing wellness through knowledge, personal agency and capacity for making healthier lifestyle choices and for adapting to changing circumstances" (Western Cape Government Health

Department, 2016, p. 6). The new model segments the work as "10% home based care, 35% adherence/self-management, 35% wellness health promotion activities/case-finding, 10% in-service training, and 10% administration" (Western Cape Government Health Department, 2016, p. 17).

In summation, the view from government hinges on two sides of the same coin. While there is some doubt as to whether that non-profit organisations (NPOs) are able to operate in the community as they see fit (Moshabela, Gitomer, Qhibi & Schneider, 2013), there is a general understanding that the creation of these organisations has largely been positive and can be seen as a necessary development vital to end the gap caused by a strained health system. These NPOs were often developed rapidly with the funding being provided through government structures (Moshabela et al., 2013). The community-based NPOs leverage their capacity from integration within the community and their ability to utilise relationships and understanding of that particular community.

2.1.2 Service Provider – Government Relationship

While government may be generally satisfied with the CBHP framework, the NPOs, which are providing these services, are not quite as content.

The literature (Loevinsohn & Harding, 2005; Steiner-Khamsi, 2002; Stern & Green, 2005; Rafter, 2008; Dawab & Johnson, 2011) on the balance of donor (government), service provider, and community relations often takes a very distinct partisan view, with different authors analysing the power-imbalances in the different contexts. Some see fewer imbalances than previously postulated, as there is a trade-off that the donor needs the recipient (to implement), the recipient needs the donor (for funding), the community needs both the donor and the recipient [organisation], and the donor and recipient in the end also need the community (the very reason for the NPOs existence and donor's philanthropy). An interdependent, symbiotic relationship exists between the actors and their mutual growth (Reimann, 2006; Skjelsbaek, 1971). This more benign approach is seen within the Community Health Worker (CHW) programme in South Africa which serves to empower the organisation and build a bridge between patients and the health system, although not without the concern that the public health system will continue to rely on a health workforce which is not completely formally integrated, nor is deployed into the health system; thereby not challenging the overall question of health staffing on a national level (Schneider et al., 2008). In contrast, there is an argument to be made

that organisations have been corrupted by the organs of the state into quasi-non-governmental organisations (QUANGOs) which implement projects that were formerly the responsibility of the state to provide (Steiner-Khamsi, G., 2002). In a pivotal study of this uneasy balance, Grover, Burger and Owens (2010) uses economic models, which have found that it would be "naive" to think the priorities of the community and NPO activities would be compatible.

In any study of the various service providers, it must also be stressed that there is no overall homogeneity in how they are structured and/or operate in the community they serve (Moshebela et al., 2013). These organisations can be broken down to the larger NPOs operating at the provincial or national level, and the generally locally subscribed community-based organisations (CBOs) which are sub-contracted to carry out the actual service provision (Moshabela et al., 2013). They operate with different levels of capacity and consequently have a myriad of relationship features with government.

The view of the WCG – DoH from the service provider position can be best summed up by their belief that "statutory authorities remain structured in bureaucratic patterns, characterised by self-interest, inflexibility and resistance to change, and are typified by hierarchical structures and distinct boundaries" (Stern & Green, 2005, p. 270). This view has changed marginally over the preceding decades and continues to underline the day-to-day workings of the two entities. In the review of many studies focusing on the provision of various health interventions including PMTCT, community-based care for orphans and vulnerable children (OVC), and rehabilitation the main focus has been on the particular intervention, but all have come up against the challenge of working effectively and in partnership (collaboration) with the Department of Health (Dawd & Jobson, 2011; Mate, Nuguabane & Baker, 2013; Murray, 2010).

An additional reason for the gaps on both a national and local level, is that a framework that stresses compartmentalisation and 'silo-ing' of services to the community has developed over time. This has been only compounded by the extreme workloads and staff shortages within both government departments and organisations in the community providing much needed basic services.

There is also a sense that the organisations based in the community have a comparative advantage over the Department of Health in that they better understand the communities they are based in, and can therefore reach vulnerable individuals more efficiently than government (Loevinsohn & Harding, 2005; Rosenberg, Hartwig & Merson, 2008).

It is important to better understand how the process of interaction is contextualised between the two entities, including how the various actors respond to the conditions explicit in their exchanges. In addition, it is important to unpack the conditions that have given rise to dynamics of the relationship and the consequences thereafter, leading to outcomes that encompass both the positive and negative aspects of the day-to-day interactions between the two entities.

There is also the thought that government has failed to fully understand the interdependencies between government and the NPO sectors, which require government to be fully engaged in service provision (Rafter, 2008). This has often lead to failure of many NPOs for a number of reasons including: "philanthropic insufficiency, particularism, and amateurism" (Rafter, 2008, p. 19). Philanthropic insufficiencies occur because an NPO relies on donations, usually from only a few sources, to cover its operational costs. Philanthropic particularism arises when the services are developed for a specific set of community members, resulting in gaps for subgroups that cannot mobilise resources for their own needs. Lastly, philanthropic amateurism stems from relying too much on voluntary management efforts by an NPO, and not enough professional support (Rafter, 2008). Government, through an intensive engagement with NPOs, can negate or lesson these potential threats to organisations and their rendering of health services in the community.

The literature also reflects the need to establish collaborations between the Department of Health and the NPOs providing the various health services in the community. Mate et al. (2013) suggest that it is very difficult for NPOs and government to work together in a genuine collaboration, even though it would be in both their interests for the effective implementation of health programmes. Dawab and Jobson (2011) concur with this view and see the top down way programmes are managed from government as leading to a dictatorial, silo-based approach that leaves little room for NPOs' views and needs. If true collaboration is to be developed it would require a longer, more empowering, capacity building initiative bringing together the two entities into a relationship on a truly equal footing (Stern & Green, 2005).

A recent literature article, authored by Schneider et al. (2015) summarise very succinctly the challenges of community based services through research conducted in the Western Cape and indicate that a major concern remains that NPOs have a set of their own goals and objectives, which at times may or may not be in alignment with the WCG - Department of Health. The study revealed that there had been a diffuse set of responsibilities, coordination, and clarity in communication amongst the various stakeholders, which lead to impediments in the overall

relationships. The study also exposed the debate within WCG - Health as to whether a NPO model is preferable to that of a WCG - Health platform, where the department would take on the HR responsibilities directly for the CBS system. It was generally agreed from the various case studies that the NPO model was more favourable, as the NPOs had a greater footprint and "embeddedness" in the local communities (Schneider et al., 2015). Finally, and crucially, the study found there has to be a trust element in the relationship between WCG - DoH and the NPOs, more than something that is built on a contractual (transactional) association. The article very aptly ends by noting that for the CBS programme to succeed, "it requires the capacity to shift from modes of command-and-control (managing up and down) that are dominant cultures within frontline service provision towards new relationships across organizational boundaries based on networking, cooperation and reciprocity (managing out)" (Schneider et al., 2015, p. 10).

2.2 Collaboration Theory

Collaboratives have been one mechanism on an international basis that has been postulated to improve uncoordinated and fragmented health and social service delivery systems (Hoge & Howenstine, 1997; McLaughlin & Covert, 1984) and ultimately support sustainability. Collaboratives are groups set up in the community made up of leaders and staff, comprising non-profit, government, and commercial entities, all working together on a common interest (Nowell et al., 2009). It is vital that there is a development of a cooperative relationship among stakeholders if such collaborations are to succeed (Bond and Keys, 2000; Cambell Dienemann, Kub, Wurmser, and Loy, 1999). Gray (1989, p. 5) defines collaboration as the "process through which parties who see different aspects of a problem can constructively explore their differences, and search for solutions that go beyond their own limited vision of what is possible." Where on the continuum of service provision, from no interaction, to high-level coordination, to collaboration the relationship between WCG – Health and NPOs sits, is the fundamental basis of this research study.

In terms of initiating coordination of services and then achieving a collaborative effort, the end goal would certainly endeavour to promote a substantive collaboration. There is a significant difference between cooperation and collaboration along the continuum in their intensity of integration, complexity, obligation, and interface (Thomson & Perry, 2006). Lozano (2007) breaks down the various definitions on the continuum as being *coordination*: actions performed by different entities in order to make them like-minded with a common goal or result;

cooperation being: connecting in work on M&E, learning from each entity, and distributing experiences; and finally *collaboration* being: using information to establish something innovative, jointly expanding proposals, communicating information, raising funds together, and partnering in activities.

Lozano (2007) further breaks down interactions between organisations to *Inter-personal interactions* which usually take place between individuals; *inter-group interactions* that is found from different groups within an organization or between different organisations. Even if an individual represents a group, that individual is inter-acting on a group level; and finally, there are *inter-organisational interactions*, which clearly looks to interactions between different organisations in the community.

The literature on collaboration includes the manner in which effective collaborations can be achieved and the pitfalls associated with its many challenges. A significant researcher in the field of collaboration in South Africa, Walid El Ansari, has lead a number of studies looking at a unified approach to collaboration in communities. His work presents a comprehensive review of the collaboration process. His definition of collaboration is a more refined form of those developed above and specific to health projects in South Africa. Accordingly, he defines collaboration as "to work jointly with others on a project, where those collaborating with others take on specified tasks within the project and share responsibility for its ultimate success" (El Ansari & Phillips, 2001a, p. 231).

While his focus is on community collaboration, it also looks at the partnership between government and civil society. He notes that there has been little study of how collaboration can affect the quality of health (El Ansari & Phillips, 2001a). He studied five interprofessional partnerships (health, nursing, and associated health professionals) in South Africa working with the W.K. Kellogg Foundation to provide health care.

El Ansari and Phillips (2001a) argue that health is not only driven by the usual determinants (behaviour, income, access to health care), but also by the relationships or interprofessional alliances. They utilised a (validated) self-administered questionnaire for the study to a relatively large sample of 427 participants within the five partnerships. The participants included community health workers, as well as core project staff. They did not sample, however, participants from the government side. The outcomes of the collaboration were generally beneficial, but required intensive inputs (Eshel et al., 2008). These inputs will be discussed in greater detail later.

El Ansari and Phillips (2001a) have seen the growth in partnerships within the health care field in respect to the provision of a wide range of disease and health services including maternal and child health, family planning, and STIs. Donor organisations stress the need for collaborations in order to gain efficiencies of scale in the implementation of programmes, therefore gaining more impact from their investments. Collaboration is taken as a positive, yet true collaboration is very difficult to achieve (El Ansari & Phillips, 2001a/b/c). In addition, it is argued that it has been very difficult to study collaboration effectively as randomised controlled trails are not feasible to test the viability of collaboration (Foster, Gomm & Hammersley, 2000). Collaboration is made up of various components, including social capital and network theory. This paper will address these theories later in the literature review, but it must be stressed at this point that collaboration is a complex interaction involving many diverse, distinct topics of views.

Because collaboration is built on so many interacting facets, it is a significant challenge to build and evaluate a fully collaborative initiative (El Ansari & Phillips, 2001a/b). From the available data, however, there are a few foundational pillars that can be utilised to develop a collaborative effort. In their ground-breaking work, El Ansari and Phillips (2001b) looks extensively at these fundamental pillars and from their review of the published work, develop a number of principles that lead to collaboration successes within the health care framework.

These principles include: 1) utilisation of networks that have already been established, however, other stakeholders should be brought in as warranted; 2) patience, there is a need to spend a significant period of "quality" time on developing and retaining the various aspects of the collaboration; 3) effective communication is essential, as all parties have to be able to know what is occurring, what they are responsible for, and what the ultimate goal of collaboration is; in addition, all partners need to feel heard and be able to communicate openly, in a transparent environment; 4) there has to be a development of broad-based social capital in-order to provide a sound foundation for the coming together of the various partners; 5) an understanding that the partners bring various levels of resources and skills to the collaboration, and this may lead to power imbalances if not managed properly; and finally 6) there has to be a clear common vision with a sense of ownership, clear and transparent policies and procedures that support trust and motivate for a common purpose (El Ansari and Phillips, 2001b).

The literature notes that, while the benefits attained from collaboration are significant if done correctly, if not carried-out effectively, it can lead to additional stresses on the system and result

in a dissolution of services over time. "Transactional costs theory, which premises that cooperation with others has costs (e.g. loss of autonomy, commitment of time, energy, and/or other resources, investment of political capital) and therefore risk associated with it, puts a value to the process costs. These costs are a key consideration for stakeholders in deciding whether to cooperate with others" (Nowell, 2009, p. 197). Ultimately though, previous research has validated, that if coordination and collaboration are operationalised optimally, then there are significant benefits accrued to the participating organizations and a higher rate of return in the specific service provision (Jennings et al., 1998; Nowell, 2009; Hook & Ford, 1998; Bond & Keys, 2000). It is vital therefore, that any proposed collaboration be based on sound footings of mutual understandings of the problem, how the different entities will work together to render services, the relationships between these organisations, and ultimately who takes responsibility for what (Seidman & Gilmour, 1986). The process is time-consuming, and therefore the rewards have to be significant enough to warrant the additional work in setting up a collaboration.

In their seminal work in southern Africa, including South Africa, Rosenberg (2008) and his team from the Center for Interdisciplinary Research on AIDS (CIRA) at Yale University, looked at the nature of collaboration between government and NPOs operating to provide services for orphans and vulnerable children (OVCs). Even with their relative comparative advantages, however, their findings proved without a doubt that, without collaboration with government, it was impossible to ensure sustainability and increase the overall impact of the service provision to the OVCs (Rosenberg et al., 2008).

The work of CIRA in South Africa included psychosocial support, material, and training in order to provide holistic support for OVCs, including the prevention of HIV/AIDS. As noted above, the study indicated that the role of government is crucial, particularly for OVC work, as government needs the complementary services of NPOs in order to put policy into action (Rosenberg et al, 2008). The CIRA study looked at nine OVC projects through a short questionnaire about their collaboration with government. The conclusions reached, reflect very similar issues mirrored in much of the other research. It was seen as crucial for sustainability to have a good relationship with government and the provision of services, such as grants, was enhanced by the collaboration between government and NPOs. These NPOs were able to initiate community-based solutions, which resulted in more impactful service provision. In turn, government can, as administrator of funding from such sources as the Global Fund, provide a conduit for funding for these community-based organisations. These synergies arising

from collaboration between civil society and government agencies, are clearly defined from the study. However, the one proviso is that there is a "clear delineation of appropriate activities" (Rosenberg et al., 2008, p. 59).

Effective collaboratives are recognised in the work of Eshel, Moore, Mishra, Wooster, Toledo, Uhl, and Wright-DeAguero (2008) in HIV prevention in four communities in the U.S. In their study of the effect of the Minority AIDS Impact (MAI) initiative, they were able to identify the role collaborations played in both organisations and the community. In addition, they indicated that the collaborations, especially formal ones, lead to the MAI being more responsive to the complex needs of their clients and the ability for them to support a wider range of resources, given the situation on the ground (Eshel et al., 2008).

Another model for collaboration is the Centre for AIDS Development, Research and Evaluation (CADRE) who work on AIDS responses on a national level. A study of their work reveals that for maximum impact, it is necessary to collaborate, even at a basic level on key services, for example referrals and integrated case management (Birdsall et al., 2007). A major challenge to the implementation of effective AIDS services has been insufficient networks between the various stakeholders. Strong networks were also found to increase the "power" of advocacy activities and promote their work. As was found with other studies, collaboration takes a long time to implement and involves a lot of work. A risk that was identified stemmed from networks competing with the organisations within that network for funding and other resources (Birdsall et al., 2007). A way around this challenge was found to be a central funding conduit, which would then disperse the funds to the member organisations through a designated framework. Finally, the models that worked best incorporated independent, grass roots approaches to growing trust over time, in order to leverage the strengths and interconnection of the network.

A look at interdisciplinary experiences between social workers and physicians examined the positive and negative impacts of collaboration in health and social care in the United States (Abramson & Mizrahi, 1996). The study cohort was made up of 51 physicians and 54 social workers who were given a questionnaire to assess their views on a collaborative initiative bringing together the two professions within a hospital setting. A positive benefit of the collaboration allows for a shared "burden" of care for patients with serious problems needing the support of a social worker. This division of responsibility can also result in less burnout by the professionals, as there is greater support for each other. On the negative side, there was a

concern with the imbalance between the physician and social worker, where the physician naturally took the lead role within the collaboration. Social workers sought validation from the physicians, but the physicians rarely sought validation from the social workers. Surprisingly, the physicians did value the partnership as it relieved some of the care burden with their patients. Communication was seen as crucial, and could be seen as a liability or asset, depending on how open the lines of communication were. Communication was highly valued by both the physicians and the social workers. The study ultimately revealed how crucial relationships (interactional skills) are for a collaboration to succeed (Abramson & Mizrahi, 1996). Negotiation and compromise were also important as too the ability to learn from each other.

A final international study looked at the linkage model (collaboration) for mental health services in rural communities in the U.S. This study focuses on the linkage model, which brings in collaboration from both government and interorganisational groupings. The results of the study clearly reflected the benefits of collaboration in rural areas where resources are dispersed and scarce (van Hook & Ford, 1998). Although the study focused on the perceptions of the health professionals, other studies from the client perspective reveal the benefits from an integrated approach (Brown, 1997; Slay & Glazer, 1995). Pitfalls that need to be addressed include organisational variances surrounding policy, processes, and cultures.

Once the decision has been made to enter into a collaboration, there are several stages that the 'new-born' entity has to progress through. El Ansari and Phillips (2001b) conducted a major analysis of the process of the development of a collaboration in two organisations in South Africa. As discussed earlier, in order to enter into a collaboration, there has to be a specific goal and an understanding that there will be the recruitment of diverse and distinct partners. Additionally, there has to be a level of durability and flexibility amongst the stakeholders. The point that the coalition transforms from formation to maintenance occurs when "organisational actors coalesce around an issue(s), mobilise resources, and establish a purpose and a leader, for all practical purposes the coalition has [then] been formed" (Roberts-DeGennaro, 1987, p. 234). Once this collaboration has been formed, it is crucial that the various participants each add their own individual strengths to the coalition in order to retain their overall value to the entity. El Ansari and Phillips (2001a) also argue that in order to maintain the sustainability of the collaboration and to keep it moving forward, against the many challenges, there has to be a maintenance process. This maintenance process includes conflict resolution, open communication, regular interaction, provision of individual strengths, lowering turfdom

loyalties, and staying focused on the common goal. Ring and Van de Ven (1994) summarise the process as shown in Figure 3.

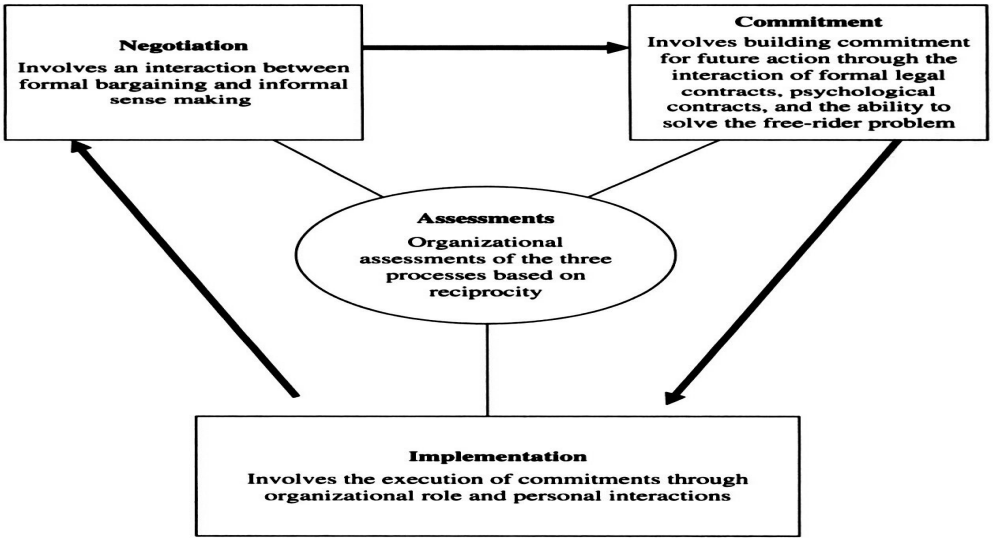

Figure 3: Maintenance Process (source: Ring & Van de Ven, 1994)

Finally, in assessing the effectiveness of collaboration, El Ansari and Phillips (2001) ultimately specify that the best indicator of a programme success is that the intervention makes the community more able to meet their current health needs. This approach, however, has to be balanced with the need by partners to indicate which indicator(s) are best. Quick wins may be necessary to increase unity, commonality of purpose, and motivation. After the coalition has been formed, success can also be measured in goals attained and longevity of the entity. Not surprisingly, Kazemek (1991) reveals that fewer than 50% of partnerships succeed and almost 80% do not meet the expectations of their participants. Thomson and Perry (1998, p. 408) have stated that "collaboration is like cottage cheese. It occasionally smells bad and separates easily."

Barriers to collaboration are manifold but can be summarised as follows: "personnel factors (benefits, costs and benefit/cost ratio); personnel barriers (member priorities, turnover and interest); organization factors (rules and procedures); organizational barriers (goal setting and decision making); power-related factors (power disparities); and [finally] other factors (procedural delays)" (El Ansari and Phillips, 2001a, pp. 242 – 243). There are also numerous built-in constraints to collaboration, which have to be fully considered before embarking on the process. The density of each partner has to be understand, and also the fundamental idea that the collaboration may not be the sole or most important determinant for that particular organisation (although it should be somewhere high up on their priority scale, otherwise the

work entailed entering into the endeavour should not be started). Individuals in the respective organisations often have limited time, and may not be fully engaged in the activities of the coalition. Collaboration requires a give and take attitude between the various partners. The key is to stimulate enough interest in the activities (value) in the collaboration to ensure that the various partners stay interested and motivated (this same framework will be discussed further in the literature surrounding social capital and the "value" given or received).

In conclusion, the literature on collaboration reveals that there is a fine line between the benefits of collaborating and making the particular condition poorer. As Thompson and Perry (2006) agree, collaboration takes extensive time, energy, and cost. Collaboration remains a fragile environment that is inherently complex and turbulent. "Like the ideal of civic republicanism, collaboration represents an ideal to which we aspire but sometimes fall short of achieving" (Thompson & Perry, 2006, p. 29.)

2.3 Social Capital Theory

At the heart of the fragile yet valuable tool of collaboration, social capital presents a foundation for attainment as it encompasses the very building blocks of collaboration. While definitions of social capital are today routinely modified to fit a multitude of requirements, social capital has been described as the "glue" that generates coordination. "This glue makes people work together either for reasons of their own or due to pressure within the group" (Paldam, 2000, p. 629). This in a nutshell defines the motivation for coordination and collaboration of disparate groups. Yet if one traces the derivations of Paldam's definition of social capital, one would find it has had many incantations and evolutions over time. The evolution of thought on social capital theory is on-going and multifaceted. The debate has lead to two camps of thought on the makeup of social capital encompassing the "social support" school (lead by Robert Putnam) and the school (lead by Richard Wilkinson) focusing on the psychosocial effects of the significant growth in the levels of socioeconomic inequality (Szreter & Woolcock, 2004).

Social capital has seen a marked change in definition from Pierre Bourdieu's original designation in 1980, that it is "the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalised relationships of mutual acquaintance and recognition" (Bourdieu, 1985, p. 52). Bourdieu saw social capital as an outgrowth of the classical (neo-capitalist) theory of Karl Marx (Lin, 1999). Bourdieu (1985) also saw social capital as reinforcing the privileged class dominance within a closed system that allowed the network to sustain benefits for its internal actors. Therefore, social capital was seen

through the prism of the continuing class struggle. Rewards were attained for a few within a closed set or group. Subsequent researchers diverged from this premise to focus on the various components of social structure that impacts relations amongst individuals and assists with production or utility function (Schiff, 1992), [which includes] all ones associates, including friends, people one works with, acquaintances, etc. where one could potentially receive opportunities to provide financial and human capital (Burt, 1992).

Seen in a more positive light, social capital reflects "the ability of actors to secure benefits by virtue of membership in social networks or other social structures" (Portes, 1998, p. 6). In this account social capital is cast in an activist sense allowing for benefits that would not naturally occur devoid of the process of securing social capital. Nahapiet and Ghoshal (1998) builds on these foundations and shapes a structure of networks where social capital is the total of the actual or potential resources actually held or gained from a network of relationships held by a person or a collective. So then, social capital is made up of relationships, resources, and networks of individuals and groups. Instead of assisting a limited few as Bourdieu (1980) initially argued, the masses could attain these benefits as well, if the manner of attaining social capital was implemented effectively.

As social researchers have drilled down further to better understand the interplay of the varied components so as to grasp the benefits derived from social capital, the nature of what is social capital continues to evolve. Social capital is inherently seen as part of a triumvirate made up of *intellectual capital*, "the knowledge and knowing capacity of a social collectivity, such as an organization, intellectual community, or professional organization [and] *human capital* which embraces the acquired knowledge, skills, and capabilities that enable persons to act in new ways" (Coleman, 1988, p. 598). Robert Putnam (2000) further dissects social capital in accordance with Coleman (1988) to delineate between physical capital that are the tools and human capital which can be said to be the training which combined lead to greater productivity, "social capital" and ultimately a form of barter. Networks are formed to engage the various components and provide the coordination and communication, with trust as its main driver (Putnam, 2000).

Networks are beneficial because they bring together often discordant individuals (or groups) into a situation of trust and mutual benefit that then works to the greater good of the individual units. Social capital is built on the ability to increase economies of scale from working together, which is based on trust between often highly distinct individuals or groups. Yet, what are the

actual ties (glue) that this framework is built upon that allow for the myriad of individuals and groups to work effectively together? Gittell and Vidal (1998) and Szreter and Woolcock (2004) look at three different levels of social capital stickiness: "*Bonding*, social capital generated from amongst members of a group or network who see themselves as similar. *Bridging*... relationships between people and groups of people who are some dissimilar in some demonstrable fashion... and *Linking*, the by-product of exchanges that arise from relationships that individuals and communities build with the institutions and people who have relative power over them" (p. 656). Bringing together this framework, is the network.

As Hawe, Webster, and Shiell (2004) and Hawkins and Maurer (2011) attest, there are several terms that need to be clarified in any discussion on network analysis. The basic component in any network is the *actors*, who are a distinct individual (e.g. patient) or a collective unit (e.g. community health facility). The types of networks can be further broken down into *one mode* networks, where there is a particular set of comparable actors; *two mode* networks, which provide relations amongst two distinct actors (e.g. government and NPOs); and finally *socio-centric* networks which are complete networks which are part of a single, bounded cohort (e.g. relational ties of staff within a clinic).

Measurement of any network can be best understood graphically (Figure 4). Graphs are a representation of a network with actors (nodes) and the relational ties connecting actors (lines). Cohesion looks at the interconnectedness of the actors through distance between the two nodes (actors), which is called degrees of separation; reachability, which measures if the actors within the network are related; and density, which is the total number of relational ties divided by the total possible number of relational ties. Density is a common measure of network analysis (Hawe et al., 2004).

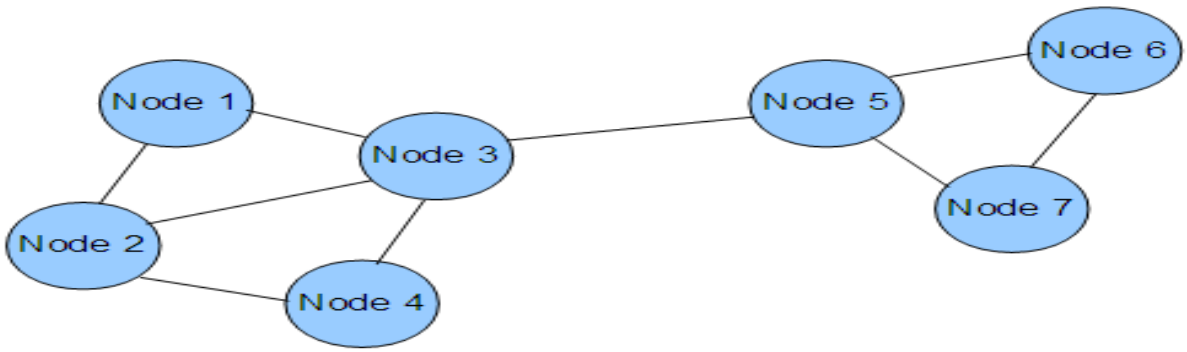

Figure 4: Graphic Representation of a Network (source: Hawe et al, 2004)

Lin (1999) takes the measurement of social capital in networks to a more complex level in order to provide a sophisticated tool for understanding their complexity. He argues that the location of the individual in a network is crucial to the ultimate value of social capital generated. The other indicators of social capital intensity are the strength of ties and density. Finally, Bourdieu (1986, p. 254) sees network closure as being highly important because "it is closure that maintains and enhances trust, norms, authority, sanctions, etc." Lin (1999) disagrees because he argues that bridges need to be open in order to allow the flow of information and stimulus. The debate within social capital theory continues and the most appropriate and valid argument will be utilised for the research entailed in this study.

Further study of social capital has glimpsed the minutiae that encapsulate the understanding of the basis for its on-going theoretical justification. If the core to social capital is relationships, then the epicentre is the network. Nan Lin (1999) looks at the benefits of networks in social capital theory, yet he sees it in a broader framework than just trust, density, and issues of outcome. In Lin's seminal paper, *Building a Network Theory of Social Capital* (1999), he argues that the debate over the usage of the very term "social capital" needs to be explored. He contends the requirement for network density or closure is unrealistic. There may or may not be benefits for network density or closure. He further contends that "the value of social capital is governed by 1) network characteristics, 2) strength of social ties, 3) network member assets, [and] 4) the goal of the purposive action that motivates the capital-generating social exchange" (p. 37). Lin has brought together the divergent arguments into two central components, social networks and social relations. The volume of social capital it is argued depends on the size of the network and the volume of capital (Bourdieu, 1980), network position, or network size, relationship strength, and resources held by the network (Paldam, 2000). Lin (1999) concurs with many of these arguments, yet postulates that some bridges or networks do not necessarily lead to greater influence, reinforcement, or information (Lin, 1999). He finally sharpens the definition "of social capital as investment in social relations by individuals through which they gain access to embedded resources to enhance expected returns of instrumental or expressive actions [from which can be identified three processes] (1) investment in social capital, (2) access to and mobilisation of social capital and (3) returns of social capital" (Lin, 1999, p. 39).

Consequently, the underlying tenants of these arguments point to the need for a real return on the investment incurred with the process of building social capital. If the network is like a set of webs, its potency may or may not be dependent on the number (density) or proportionality of their strands (closure). Rather, to take the metaphor further, it is the environment (network

characteristics) the webs hang in, the strength and stickiness of the individual strands (social ties), the advantage (network assets) of a set of spider-webs, and finally the motivation (purposive action) for the spiders to construct these webs and wait for their prey (return on investment), which will ultimately benefit all the spiders (individual or groups).

It has been seen through various distinctive studies that social capital contributes directly to a significant level of important health outcomes (Szreter & Woolcock, 2004). What Szreter and Woolcock (2004) attempt to amplify in their seminal work on social capital, social theory, and public health is the link between social capital and these public health benefits, and whether social capital can be directly linked to improved public health outcomes or is it more causal in nature.

Underlying the complexity of the situation, theorists continue to argue the basic tenants of social capital. This clouds any answers on the theoretical and empirical aspects of social capital and health. Social capital is not the panacea to alleviate all of society's ills; in effect it can actually heighten these challenges, but ultimately there is evidence that social capital assists in health promotion. How and through what mechanisms this occurs is also a continuing dispute amongst epidemiologists and academics. As the debate continues on the distinct aspects of social capital and health, Szreter and Woolcock (2004) argue in summation that "none of the three epidemiological schools of thought is wrong, in its own terms, about the relationship between social capital and health, but that, like the sequence of conceptual developments of social capital theory, they represent successively more comprehensive formulations of the scope of the causal factors involved in analysing the relationship between health, citizens, society, and ultimately, the policy and state" (p. 362).

As can be seen in the evolution of social capital theory, it can act as the underpinning of any research into the mechanisms and potential benefits of collaboration in the provision of health and social services. Ultimately, these potential benefits derived from collaboration should result from some form of social capital (although Putnam (2000) would probably see the concept as a much more neutral output). The social capital at the heart of the relationship should in turn allow for continued support for coordination and collaboration both by the service providers and the recipients. In other words, the investment (costs) in working within a collaborative is outweighed by the return gained from the enhanced deliver. This social capital represents a value of networks, be it of a social nature, or in the case of this study, the creation of a network of health and social services providers and stakeholders. Putnam (2000) has written extensively

on the role social capital has had in democracy and one central component of a strong democracy is the ability of government and civil society to ensure the provision of effective and efficient health and social service provision. The ability to strengthen ties within the network will be vital for the success of any model of coordination and collaboration. Coleman (1998) argues that social capital leads to action on an individual or group level (Portes, 1998), which can then follow on to networks. Social capital theory, by conceptualising the glue that makes people work together either for reasons of their own or due to pressure within the group, creates a framework for the theoretical foundation of a model of collaboration in health services.

2.4 Conclusion

The study of the nature, extent, and experience of collaboration between the WCG - Department of Health and their community-based service providers is built upon the investigations of many other researchers who have examined the home and community-based care programmes (HCBC) as a review of the primary health care system, and as the HCBC Programme as a sub-set thereof.

The literature on the evolution of community-based care provides a comprehensive perspective on policy formation by government, and the concurrent participation and reaction from NPOs operating in communities throughout the Western Cape to their proscribed involvement in the programme. In addition, there is a wide-ranging body of work, which has been recently completed, that provides a thorough foundation for the research in this study.

The current HCBC model has evolved over many years, through much iteration. It grew out of a partnership between the European Union, the South African government, and NPOs, who were contracted to implement a Home Based Care (HBC) Programme supporting efforts in the fight against the HIV / AIDS pandemic. Over the years the HBC Programme has evolved to incorporate the Millennium Development Goals, palliative care, adherence support, prevention, and health promotion (Western Cape Government Health Department, 2016). It was seen as the cornerstone of health care (informal and formal) in the household, based within a community.

The literature reflects a wide review of the latest thought on the home and community based care programmes (HCBC) in the Western Cape. It additionally provides a framework for the future of the HCBC programme and the role and responsibilities of the various stakeholders (Western Cape Government, 2015). Studies conducted by other researchers, lays out the

situation on the ground currently, while looking back at the system in the past (Schneider et al, 2008; Schneider & Lehmann, 2010; Friedman, 2006; Moshabela, 2013). It also provides an agreement on the way forward (Schneider, Schaay, Dudley, Goliath, & Qukula, 2015). These studies reach a consensus on the need for broad participation by community-based service providers in policy and strategic planning from the outset, yet government policy documents retain only minimal discussions on the inclusion of these groups for the entirety of the process.

The literature clearly underlines the elements of collaboration between the Department of Health and its community-based service providers, albeit in a non-formalised manner (El Ansari & Phillips, 2001a; Birdsall et al., 2007; Moshabela et al., 2013; Schneider et al., 2008).

The focus on collaboration theory as argued by Nowell et al., (2009), El Ansari and Phillips (2001a/b/c), and Nowell (2009), exemplifies their work to review collaboration in all its various forms and necessary requirements. A central component of collaboration theory is social capital, as advanced by the standard-bearers in the field, Bourdieu (1986), Paldam (2000), Coleman (1988), and Portes (1998). They detail and debate the glue that makes people work together, which is the very heart of the collaborative process. Finally, Lin (1999) and Hawe et al., (2004) offer the networks and linkages that frame (and to some extent quantify) the social capital paradigm and allow for modelling of the various role-players in any collaboration, which takes network theory, and by relationship social capital to a point where it can be measured; thus into the realm of "hard" science.

3. Research Methodology

3.1 Research Approach & Strategy

In practical terms, to conduct this research it is necessary to utilise a qualitative approach to the study, as the data to be sourced arose from a number of elements that are centred on interaction between the various entities operating in the government and NPO environment. A review of the literature reveals that almost all of the previous studies on the subject, or those of a similar nature, have relied on a qualitative approach (Mate et al., 2013; Moshebela, 2013; Murray, 2010; Stern, 2005). The qualitative approach also allowed for a nuanced understanding of the dynamics that make up the interplay between the two organisations, which would not be fully addressed in a quantitative framework. Additionally, the literature, especially the more recent, is predominately qualitative in nature, due to the information gained through (semi-structured) interviews, focus groups, mapping, and case studies (Naledi et al., 2011; Schneider et al., 2015).

As the author was 'embedded' within the daily interactions and relationships between the two entities, Insider (Emic) Ethnography was the appropriate methodological framework for this study. "Emic perspectives are those taken by a researcher who is a member of the community being studied (Naaeke et al., 2011, p. 1)," in this case the community being composed of the HCBC Programme. Insider Ethnography has its foundations in the fields of anthropology and sociology (Silks & Potts, 2008) although it is now utilised throughout the various disciplines. Robert Merton (1972), an early researcher into insider research indicates that one of its key doctrines is "one must not only be one in order to understand one; one must be one in order to understand what is most worth understanding" (p. 16). Merton later argues the merits of the insider-outsider dichotomy. He contends, however, that one does not have to be a member of the community to understand or study it. Later researchers (Breen, 2007) have debated the insider-outsider contradiction and now view it in a more nuanced sense across a continuum; however, there are still specific aspects to insider research that have to be addressed.

A paramount concern with insider (emic) ethnographic research is positionality and bias (Naaeke et al., 2011; Greene, 2014; Chavez, 2008). The positionality of the researcher is critical, as even an insider ethnographer has a range of "embeddedness," from total insiders who hold multiple layers within a relationship in an in-depth experience with the community being studied, to a partial insider who has certain common aspects within the community, but could also be detached from that community (Chavez, 2008). The positionality of the researcher has been broken down further, to indigenous-insider and external-insider (Banks, 1998). The indigenous-insider is a researcher who "holds the values, perspectives, behaviours, beliefs, and knowledge of his/her indigenous cultural community that is under study [whereas] the external-insider has been socialised or adopted into the outsider culture, rejecting the cultural values of his/her indigenous community" (Greene, 2014, p 3). While these categories are focused more towards the cultural ethnographic environment, the insider / outsider paradox also has bearing on communities made up of organisations and entities that have their own internal cultures.

The positionality of the insider ethnographer has both positive and negative repercussions for the researcher. In terms of benefits for research, the insider ethnographer has the advantage of coming into the research environment with a basic understanding and knowledge of the context of the situation under study (Merriam et al., 2001). The insider ethnographer does not have to go through the long and exhaustive process of gaining an understanding of the underlying contexts of the relationship under study. Additionally, an insider ethnographer generally has greater access to individuals and the group under study. The insider ethnographer is usually

welcomed into the group and has open access to interviews with individuals within the group, allowing for a more efficient flow of information (Greene, 2014).

While insider ethnography has many positive aspects, there are a number of features that pose a risk to the research process, subjectivity and bias being two such elements. Being too subjective can lead to a major challenge in the analysis of the data. DeLyser (2001) argues that if a researcher is too comfortable or acquainted with the subject matter and the community under research, he/she could lose objectivity and risk making assumptions based on the prior knowledge or involvement. The insider's worldview becomes too narrow and there is the potential loss of analysis and insight, which could have provided the insider ethnographer a more balanced approached to the subject matter.

Ultimately, but crucially, insider ethnography has been accused of inherent bias, as the researcher is considered to be too close to the community or group under study (Greene, 2014). The insider ethnographer comes into the research with a bias that reflects both a personal interest in the matter under study, as well as a relationship with colleagues, which has been built over time in a certain prescribed manner. In addition, in the data analysis stage, the inherent biases held by the insider ethnographer may preclude a more objective examination of the data.

In order to overcome their internal biases, the insider ethnographer should deconstruct his/her research, speak with others [outside the community] to create space and open him/herself to intensive scrutiny (Greene, 2014). In addition, the idea of opening oneself up to the practice of reflexivity which creates a platform for self awareness, questioning perceptions, and a better understanding of any biases, can limit many of the challenges associated with insider ethnography. It is vital therefore, to gain a better sense of ones biases and build distance (space) between oneself and the community being studied. Constant reflection throughout the research process, and especially in the data analysis stage, is crucial to avoid bias and subjectivity. Finally, a researcher should carefully articulate his/her positionality within the study so as to be able to identify any methodological or ethical implications (Greene, 2014).

There remains a cohort of scholars (Banks, 1998; Paredes, 1978) who still, however, contend that an insider can bring unique insights and access to the group under study, which is precluded from an outsider. This is especially pertinent to minority groups / communities, as well as those operating in a power imbalance. Vernooij (2017), in her study on an insider ethnography project looking at HIV treatment or prevention in Swaziland, notes the valuable benefits of utilising researchers from the community under study, while identifying potential pitfalls that

can arise. She notes that a balance has to take place between active involvement and distance from the matter being studied, and constantly "checking-in" to see that biases and other challenges do not develop.

Finally, a number of researchers (Naples, 1996; Banks, 1998) "have argued that the outsider-insider distinction is a false dichotomy since outsiders and insiders have to contend with similar methodological issues around positionality, a researcher's sense of self, and the situated knowledge she/he possesses as a result of her/his location in the social order" (Chavez, 2008, p. 474). The debate on bias in relation to the researcher approaching the study as either an outsider or insider, has often clouded the process, while there is little empirical evidence as to where positionality and biases fit within the insider-outsider spectrum (Chavez, 2008). It crucially must be understood that the positionality of even an insider is fluid and complex. The positionality of the insider researcher is often in a state of flux and his/her positionality within the community under study is also fluid. Naples (1996) states "insiderness or outsiderness are not fixed or static positions, rather they are ever shifting and permeable social locations that are differently experienced and expressed by community members" (p. 140). This must be taken into account during the research process.

3.2 Research Design, Data Collection Methods and Research Instruments

The research design is broken down into seven primary components: the literature review, development of semi-structured interview and focus group guides, identification of the sampling cohort, interviews of these cohorts, data analysis, and writing up of the thesis. The underlying basis (unit of analysis) of the research is the relationship between the WCG – Department of Health and the NPO service providers. A better understanding of this relationship is central to answering the research questions.

The data collection methods utilised for the research are primarily semi-structured interviews (Appendixes E, F) and a focus group (Appendix G), with some additional review of primary policy / strategic planning documentation, as well as a limited amount of participant observational interactions. All the semi-structured interviews and focus group were recorded and professionally transcribed. The use of semi-structured interviews and/or focus groups has been employed in similar health studies (Schneider et al., 2015; Schneider, Hlophe, & van Rensburg, 2008; Schneider, 2008; Moshabela et al., 2013; Dawad & Jobson, 2011). Additionally, the author, embedded within the system, was also able to observe the interactions between the WCG – Department of Health and the NPO service providers on a regular basis.

The author noted significant aspects of the interplay in the relationship between the two entities, and incorporated some of these characteristics in the findings section of the dissertation.

3.3 Sampling

The sample groups were broken down into two cohorts, an interview group focused on the HCBC Programme and a focus group looking at a newly developed referral standard operating procedure (SOP). The initial sampling method entailed interviewing 10 interviewees, equally split between staff members of either the Western Cape Government Department of Health or non-profit service providers in the Eden District of the Western Cape, who have direct, day-to-day participation (and/or management, policy setting) in the Home and Community Based Care (HCBC) programme. A random sample was not utilised, as the overall number of possible interviewees was small, given the specialised nature of the work at the level of management, coordination, and planning in the Western Cape, and specifically the Eden District. Instead, participants were purposively sought from WCG - DoH based on their role within the department in terms of their involvement in the HCBC programme, while individuals managing, coordinating, and planning were sought from the three medium to large service providers (Ithemba Lobomi, Bethesda / CMSR, Knysna Hospice) & one small-sized (PlettAid) NPO service providers in the Eden District (Table 1).

The Eden District currently has altogether 11 NPO service providers implementing the HCBC programme for WCG - Health. A sample of one third of the total number of NPOs was deemed appropriate for the study. The NPOs identified to participate in this study represent a cross-section from small to large (Table 1), in three diverse regions (Knysna, George, and Plettenberg Bay), offering a multitude of services in addition to the HCBC programme. The four NPOs' contractual relationships with the WCG – DoH span both longevity and shortness in length. Ultimately, the four NPOs were chosen because they are a good representation of the diverse NPO service providers operating in the Eden District.

Each NPO service provider has its own vision and mission, yet has made the decision to be part of the HCBC programme, under contract to the Western Cape Department of Health. The organisations that made up the sample include these discussed below in greater detail.

3.4 Bethesda / CMSR[1]

CMSR started in 2000 as a result of the threatened closure of St Mary's Children's Home. A

[1] http://sur.ly/o/cmsr.org.za/AA000014

Board of directors was founded in an attempt to save the Children's Home. Through the kind mediation of Bishop Adams, the Roman Catholic Diocese of Oudtshoorn, the premises surrounding the St Mary's Children's Home were made available to the newly founded Board. The Board took over the operational aspects of the children's home and formally registered the organisation as Christian Medical and Relief Services trading as CMSR. The latter name was recently changed to Bethesda Medical and Relief Services NPC.

Bethesda In-Patient Unit was opened in February 2002, initially with ten beds that increased to 20 in 2005 and then to 28 in 2006. The need for oncology respite beds was identified in 2006 and eight more beds were opened in April 2007 bringing the total to 36 beds.

In 2013 the Department of Health yet again upgraded the status of the unit to an Intermediate Care Facility; thus ensuring that services were formally divided into: (1) Palliative Care; (2) Sub-Acute Care; (3) Rehabilitative and Restorative Care.

Bethesda Home Based Care was established in October 2002 in response to the needs of discharged Bethesda In-Patient Unit patients who required ongoing nursing and support after discharge. Recognising that there were many more patients in the community who were not accessing primary health care services because of poor health, inaccessibility or stigmatisation, Bethesda conducted a door-to-door survey to gain an understanding of the community's health and social profile. This was an undertaking in consultation with the primary health care clinics. As a result the initial client base was established and seven Community Care Workers were appointed. In 2006 the Home Based Care (HBC) programme qualified for European Union Funding and another eight Carers were employed.

3.5 Knysna Hospice[2]

In 1986 a nurse from Sedgefield and a doctor from Knysna started working together to help those who needed care at home. The nurse was Sue Brukman and the doctor was Joan Louwrens. There was no name, no office, no funding, no mission statement, simply two people working together to care for others. This was the start of the Knysna Sedgefield Hospice – people working together to care.

Peggy Grinaker donated a house in Hunters Home in 1990 after Hospice cared for her husband, Ola. This is still the Hospice Headquarters. It came to her one night that the initials of four of her family members who have died of cancer could make up the name of the Hospice

[2] http://www.hospiceknysna.org.za/about/history.html

House – B.O.N.D. HOUSE:

Bella her grandmother
Ola her husband
Nell her mother
Doug her cousin

In 1990 BOND a company not for gain, registered in terms of Section 21 of the Companies Act. In the same year a Board of Directors was elected and a Day Care programme started at Bond House.

In July 2002 KSH received Hospice Palliative Care Association of South Africa (HPCA) accreditation and became an official Integrated Community-based Home Care (ICHC) 2 site. Council of Health Services Accreditation of SA (COHSASA) granted full accreditation status in May 2006. Re-accreditation was achieved in August 2008 and November 2011.

In 2010 it was recognized that no palliative care services were delivered in Wilderness and it was decided that to extend the services from Sedgefield to Wilderness.

Knysna Sedgefield Hospice continues to enjoy the support of many committed volunteers and of the community of Knysna and Sedgefield and adapt to the changing needs of the community.

In 2011 Hospice celebrated 25 years of service to the community.

Today, they care for the community by providing holistic home based care to patients and their families in our wider Knysna Sedgefield Community; this involves taking care of the physical, psychological, social and spiritual needs of these patients and their families. KSH also train and mentor their staff, volunteers and health care professionals in the public and private sector.

3.6 PlettAid[3]

Mission
Access to quality holistic and palliative care, provided with compassion, dignity and humanity to all in Bitou regardless of race, age, creed, sexual orientation or ability to pay.

Vision
Quality of life, dignity in death, for all in Bitou

Hospice Plett renders holistic palliative care to patients in their homes. They cover the area from the Crags to Harkerville and Kranshoek. Their patients are any persons living with a life-limiting illness.

[3] http://www.plettaid.co.za/about-us/

Palliative care is the relief of pain and other symptoms, whether physical, social, emotional, spiritual or cultural. This care is extended to the immediate families of their patients as well. It also includes support of patients from diagnosis, through the treatment phase, to the end of their lives. Some of the issues they assist patients with are life planning, emotional support and medical decision-making.

They assist their patients from diagnosis, through the treatment phase, to the end of their lives. Plett Hospice also renders subsequent bereavement care to the families.

3.7 Ithemba Lobomi[4]

Ithemba Lobomi, which translates to "Hope for Life", is a non-profit, community-based organisation. Initially mentored by the Isisombululo Programme of the University of Cape Town, Ithemba Lobomi was formally founded as an independent organisation in 2007. Ithemba Lobomi addresses issues related to HIV/AIDS, TB and chronic diseases within Thembalethu community, and assists in alleviating the burden on health department services in the area. It is common knowledge that HIV and TB are a major cause of chronic illness within the community. Ithemba Lobomi deals with effectively managing these conditions, and mitigating their negative impacts. This is achieved through the provision of essential health and psycho-social support to individuals, children and families who are infected and affected by HIV and AIDS, illnesses, injuries, neglect, abandonment and child abuse. Its main objectives are:

- *to promote health and disease prevention - educate community on basic health awareness to reduce the impact and burden of disease and influence positive changes in behavior;*
- *to promote medicine adherence and support - monitor compliance of HIV, TB and chronic illness patients and capacitate families to offer their support;*
- *to provide community home-based care - offer basic health services to patients that have been discharged from hospitals or clinics, providing them with health services in their homes;*
- *to improve the psycho-social well-being of households and individuals, especially those who are vulnerable such as women, children, at risk youth, and the elderly*
- *to capacitate individuals, families and communities with basic training and skills, to enable them to make informed choices about their lives; and*

[4] Ithemba Lobomi brochure, 2014

- *To provide education and awareness in order to prevent health and socioeconomic challenges.*

Organisation	No. of CHWs	No. of Nurses	Geographic Area Served	Years Operating HCBC Programme contracted with WCG-DOH
Bethesda / CMSR	66	1 Staff 1 Professional	George, Uniondale	13 years
Knysna Hospice	30	5 Staff 1 Professional	Knysna, Sedgefield	14 years
PlettAid	5	1 Professional	Bitou Municipality	2 years
Ithemba Lobomi	45	1 Staff 1 Professional	Thembalethu, Pacaltsdorp, Hoekwil	8 years

Table 1: Summation of HCBC staffing and geographic distribution per organisation (source: Author)

3.8 Western Cape Government – Department of Health[5]

Core Functions and Responsibilities
The core function and responsibility of the Western Cape Department of Health is to deliver a comprehensive package of health services to the people of the province.

Vision
Quality health for all.

Mission
We undertake to provide equitable access to quality health services in partnership with the relevant stakeholders within a balanced and well-managed health system.

Values
The overarching values identified by the Provincial Government of the Western Cape are:

- *Caring;*
- *Competence;*

[5] https://www.westerncape.gov.za/dept/health/about

- *Accountability;*
- *Integrity; and*
- *Responsiveness.*

Summary of the Western Cape Provincial Department of Health Services:

Primary Health Care Services - 479 facilities in 32 sub-districts and six districts (five rural districts and four sub-structures in the district of metropolitan Cape Town)

The Following Free Services are Offered to All (Excluding Medical Aid Patients)
- *Family planning services;*
- *Infectious diseases management;*
- *Termination of pregnancies;*
- *Legal services related to medical attention;*
- *Oral (dental) health services (scholars and mobile clinics only);*
- *Immunisations;*
- *Primary health care services; and*
- *Antiretroviral (ARV) services for AIDS patients.*

The geographical location for this study is the Eden District of the Western Cape. The interviews were conducted with organisations in George, Knysna, and Plettenburg Bay (Bitou), encompassing four HCBC programmes in three diverse regions. Demographic and health data for the district is reflected in Tables 2 - 8.

The Eden District, Western Cape

Eden District at a glance

Population	**2001**	**2011**
Eden District	454 919	574 265
Western Cape	4 524 331	5 822 734
Eden District as percentage of Western Cape	10.1%	9.9%
Percentage share	**2001**	**2011**
African	19.9	25
Coloured	58.4	54.0
Indian/Asian	0.2	0.4
White	21.5	19
Other	N/A	1.5

Socio-economic indicators

Education	2007
Literacy rate	77.1%

Health

Number of Primary Health Care Facilities 2012: 0 Community Health Centres, 5 Community Day Centres, 35 Clinics, 13 Satellite clinics, 22 mobileclinics; 6 district hospitals and 1 regional

hospital

	Jun-11	Jun-12
Immunisation rate	91.8%	88.6%
Anti-retroviral patient load (HIV/AIDS)	7 847	9 397

Table 2: Eden District Demographics & Health Statistics (Source: Western Cape Government – Provincial Treasury, 2012)

Access to housing and municipal services (Percentage share of households with access)

	2001	2011
Formal dwellings	82.1%	91.1%
Informal dwellings	12.9%	8.1%
Electricity for lighting	85.5%	82.6%
Flush toilets (sewerage system/with septic tank	80.7%	80.0%
Access to piped water	95.7%	88.9%
Refuse removal	83.3%	86.0%

Table 3: Eden District Access to Housing and Municipal Services (Source: Western Cape Government – Provincial Treasury, 2012)

	Number of Anti-Retroviral Treatment (ART) Sites; June 2010	Number of Anti-Retroviral Treatment (ART) Sites; June 2011	**Number of Anti-Retroviral Treatment (ART) Sites; June 2012**	ART Patient Load; June 2010	ART Patient Load; June 2011	**ART Patient Load; June 2012**
Kannaland Local Municipality	0	1	**1**	0	14	**32**
Hessequa Local Municipality	1	2	**2**	154	184	**235**
Mossel Bay Local Municipality	1	3	**5**	1 197	1 395	**1 758**
George Local Municipality	2	6	**9**	2 476	2 917	**3 377**
Oudtshoorn Local Municipality	1	2	**3**	591	652	**867**
Bitou Local Municipality	1	5	**7**	1 004	1 212	**1 383**
Knysna Local Municipality	3	4	**5**	1 355	1 473	**1 729**
Eden DMA	0	0	**2**	0	0	**16**
Eden District	9	23	**34**	6 777	7 847	**9 397**

Source: Western Cape Department of Health, 2010, 2011 and 2012

Table 4: HIV / AIDS Prevalence and Care in Eden District Municipalities

List of facilities at February 2012	Community Health Centres	Community Day Centres	Clinics	Satelite Clinics	Mobile Clinics	Total Primary Healthcare Facilities*			District Hospitals*			Regional Hospitals*		
						2012	2011	2010	2012	2011	2010	2012	2011	2010
Kannaland	0	0	4	0	3	7	6	5	1	1	1	0	0	0
Hessequa	0	0	3	3	3	9	9	10	1	1	1	0	0	0
Mossel Bay	0	1	3	6	4	14	14	14	1	1	1	0	0	0
George	0	2	10	1	5	18	16	16	1	0	0	1	1	1
Oudtshoorn	0	1	5	0	3	9	9	9	1	1	1	0	0	0
Bitou	0	1	4	2	1	8	8	7	0	0	0	0	0	0
Knysna	0	0	6	1	3	10	10	10	1	1	1	0	0	0
Eden DMA**	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	4	4	*n/a*	1	1	*n/a*	0	0
Eden District	**0**	**5**	**35**	**13**	**22**	**75**	**76**	**75**	**6**	**6**	**6**	**1**	**1**	**1**

* *Information for 2010 and 2011 from 2010/11 and 2011/12 Annual Performance Plans.*
** *In 2012/13, Eden DMA included in George Local Municipality.*

Source: Western Cape Department of Health Annual Performance Plan 2012/13

Table 5: Number of Eden District Municipalities Health care Facilities, 2012

City/Districts	Population < 1 year fully immunised 2010/11	***Population < 1 year fully immunised 2011/12***	Number of severely underw eight children < 5 years per 1 000 population 2010/11	***Number of severely underweight children < 5 years per 1 000 population 2011/12***
Eden District	91.8%	***88.6%***	0.8	***2.9***
Kannaland	60.0%	***70.1%***	0.2	***2.6***
Hessequa	95.5%	***85.4%***	0.1	***2.5***
Mossel Bay	93.9%	***85.7%***	1.5	***1.3***
George	88.6%	***89.2%***	0.8	***5.5***
Oudtshoorn	87.8%	***86.6%***	1.6	***2.4***
Bitou	94.2%	***84.7%***	0.6	***0.2***
Knysna	122.7%	***111.0%***	0.3	***1.2***
Eden DMA	79.9%	-	0.3	-

Source: Western Cape Department of Health, 2011 and 2012

Table 6: Child Health in the Eden District: Full Immunisation and Malnutrition, 2011/12

Maternal mortality	Total number of live births in facilities 2010/11	Total number of maternal deaths in facilities 2010/11	***Maternal Mortality per 100 000 live births 2010/11***	Total number of live births in facilities 2011/12	Total number of maternal deaths in facilities 2011/12	***Maternal Mortality per 100 000 live births 2011/12***
Eden DM	9 507	2	***21.0***	8 220	5	***60.8***
Bitou	48	0	***0.0***	0	0	***0.0***
Eden DMA	151	0	***0.0***			-
George	3 631	0	***0.0***	3 080	2	***64.9***
Hessequa	548	0	***0.0***	523	1	***191.2***
Kannaland	197	1	***507.6***	202	0	***0.0***
Knysna	1 758	0	***0.0***	1 587	1	***63.0***
Mossel Bay	1 434	0	***0.0***	1 211	0	***0.0***
Oudtshoorn	1 740	1	***57.5***	1 617	1	***61.8***

Source: Western Cape Department of Health, 2011 and 2012

Table 7: Maternal Mortality: Eden District, 2011/12

Community Based Services	Total number of Non Profit Organisation appointed home carers 2011/12	Total number of visits 2011/12	Average number of monthly visits per carer 2011/12
Metro	1 639	2 859 780	145
West Coast	311	785 440	210
Cape Winelands	264	552 302	174
Overberg	233	467 010	167
Eden	329	568 639	144
Central Karoo	77	145 848	158
Western Cape	**2 853**	**5 379 019**	**157**

Table 8: Community Based Services by NPOs in the Western Cape, 2011/12 (Source: Western Cape Department of Health, 2012)

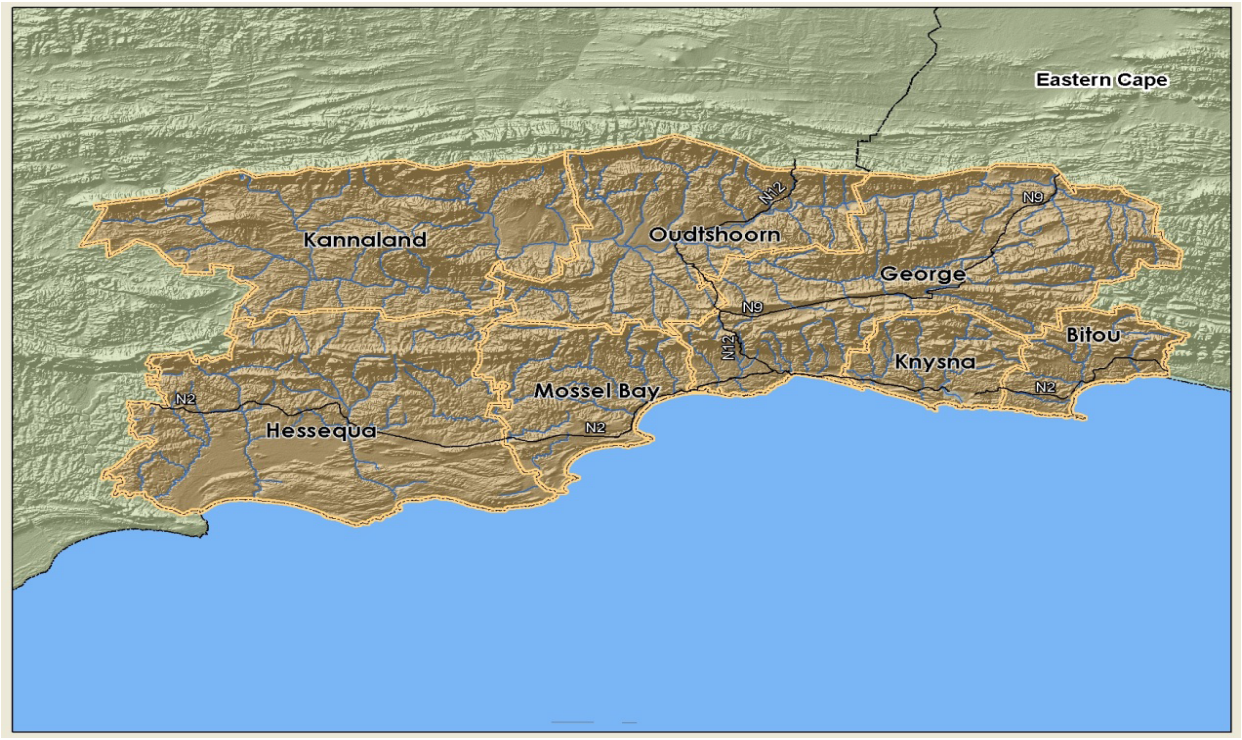

Figure 5: Map of the Eden District, Western Cape. (source: Western Cape Government, 2012)

(All data sourced from Regional Development Profile, Eden District. Western Cape Government, Provincial Treasury, 2012).

The semi-structured interview sample included:

Organization	Title / Function
Knysna-Sedgefield Hospice	CEO / Medical Director
Knysna-Sedgefield Hospice	HCBC Coordinator
PlettAid Foundation	Operations Manager
Bethesda / CMSR	HCBC Coordinator
Ithemba Lobomi	Staff Nurse: HCBC Supervisor

Western Cape Government - Health	Deputy Director: De-hospitalised Care
Western Cape Government - Health	Director: HCBC Services
Western Cape Government - Health	District CBS Coordinator
Western Cape Government - Health	CBS Coordinator: George Sub-District
Western Cape Government - Health	George Sub-District Manager

Table 9: List of interviewees

As part of the research requirements for the UCT Graduate School of Business, integration of a prototype tool, a referral SOP (Appendices D & E) was developed and piloted by the WCG – Department of Health in order to study collaboration in real-world setting. A focus group was then utilized to assess the viability of the newly developed referral SOP. The sample group (Table 10) for the focus group was determined by identifying the key members of the referral process from the WCG –DOH (clinic) and the NGO service provider (Bethesda) in George.

Organisation	Title / Function
Bethesda / CMSR	HCBC Coordinator
Western Cape Government Health	CBS Coordinator: George Sub-District
Western Cape Government Health	Facility-Supervisor: Thembalethu Clinic

Table 10: List of focus group attendees

3.9 Data Analysis Methods

The data was analysed by the researcher alone utilising Nvivo 10 to produce a set of nodes (themes), which arose from the data (interview / focus group transcripts) inductively. Repetitive analysis of the interview and focus group transcripts generated additional nodes, while confirming established themes. This process was repeated until no additional nodes were generated and the transcribed interview components could be categorized within the existing themes.

4. Research Findings & Analysis

4.1 Research Findings

The study was able identify a number of themes common to all the stakeholders within the various features that populate the collaborative process. The interviews reveal all the aspects of

collaboration theory to varying degrees, namely: a clear common vision with a sense of ownership; some level of broad-based social capital; networks; communication; quality time; and stages of various resources and skills. The research findings expose a dominant and noticeable theme centred around the relationships between WCG - DoH and the NPO providers that present two sub-categories. These reveal significant differences in objectives, procedures, and challenges, and also provide a framework for collaboration on a practical level as part of the home and community-based care programme. The two sub-categories include: the relationship between WCG – DoH on a sub-district / clinic level and the relationship between WCG – DoH on a district / provincial level. These sub-categories, although distinct, are interlinked and have an influence on the overall relationship between the WCG – Department of Health and NPO service provider. A final sub-set of these sub-categories is the role that the Health Care 2030 framework plays in the relationship between the WCG – Department of Health and NPO service providers.

4.2 Relationship as a Necessity for Implementation

The findings reflect that relationship is a central theme to the understanding of the extent of collaboration between the WCG – Department of Health and the NPO service providers. The very nature of the "stickiness" of social capital is what needs to be leveraged between the two entities. The level of social capital [or social cohesion], however, remains challenging.

In general, the NPOs clearly see themselves as distinct from WCG - DoH, even as many of them receive the bulk of their funding from government. This can place NPOs in an uncomfortable position, with a vision and objectives widely divergent from those of WCG - DoH, yet having a practical need to partner with WCG - DoH for both monetary and operational gain. As one NPO representative states, WCG - DoH's objectives and goals:

> *"have a conflict with our objectives, which is care of people with life limiting illnesses in their homes and the care of the family that looks after that patient, so we've had to take the [WCG] Health Department proposals to our board every year to make sure that they are comfortable with quite a broadening of our objectives" (NPO).*

This dichotomy is further reflected in the view from the same NPO that:

> *"I think we try as hard as we can to build the relationship. We could just hive off and do care of people who are facing life limiting illnesses, but our board has*

agreed that looking after people through the teamwork that the community care workers allow us is, is the socially responsible thing to do and so, the objectives have to be re-visited fairly frequently, but the decision was that we should continue to work with the [WCG] Department of Health because it helps to extend our reach in the poorly resourced communities. However, it means that we end up subsidising the community care workers and their work from our private fundraising" (NPO).

One can see the inner conflict between the cost benefit analysis in working with WCG - DoH.

WCG - DoH, to some extent understands the nature of this dichotomy, and, while trying to strengthen the ties, has to operate under their own constraints. A WCG - DoH representative put it succinctly:

"I think the NGOs really try to stay within what is expected from them but I mean I think that is, that is the difficult thing about being an NGO. You get funding from different streams and you have got to satisfy each funder so it becomes very difficult… Let me put it this way, it is very easy to lose your identity and I think that is quite important that you don't. So the NGO must have its own identity their own culture, its own objectives, I think that is good they should have it and then they will have the different funders and the DOH would be a funder so with regards to that funding they will follow the rules or the, and say this and this is how we are going to do it and we link with your objectives but that doesn't mean I don't have other objectives too" (WCG - DoH).

4.3 Sub-district / Clinic Level

Locally (sub-district / clinic), the relationship between WCG - DoH and the NPOs is complex and substantial.

"It needs to be a very close relationship and especially at operational level; it doesn't help that [only] the CEO's and the medical manager have a good relationship. The NPO coordinator and the operational manager they must also. That is the important relationship and there must be good communication and there must be weekly or daily communication with regards to patient care" (WCG - DoH).

This relationship on a local level works because it has to. The necessity to work together to provide a common objective (health services in local communities) outweighs many of the costs. It has also been made to work. A level of collaboration exists between WCG - DoH and NPOs because on a day-to-day basis, it is vital to achieve the common objectives of the two entities. As an NPO staff member indicates, "*Okay so, on a local level we have an ever-improving relationship with the hospital and the clinics*" (NPO). The level of collaboration provides tangible benefits to both entities. The NPO and WCG - DoH work well together on a clinic / hospital / community level as the individual players know each other and meet to talk if not on a daily basis, then at least weekly. "*And there should be relationships [between clinic and NPO staff]; very close relationships between [these groups] because you could kind of manage your case load more affectively.*" (WCG - DoH). An NPO staff member concurs, "*I would say it is not really conflictual. It's more you didn't do that, well you didn't do that, but we are friendly and it has definitely improved*" (NPO). The NPO HCBC Coordinator or CHW knows it is in their interest (and ultimately that of the patient) to work effectively with the WCG - DoH facility nurses and vis a versa. The patient referral programme is also based on effective collaboration between the partners (discussed further in Appendix B), and therefore requires a sound relationship.

Many of the interviewees expressed the view that in the past the system did not function appropriately, because of the immense workloads in the clinic and a feeling that patients could not be trusted in the care of the NPOs.

> *"I think in the beginning the carers didn't feel welcome in the clinics because the clinic people there are skeleton staff and everybody is busy and now somebody else comes in and asks for your attention. So now you [move] away from what you were busy doing and it's a lot of haywire so that was previously and it is becoming better I think some of the clinic staff they start to begin to understand a bit better what's happening with the CCWs" (NPO).*

This improvement [substantially, in the George sub-district] also seems to stem from better communication through mandated meetings on a weekly and monthly basis, and more informal daily dialogues. These meetings, especially around patient referrals, allow for face-to-face debriefings about specific patients and the system in general. Given that the individual clinics are now responsible for the statistics and ultimate "success" of the HCBC programme in a given

area, it has now become even more important to maintain open lines of communication. One NPO staff member notes that:

> *"[the] relationship between [NPO] and [WCG] Department of Health, is good, because communication is very important to us in terms of the change, because nursing of people is dynamic It changes every day, so with the help of [WCG] Department of Health, if there is anything that is changing that we have to do as an [NPO] it is where they communication with us" (NPO).*

The level of collaboration remains high as the teams work together to provide the HCBC service to local communities. Regular communication and interaction provide a strong framework for the collaborative process, leading to a level of successful implementation.

4.4 District and Provincial Levels

As the relationship between WCG - DoH and NPOs moves up to the district level, there is a commensurate decrease in the quality of the relationship and level of collaboration. The voice of the NPO service providers and government is more unresponsive. This is based both on a natural result from the physical distance, as well as a general lack of regular interaction. The district, like the sub-district, essentially takes its directive from province, which is the ultimate developer / driver of the HCBC programme. The district's main role within the HCBC programme is to assure the operational requirements for the programme, such as going out to tender for the NPO service providers and assuring that the various sub-districts perform as laid out in the protocols. The district level represents the face of WCG - DoH to the local NPOs, as well as to WCG - Health operations on sub-district level. District, as indicated, is intrinsic to the proscribed policies and procedures laid down by province.

Therefore, the findings from the research on the district level have to be discussed in parallel with those of province. Importantly, the essential understanding from the findings is that WCG - DoH, in terms of policy, does not create a broad space for dialogue on planning of policies & procedures, but adopts a top-down, highly centralised approach. A vocal minority from WCG - DoH argue "*I think that the department is way too authoritarian about the whole programme and decisions are just made and NGOs are just told to implement, so actually with this whole new programme I don't think there was much consultation with the NGO's*" (WCG -DoH). The perception remains that the new HCBC programme, in general, has been developed by WCG - DoH with very little buy-in from outside stakeholders (in the rural areas). The reality (or

perception) by the NPOs that they were not consulted in the planning and development of the new HCBC programme and the subsequent disquiet with some of its protocols can not be take too lightly. Even when WCG – DoH argues that a consultative process occurred, it cannot counter the belief that this didn't happen.

WCG - DoH, in general, still indicates that there has been a consultative process (CBS Summit in 2015). A WCG - DoH representative noted:

> *"They have a voice at that summit… because they're presenting, and then we break into groups. Then there were working groups and there is the NPO sector, and the [WCG] Department of Health, and they get a topic that they should discuss. And the feedback from the groups is noted there" (WCG - DoH).*

Yet, from a NPO viewpoint these have been superficial and there has been no follow-up subsequent to the last summit. As a representative from a NPO asserts:

> *"I started in 2006 and from 2006 until now, there has been one annual community based service meeting in Cape Town where the objectives from the [WCG] Department of Health's side are explained, but there hasn't really been an opportunity for us to be consulted on a strategic level at all. We've made quite a lot of approaches about doing things that are innovative to take advantage of the fact that we are a national health insurance pilot site, but those approaches haven't really yielded any invitation to do things in an innovative way locally, so that's been a missed opportunity in my opinion" (NPO).*

Still, many within WCG - DoH argue that WCG - DoH has tried to meet the NPOs halfway, but ultimately WCG - DoH is the funder. "*And to [do] that what we want and what they want half way is the challenge, that is the challenge. And there's no right or wrong, there's no right or wrong, but yes. We are the funder, and we say we want these people that you employ, to do this and this*." (WCG - DoH). Another WCG - DoH interviewee argues that there was a level of consensus.

> *"We consulted with the NPOs and so if there are things that they feel they not happy about, we consider those; so there is consensus. We actually listen to what the NPOs were saying, such as, "no it's too cumbersome, we are not implementing it." And the ones that say they would like to use it, then we do." (WCG - DoH).*

Finally, yet another WCG - DoH interviewee stressed that NPOs are listened to:

> *So I would say, yes, they do have a voice because they [are] almost an expert in our opinion; we work as working groups at the provincial office level or registrar, so there's compromise on both sides. We would like things to be done in a certain way, but they say no. We know practically that's not gonna work, so we have to compromise. So we do meet each other half way" (WCG - DoH).*

A representative from WCG - DoH concludes "*I think from my side it is that we must get more input from the servicers, the NPOs, before we plan so they must be part of the planning. And before we even develop policies or guidelines or SPOs, we all need the NPOs input*" (DoH).

Ultimately, province gets directives from national government.

> *"So as a province we also had to be responsive to request coming [from the] national side. How many of these teams do you have and have you rolled out this training, because there were interim training models that would provide, etcetera. So we also buffer some of the things that come [from] national at the provincial office and don't let them kind of muddy the water further down. But I do appreciate and it feels like there is a lack of potentially listening from the bottom up" (WCG - DoH).*

The findings reflect a schism between the NPOs on the ground and the provincial head office in Cape Town. There is a tangible feeling amongst some of the interviewees that the information going up the line from the local level, up through district to province, is filtered to some degree both ways; so that the district and province do not always know what is going on at a local level and the local level is not always told what district or province requires or advises. An interviewee put it this way about what is happening on the ground:

> *"They take it, but my person that I am supposed to [speak with], sits here and they [talk about] it up here, so then any filter of information about what's happening on the ground, is missing the person, because it seems as if it's my little person that is making a lot of the decisions. If they just recognized that, I don't think that they know how many sick people there really are and that is one of the sad things, is because I send information to Mr "X" who sends it on to the district. I don't send it direct to the district. I think he filters it so that he takes out some of the explanations where we say okay 50% of our patients are still being*

seen outside of the six weeks. I report what they do, but it is not a true picture, because the questions that they ask are not the right questions" (NPO).

While there is some understanding that the system is not optimum, additional outreach needs to be done by province. Province, the district, and to a lesser extent the sub-district are seen as prescriptive and unresponsive to the reality on the ground. Province and the sub-district, like many large entities have carried along with a philosophy of, if it isn't broken, why fix it. "*When I put the call for proposals out they apply for the funding, so if they're not happy I think they don't [apply], they say to me, I'm not going to tender*" (WCG - DoH).

Conversely, the NPOs sometimes do not understand the constraints faced by WCG - DoH. As they are not part of the planning / policy-making process, there can be a lack of comprehension of the challenges WCG - DoH faces in terms of the overall disease burden, and budget, staffing, training, and resource allocation limitations. WCG - DoH is, however, trying to devolve the planning to a degree, to the local level.

"So the NPO should be part of the planning for that area. For instance, if the primary care facility says, there's lots TB [patients] that we seeing here, especially in that area. Can we go and have a campaign that the NPO will understand because they've had a discussion with the facility. So, we ([are] wanting to strengthen the relationship between the NPO and primary care facility" (WCG - DoH).

This will hopefully allow for a more detailed approach to the specifics of the implementation of the HCBC programme, abet, through the proscribed policies & procedures. WCG - DoH is also hoping with the new HCBC programme to dialogue with the NPOs on the viability of the programme. "*This year we [are] spending the year negotiating with the NPOs about this integrated package and how they think it could be implemented*" (WCG - DoH). A formalised process to ascertain the effectiveness of the various components (and allow for feedback on other issues from both sides) has yet to be established, however.

Finally, a sub-set of this theme is the perception by the NPO service providers that they do not have a voice in the HCBC planning process. A constant theme of the interviews was that the NPO service providers do not feel as if they are being heard by district and province when it comes to the HCBC Programme. From observations by the author, the district only meets with the NPO service providers when the tenders go out for the HCBC Programme on an annual

basis. As discussed above, the NPO service providers have little or no input on the strategic planning on a macro level. They consequently perceive that their opinions are not valued by government, rather they are seen solely as implementers, not as true partners. An NPO manager stated, "*I think the consultation is there [but] they just don't listen to [us]. It is [as if] they made up their mind but they will do the consultations because that is one of the things that they have to do, one of the boxes they have to tick but they don't really listen what the service providers need"* (NPO). Another NPO staff member when asked if the WCG – Department of Health listens to the NPOs, stated, "*Not at the level of agreement between the regional office and us when we sign the contract, but at a local level, on the ground, between individual clinics and the hospital, there is accommodation"* (NPO).

4.5 Health Care 2030

The original goal of the Home Based Care Programme was,

> *"to work in the community. And then also a very important role [was] to do visits and screen clients and give them health education. And then also the basic care of the sick people who need nursing care. And then also as a link between the community health facilities, the clinics and the community. So they are part of the referral system." (WCG - DoH).*

The number of visits into a household were then factored in based on the patient's specific condition. "*The level of care is determined by the category of the patient*." (NPO). A category from I – III was utilised with the latter category reserved for the more acute-care needs of a patient. As the research reveals, the focus was on nursing care in the home for the patient. This then has been the system that has been in place for the last two decades or so. As mentioned previously, based on the evolving disease burden and challenges faced by WCG - Health to sustain the level of nursing / community-based care, a new strategy was developed by WCG - DoH to tackle the disease burden into 2030 and beyond.

The *Health Care 2030* strategy represents a significant departure from the previous Home Based Care programme. The new strategy represents an understanding that, as one WCG – DoH interviewee puts it,

> *"I well I think because the whole department's Health Care 2030 plan more focused on prevention and because the Department also realise that it is not just, the whole health system is not very sustainable. If we look at especially chronic*

diseases and ARVs with that, we are going to just be overloaded so already we are struggling to cope with patients but if we don't start putting preventative measures in place we are going to actually have more chronic patients, more HIV patients, more TB patients and we are not going actually be able to manage it. That is the one side I think the other side was with regards to the basic care of clients in the home was also not very sustainable, because the carers can't go [into the household] enough, they can't go every day to wash a patient for instance or turn a patient. So they also realised that that is not very sustainable, so you need to rather look at educating the family and getting them to look after their own family members, that is a more sustainable way of looking at and then; well, first of all preventing them, preventing them from getting strokes and stuff." (WCG - DoH).

In general, across the various entities, there was a strong understanding of the *Health Care 2030* strategy, based on a thorough briefing from WCG - DoH to the NPOs. Although interviewees from both WCG - DoH and the NPOs were aware of the basic objectives of the *Health Care 2030* strategy, they were sometimes unclear as to the logistical aspects of the new model of care. There is now a much larger focus on prevention [including adherence] and self-support and wellness.

"So at the moment only ten percent of the function of the home-based care will be basic care which is now what they call it. So [on] the whole, there has been a move around to prevention and not cure, so I think about eighty percent of will be looking at prevention. We are still hanging on to some of the adherence because I still think that adherence is quite an important and how they get support, the you know, the patients with adherence [issues], although it is not the main focus any more either. I think adherence came in, [in the past]; so it was first the sort of category three and then the adherence was the focus for a while when we had all these patients being put on ARVs and stuff and now that that is also becoming a more institutionalised, now we are looking at more prevention. So it is really been quite a big shift." (WCG - DoH)

The main objectives of *Health Care 2030*, adherence/self-management, wellness health promotion activities and case-finding do not always fit into the objectives of the NPOs, which will be discussed later, but this reveals that, while the NPOs generally understand the objectives

of *Health Care 2030*, they are not in total agreement with the mechanics of the process. Even the WCG - Department of Health in the Eden District has concerns about the rollout. The original pilot of the HCBC programme was developed in Oudtshoorn, and was a very small, focused research initiative. The subsequent rollout on a larger basis does seem to be a greater challenge. As a member of WCG - DoH put it,

> *"So I've still got my concerns about that. How will it, how will it work in a big place like George and ja, I mean not even rolling it out to the metro which is really more urban… but it is really rural even the, the urban part is rural if you know what I mean." (WCG - DoH*).

In addition, the logistics of the new HCBC programme are based on a door-to-door assessment process in the community. Will this work in local communities is a major question,

> *"So ja the numbers and the stigma are still in the community because a lot of people don't really want the carers in their house, so now they are going to just walk in and say, I am going to ask you five million questions. Is the community going to really be happy with that?" (WCG - DoH).*

In addition, the increased household assessments may lead to heightened tensions at the local clinics. As it stands now, there will be certain days / times available for specific health issues (referrals), where patients do not have to wait in line from morning to afternoon. While this could prove beneficial to some patients, there is a concern it will place additional burdens on the facility and certain individuals (e.g. children, men, etc.). It

> *"is the biggest worry. That is why we have said like we have got certain days that they can send in certain of the things, and that's why we maybe want to look at the child health rather than doing more outreaches because I don't think we can actually cope with the children in the facilities. We look at the women's health and the other thing is that they can come to the clinic and we can deal with that but the child health maybe we should rather go out [for visits] a bit more because we already see that the moms are not bringing the babies so that younger children, the under five headcounts have come down year on year for the last seven years." (WCG - DoH).*

While there was a substantial understanding of the HCBC programme under the framework of *Health Care 2030* in the Western Cape as part of primary health care component, the interviews

revealed a significant divergence in thinking on its viability and benefit to the end user. While there is a general consensus that the old system was not sustainable, there were mixed views on the new *Health Care 2030* framework. The main source of concern stemmed from a fear that current [chronic care] patients might be left behind under the new protocol of the HCBC programme. A NPO representative encapsulates this argument by stating,

> *"In the seventies and eighties they focused completely on prevention and promotion exclusively. When in the late eighties and nineties, they suddenly realised that the crisis was on their hands, they trained professional nurses to do clinical care, diagnose and treat patients and the pendulum swung completely to the other side, to a curative side. Now we [are] back where they realise that they can't let prevention and promotion go and now they are swinging it right back to the other side again. Focusing completely on prevention and promotion in the community and forgetting about this gap in the middle between where the person is actually dying and they are not sick yet" (NPO).*

There is little debate that a change was necessary. Although none of the interviewees expressed support for the old home based care programme, there is concern on how the new protocols are being taken forward. As one WCG - DoH professional summarised the apprehension,

> *"I think that is where we should be going, but it will put pressure on the other two areas which is the adherence support where we going probably to struggle a bit because we have still got so many patients on chronic meds and on ARVs and a lot of them are really poorly compliant so that is going to be a bit of a gap for me there in trying to still refer. We have said now we are still going to be referring them but it is going to be very difficult with them having now really a different focus. Then I do worry a little bit about the basic care because they are just certain patients that are living in such terrible conditions, that need care so we need to just make sure that we don't have people really falling between the cracks. So I think it is a big challenge" (WCG - DoH).*

Interestingly, culture within a specific community can also play a role in the roll-out of the new protocols. As a NPO staff member argued,

> *"In the community, they [WCG - Health] must understand that we are dealing with some other people. There are educated, other people they are old people that*

are not educated; so for them, they still have those beliefs, but this is the way as old people… So for example, if you say you as a woman, you must wash, they will say no according to my culture, I don't have to do A and B, so it is whereby we have to educate that as a human being, you have to wash at least once a day or afternoon, so other people, because of the cultures and the norms or the old people, their beliefs in the community, it is still difficult. But, it is whereby we educate those people, but sometimes it is a big challenge because you cannot take out what the person believes in and try to instil what has to be done, so sometimes it is a big challenge" (NPO).

Therefore, finding the appropriate support structures for the chronic / elderly patients remains a significant challenge as the HCBC programme transitions from the past to the present. While generally, the patients' families will be trained concerning patient support, this is not always feasible. A NPO staff member argues that

"We involve the families, we just give the support, because we don't want to be [free of] the families, but at least if we also educate the families, how do they support the sick person in the family, so it also helps the family so that even if we are not around there, they know at least the basics of what they can help with the family" (NPO).

4.9 Discussion

The delivery of community-based health services is a key component of the primary health care (PHC) system in South Africa, particularly the strategy for PHC re-engineering as part of the proposals for National Health Insurance. It represents the "coalface" where local clinics and NPO service providers interact together and directly provide services to patients (individuals) both in and outside the health facility (in the home / community). Given the current health challenges in South Africa, including funding and capacity, the home and community-based care model is vital for the sustainability of the health system. Therefore, the HCBC programme has to work, and it has to work effectively. If it fails, then the obstacles to developing a healthy population increase exponentially up the health chain and the system can never reach an efficient, sustainable equilibrium.

Thus, in the Western Cape the relationship between WCG - Health and the NPO service providers is vitally important, as they are the two main role-players within the PHC system.

How they see each other and how they work together from the local to the provincial levels is crucial to the effective implementation of the HCBC system.

The findings from this study reveal a complex set of interrelations between the WCG - Department of Health and the NPO service providers, built on mutual need, yet often-divergent goals, objectives, and/or means of attaining these objectives. This has to then be fully conceptualised within the context of a significant disease burden and operational challenges faced by both government and the NPO service providers in the communities being served. To create a simple analogy, the two entities are in a rowboat (HCBC system) carrying many people, trying to row to land in a stormy sea. To add to the challenge, the rowboat has many holes in it and is in danger of sinking. The two groups are all trying to row, albeit not at the same time, and plug the holes, while bailing water from the craft. With separate leadership, who is in ultimate control of the situation is also a matter of dispute. One can see from this analogy, that to gain a level of collaboration in such an environment is often difficult, if not impossible, yet it has to be done to save lives.

It is apparent from the many NPO service provider interviews that a NPO has to be capable of fulfilling multiple roles, with multiple objectives for government, while still retaining their overall autonomy. This is an immense challenge given all the competing forces pulling at the NPO. WCG - DoH also has vast challenges as part of government, and NPOs do not always fully understand that it operates within constrained budgets, targets, and political environments. The two entities are vastly different in everything from their management styles to their policies and procedures. It is no wonder then that they do not always concur on objectives, protocols, and other operational aspects.

The salient feature arising from the interviews was that *relationship* was central to the success of the HCBC Programme. However, the disparity in objectives, goals, and structure of the two entities often leads to challenges in social capital and operational implementation. Implicit in the findings, is that the intensity of these challenges was based to a significant degree on the quality of the relationship between the NPO service provider and the WCG – Health at a sub-district, district, provincial, and national level.

In order for the new HCBC system to be successful, relationships between WCG - DoH and the NPOs have to be strong and effective. The study found conclusive evidence that there are distinct relationship "markers" as the interactions rise from the local, to the district, to the provincial levels (Figure 6). These sub-categories reflect the nature of the operational aspects

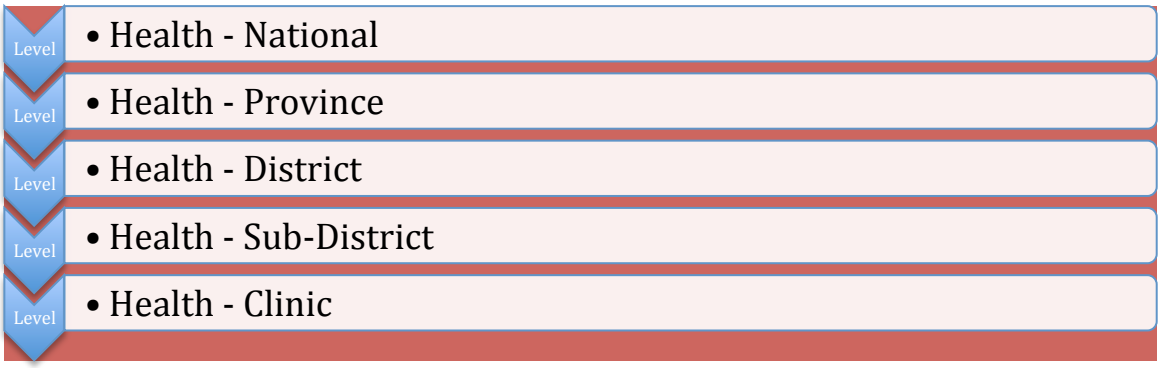

Figure 6: Various operational levels associated with planning and implementation of HCBC Programme in the Western Cape Government Department of Health (source: Author)

and perceptions of the relationship between the WCG – Department of Health and the NPO service providers at the various levels. The interviews reflect a clear delineation of relational "stickiness" the lower (Clinic / Sub-district) level that the participants enter into.

In summary, the data from WCG - DoH reflect a debate within the department between the interviewees who generally support the notion that greater input from the NPOs would be beneficial, and those who think it is already happening. It is interesting to note that, although the interviewees cannot be identified for the sake of confidentiality concerns, the closer to the local level the member of staff is (Figure 6), the more they think WCG - DoH is not consulting with NPOs adequately. As laid out, the research questions centred on how those involved in administration of the community-based health component of primary health care, understand their relationship from the perspectives of government and the service providers. A subsequent question looked into the nature of the collaborative process and extent (scale) of the collaboration between the two entities. Through the research process, and the interview method, a common set of findings was developed as discussed above. These findings concur in many respects with the literature on social capital, collaboration, primary health care, and the community-based health programmes.

The findings from the research correspond with the literature addressing primary health care and community-based health programmes in South Africa (Bam et al., 2013; Friedman, 2006a; Rafter, 2008) in that they were developed by government as a stop-gap after the end of the apartheid regime, as the new democratic government came to terms with the vast challenges and realized that it did not have the capacity (including funding and HR) for such an immense programme. Friedman (2006a) reveals in his paper many of the same challenges as those brought up through this research such as a "disconcerting range in the amount and quality of

training, inconsistent support and supervision, inadequate linkages to the district health system, poor integration, and the potential for developing conflict between different groups of CBHWs, which is great if vertical programmes do not agree on working together jointly on a community level" (pp. 167 – 168). It is interesting to note that Friedman (2006a) touches on a central piece of the data derived from this research in that, if the different groups do not work well together on a community level, there is the potential for conflict between the vertical programmes. From the current research findings, it has been established that the various entities do work well together on a local level, as they have agreed to collaborate and found a mechanism to implement this process.

The current research findings are also consistent with the work of Bam et al. (2013), who also discusses many of challenges found in this study including programme focus, funding streams, who is responsible for what, and overall autonomy for the various NPOs. The vertical programmes model, which was adopted by [national] Health, is still very much the model in use today, with variations on the specific protocols. Schneider et al. (2008) looked at the dichotomy of technical practitioner versus agent of change in the Free State, which mirrors the current findings in that often the CHWs occupy a transient position between volunteer and worker, employed by a NPO, but working for government. Many of the NPO staff interviewed in this study profess a similar feeling of having dual masters and multiple allegiances. These outcomes were originally found to be the case on a national level as part of the home-based care programme, which was rolled-out nationally in the mid 1990s, but is then also reflected in the Western Cape's community-based programmes in later years.

More recently, the Western Cape Government Health Department's *Health Care 2030* has significantly modified the community-based approach and, while it is too early to assess its viability and successes or failures, from the current findings, one can argue that there is support for the objectives of the programme, but concern that the overall framework reflects many of the challenges associated with the past. The work of Schneider et al., (2015) in the Western Cape is consistent with the current findings in that the embeddedness of an NPO in a community holds great value, however, there needs to be a fundamental change in the affiliation from "managing up and down…. towards new relationships across organisational boundaries based on networking, cooperation and reciprocity" (p. 10).

The new approach, as specified by the Western Cape government's *Health Care 2030* document, was in general well understood by all the interview participants, both from WCG -

Health and the NPOs. This may stem from a workshop process instigated by WCG - Health to provide their NPO service providers with a sound understanding of the new approach, under the banner of *Health Care 2030*. It follows, that, with the on-going discussions of the HCBC programme running concurrently with this research study, there was an obvious commonality in understanding of the objectives, goals, and overall vision of *Health Care 2030* framework.

Where the previous literature is lacking is in the complexities of the relationship as one moves from the local, to the sub-district, to district, to provincial levels of government and the ramifications for the HCBC Programme, as information and operational aspects move up and down the scale. Schneider et al. (2008, 2015) do make mention of it to a degree, but they were looking at the entire programme as a whole, in contrast to this study which is focusing specifically on the relationship. They have not captured some of the less tangible aspects, such as filtering of information, non-compliance with all protocols, and/or a general lack of a voice of the NPOs as they interacted with higher levels. Stern and Green (2005) come closest to realising the environment NPOs are operating in, when they state "statutory authorities remain structured in bureaucratic patterns, characterised by self-interest, inflexibility and resistance to change, and are typified by hierarchical structures and distinct boundaries" (p. 270). While this quote remains relevant at the macro level, it does reflect the sense that many NPOs have in working with WCG – DoH on a daily basis.

An area where the literature is not always as specific (demonstrative) on a sub-district level, as the findings is the extreme pressure (disease burden) and the challenges (e.g. funding, HR, training, staffing, management) under which WCG - DoH operates. The findings from the current study reveal that WCG - DoH is operating in a high disease burden environment with limited budgets, staffing, management, and lack of general capacity to implement a broad set of health interventions. Schneider and Lehmann (2010), Schneider et al. (2008), Naledi et al. (2011), and Friedman (2006a/b) do discuss the disease burdens (including HIV/AIDS) and the other challenges faced by WCG - DoH, but do not address the effect these have on the day-to-day operations at a local clinic level. The findings from the current study show that just as NPOs believe their voice is diluted as it moves up the various level from local to province, so too do members of WCG - DoH operating at the bottom of the coalface of clinical care. There is also a sense at the lower level of WCG - Health that there is a "disconnect" between the understanding of what is happening on the ground in the health facilities in the community and their needs being communicated or addressed at a provincial level. This is not always reflected in the literature, and is crucial to understand when things do not go according to plan. In

addition, it also leads to a "customisation" of protocols on a local level, which may or may not be a good thing. While the environment WCG - DoH staff are operating in is far from intolerable in nature, it is highly stressful, complicated, and challenging.

Thus the literature and findings from the current study on the home and community-based care programmes generally provides a cohesive foundation to support this focused study of how the two entities, WCG - DoH and NPO service providers, work together based on the necessity of gaining the leverage of social capital in order to attain a level of collaboration and [values based] mutual benefit.

At the apex of this study is social capital, which is the underpinning for collaboration between two distinct entities. Whether social capital derives from collaboration, or collaboration stems from social capital, is an on-going debate, but the findings from this study point to the fact that there has to be some level of social capital to initiate collaboration. It is the social capital that has brought together WCG - DoH and the NPO service providers to support each other within the HCBC programme at local level. Further strengthening of social capital is derived from the collaboration.

If social capital is a glue, which as Paldam (2000) argues "makes people work together either for reasons of their own or due to pressure within the group" (p. 632), it represents the motivational force that brings together WCG - DoH and NPOs to provide the HCBC services in communities in the Eden District. The study also reveals that the "glue" of social capital has different strengths, and as one moves up the spectrum from the local level, to district, to province, this glue goes from very sticky, to a much lower bonding strength. Portes (1998) supports this idea that on a local level, the ability of social capital to bring players together would be stronger, as he sees social capital benefiting the actors "by virtue of membership in social networks or other social structures" (p. 6). The social network within the HCBC programme revolves around the local clinic, NPO and WCG - DoH (Figure 7) which as a network provides a sense of "community" and mutual support, even with the many challenges the various role-players face.

From this network comes a set of resources held by the collective which provides a level of social capital, which would not be available were it not for the benefits gained from this network (Nahapiet & Ghoshal, 1998). Thus, the benefit (social capital) that arises from the clinic working with the NPO, within the HCBC programme, brings to the individual players working

together, far greater economies of scale that would be absent if the actors (institutions) were operating on their own.

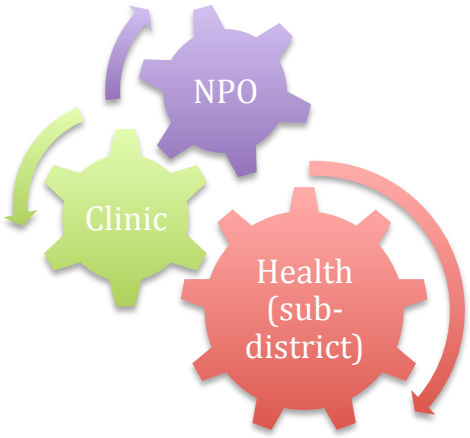

Figure 7: HCBC Social Capital Network (source: Author)

The social capital of the various entities working together comprises two components, made up of intellectual and human capital (Coleman, 1988). Within the HCBC programme, the intellectual capital entails the specialised knowledge and capacity of the individual organisations, while the human capital comprises "the acquired knowledge, skills, and capabilities that enable persons to act in new ways" (p. 598). Therefore, the intellectual capital is retained in WCG - DoH and the NPO service providers, while the human capital is the acquired capabilities of the various staff members of the entities, who attain additional skills while working together with the other various role-players.

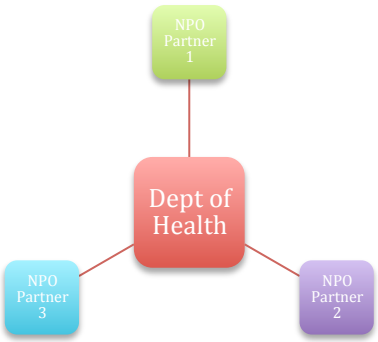

Figure 8: WCG - DoH Network Nodes (source: Author)

With the coming together of often-discordant groups, a network is set up to provide coordination and mutual benefit (Figure 8). These networks are built on trust and the ability to get things done to a greater extent than the two entities would be able as an individual entity (Putnam, 2000). These networks work well on a local level, as the various parties are linked far more closely in this environment. The NPO service providers and local clinics are

geographically close and the staff from the two entities interact with each other daily. Thus, a level of bridging, "relationships between people and groups of people who are somewhat dissimilar in some demonstrable fashion," (Hawkins et al, 2011, pp. 358 – 359) leads the diverse members of WCG - DoH and NPO service providers to act in accordance with a common goal.

Although WCG - DoH and the NPOs have distinct objectives, the bridging attained through social capital allows for the two entities to work together effectively within the framework of the HCBC programme (Figure 9). The linking, which is an outcome of the relationship between two unequal partners (WCG - DoH & NPOs), does provide a level of connectivity between the two, which is ultimately of benefit to the HCBC programme (Hawkins et al., 2011).

The findings also point to the strength of social capital within the HCBC framework. Nan Lin (1999) maintains that "the value of social capital is governed by 1) network characteristics, 2) strength of social ties, 3) network member assets, and 4) the goal of the purposive action that motivates the capital-generating social exchange" (p. 37). The network characteristics are two distinct organisations, WCG - DoH and NPOs, which have strong social ties at a local level, but deteriorate as the relationship goes up from the sub-district to province. This can be seen graphically in Figure 9. However, it must be noted that this is a summation of the findings; in fact the individual strengths of the various NPOs to WCG - DoH were also based on geographic distance within the Eden District, and personal rapport between staff within the two entities.

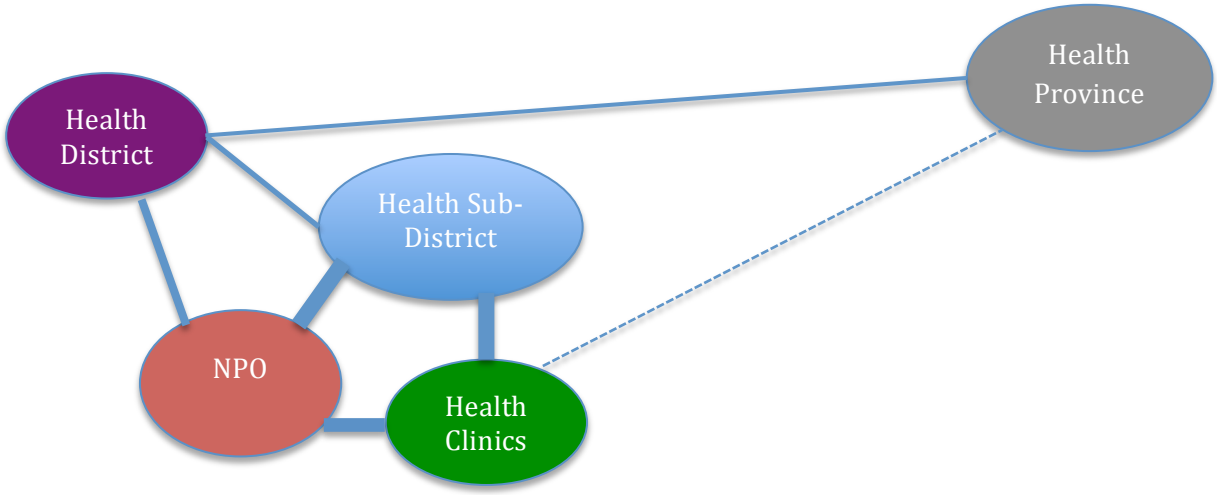

Figure: 9 Network Strength Between Actors (source: Author)

The network member's assets are very diverse, with the bulk of the resources and capacity residing in WCG - Health, yet even the NPOs have assets which are of value to the HCBC programme. From the research, it is the access to the varying resources and capacities in each organisation that brings WCG - DoH and the NPOs together to support the HCBC programme.

This is supported by Lin's (1999) argument that social capital is "an investment in social relations by individuals [or entities] through whom they gain access to embedded resources to enhance expected returns" (p. 39). The two entities invest in a collaboration hoping for a real return of investment greater than the cost. It is the strengthening of ties within the network, between WCG - DoH and the NPOs that can lead to greater returns on investment by both parties. The very focus of this work is to strengthen the network and subsequently build social capital between WCG - DoH and their NPO partners in the community.

The findings from this study have revealed that a level of social capital has led to collaboration between WCG - DoH and the NPOs in the support of the HCBC programme, and the subsequent collaboration has strengthened the social capital between the two entities (Figure 10). The ability to understand the relationship and level of collaboration between WCG - DoH and the NPOs in the Eden District has been a challenge, but the researcher has been able to reach some conclusions. Collaboration, as noted in the literature is "to work jointly with others on a project, where those collaborating with others take on specified tasks within the project and share responsibility for its ultimate success" (Ansari et al., 2001a, p. 231).

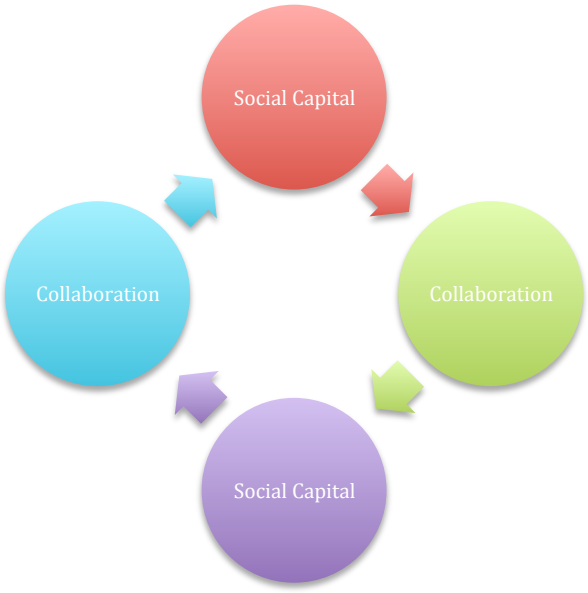

Figure 10: Social Capital – Collaboration Continuum (source, Author)

According to this definition of collaboration, WCG - DoH and the NPOs have met the basic tenets for a collaborative process on a local level, but much less so as the relationship goes from the district to the provincial level. The literature is consistent with the findings of this research that there are a number of "pillars" that underpin a strong collaborative relationship. These pillars include: 1) networks that have already been established; 2) patience; 3) effective

communication; 4) development of broad-based social capital in order to provide a sound foundation for the coming together of the various partners; 5) an understanding that the partners bring various levels of resources and skills to the collaboration, and this may lead to power imbalances if not managed properly; and finally 6) a clear common vision with a sense of ownership, clear and transparent policies and procedures that support trust and motivate for a common purpose (Ansari & Phillips, 2001b).

Collaboration is a vested goal for both organisations. Nevertheless, given the immense challenges that were revealed in the findings, it is a complex, slow, potentially divisive process that takes a large input to often attain outputs that may not be initially fully realised and only lead to greater economies of scale over substantial periods of time. It requires vested, committed individuals who value the social capital achieved through the collaborative process, given the cost to both the individual and/or organisation. Inherently then, the final collaborative product has to have a value greater than the situation at the outset of the process.

Collaboration, if any, between the two entities functions in a complex environment that both feeds and repels the collaborative process. In the forefront is the health burden, which is immense and unrelenting. It is also the raison d'être for both the NPOs in the community and the WCG - Department of Health; without this disease burden there would be no need for their services. The health burden, including both infectious and non-infectious diseases, is in reality enormous, and places a significant strain on the resources in government and civil society. This then, provides a catalyst for the two organisations to work together superficially or intensely, depending on various factors as part of the collaborative process.

The primary health care system was for many years largely curative in nature, which provided for a rather narrow framework for developing partners and programmes. This, combined with the distinct nature of the rural system that operates within the Eden District, creates a number of peculiarities specific to this operating environment. It is based to a much greater degree on personalities and the relationships between these individuals than the urban Metro, where there are a multitude of NPOs operating on the ground. In the rural environment the NPOs are few in number, and if one or two are not able to participate in the HCBC programme it can lead to catastrophic effects on the greater primary health care system, which makes the rural system far more vulnerable and fragile in comparison to the Metro. It also enhances the need for the different personalities and partners to work together effectively, ultimately requiring a stronger level of social capital built over time.

The current research findings show that the relationship and collaborations between WCG - DoH and NPOs have been ongoing for many years. Government has been partnering with NPOs since the mid 1990s when the first home-based care programmes were initiated. In the Eden District, many of the NPOs such as Bethesda / CMSR and Knysna Hospice have had a contractual relationship to implement community-based health programmes for decades. This long-term relationship has naturally strengthened over time. Other partners, such as Ithemba Lobomi and PlettAid have only more recently become part of the collaboration, but have quickly integrated themselves as part of the collaborative process. Patience seems to have paid off, as over time the role-players have come to understand the capabilities and challenges of each other, and have sought to heighten the former and assist with the latter. Again, it should be noted that the collaboration between the two entities is not between WCG - DoH & the NPO on a macro level, but on a local, micro level. The collaboration stems from a contractual agreement, which in itself is not a sound foundation for collaboration. It is the operational aspects of the process that has produced the close relationship and subsequent collaboration as compared to the managerial and governance levels in which the relationship is more transactional (contractual).

Communication is at the heart of collaboration (Abramson & Mizrahi, 1996). As the communication has become more effective between the local clinics, the sub-district, and NPOs, the outcomes of the HCBC programme have improved, especially the referral component. Communication builds cohesion between the various role-players to strengthen the system and helps to blunt or prevent challenges that could hamper the implementation of services. A paramount factor in the success of the HCBC programme is communication, which is predominantly through meetings, but also informal interactions on a daily basis.

The broad-based social capital has been discussed in detail above, but represents the catalyst for the collaboration and in turn is strengthened by the collaboration. The level of resources and capacity of the distinct organisations vary considerably. It is easy to ascertain that WCG - Health has an extensive capacity and set of resources well beyond those of NPO. Less easy to see, is that the NPOs hold their own resources and capacity that can be used for leverage. This is not to deny, however, that a large power imbalance exists. WCG - Health, as a funder and policy maker, holds significant power in the relationship, but this is offset by their need for service providers in communities to implement the HCBC programme. As discussed previously, in a rural health environment, the system is vulnerable to service providers entering and exiting the HCBC programme. While the WCG - Department of Health has never faced a

coordinated, unified non-profit sector, it could do so in the future. If the NPO service providers were able to leverage their power as a whole, or their staff were to become unionized, the WCG – Department of Health would face a potential crisis in their implementation of the HCBC programme. Although it is still highly unlikely that there would be a unified front, the WCG – DoH could also face a crisis if a significant number of NPO service providers decided to end their contractual agreements with WCG – Department of Health, thereby challenging the ability of the WCG – DoH to render the HCBC programme in a particular area or region.

The NPO service providers could also undercut the community based services of the WCG – Department of Health by simply opting out of the HCBC programme altogether. This would be a final drastic move, representing their dissatisfaction with the transactional nature of the relationship. Although it is highly probably that the WCG – DoH would be able to find other service providers, it would have an affect on the quality of the service as a new NPO began HCBC services. Clearly, the NPO service providers would then be able to affect the system by either opting out, or by opting in through a unified approach to the WCG – Department of Health. Unlikely as this may be, the potential remains if the two entities cannot truly collaborate on a holistic basis.

The power imbalance can be most clearly seen, however, at the district and provincial level where the NPOs voice is the quietest, as they have little say on planning, policies, and procedures. This power imbalance results from a substantial challenge in power dynamics between the two entities, even at a local level. The professional nurses working in the clinics for WCG – DoH retain a level of real or perceived "superiority" over those nurses and lay CHWs employed at the NPO. Throughout the relationship between the WCG – DoH and the NPOs, there is a central theme that underscores the power imbalance. While this power imbalance is more transparent at a district or provincial level, it is retained on the local / sub-district level as well, although in a much subtler, diffused manner. The nurses and lay CHWs employed by the NPO usually defer to the WCG – DoH staff on most matters related to the HCBC programme. The "professional" status of the nurses employed by WCG – DoH often trumps the inherent similar experience and knowledge held by nurses employed through the NPOs.

The research findings clearly point to the conclusion that generally, the NPOs delivery of the HCBC programme is directed (managed) by the WCG – DoH through the contracts and protocols of the HCBC programme, except for the HR component, which has been generally

been left to the NPOs. The NPOs therefore have little or no scope or autonomy to operate outside of the proscribed SOPs from the WCG – DoH. This may be of benefit to the WCG - Department of Health as it has numerous NPO service providers, but also result in subservience on the part of the NPOs. NPO staff take direction from the clinic and WCG – DoH personnel, and thus are often operating in a schizophrenic situation, where they work for a NPO, but are supervised by staff from another entity. The dichotomy is that although much of the supervision is conducted by WCG – DoH, issues relating to HR such as performance monitoring, discipline, and leave is carried out by the NPO. In many ways the NPO is a labour broker for the WCG - Department of Health. This concurs with other research that supports the notion that NPOs operate in an untenable position, with staff serving two masters (Schneider & Lehmann, 2010; Schneider et al., 2015).

This process then becomes much more transactional and less collaborative. Transactional costs are related to the field of economics, where it "identifies the critical dimensions for characterising transactions, describes the main governance structures of transactions, and indicates how and why transactions can be matched with institutions in a discriminating way" (Williamson, 1979. p. 234). For this study, transactional costs can be evaluated in two ways: 1) on a contractual level (between the WCG – Department of Health and NPO service providers); and 2) the expenses related to entering into a contract between parties (Williamson, 1979). Both entities, WCG - DoH and the NPOs, accrue costs ("subsidization, time, resources, capacity, loss of autonomy, and investment of political capital") (Nowell, 2009, p. 197) in terms of collaborating together.

The research findings support Nowell's (2009) work that looked at transactional cost theory as part of the collaboration process, which reviews the cost / benefits of collaboration, and underscores that these costs are a deciding factor in whether the various stakeholders will work together. While it is obvious from the research findings that an optimal rate of return (collaboration) has been leveraged to some degree on a local / sub-district level as part of the HCBC programme, there remain significant transactional (contractual) costs to the NPOs. NPOs have to subsidise much of the work as funding from WCG – DoH is not sufficient to administer the overall programme. These costs are often hidden as part of the normal operating costs within the daily expenses of running a NPO. It is obvious from the research that the hidden transactional (contractual) costs to the NPO are much more significant than those to the WCG - Department of Health. Autonomy, resources, and capacity are some of the costs that face the NPOs in levels disproportionate to those of WCG – DoH.

The level of collaboration, while occurring, is partially offset by the substantial and disproportionate transactional costs (contractual expenses) to one partner (NPOs) to the ultimate gain of the other (WCG – DoH). That a level of collaboration does occur ultimately rests on the understanding that, although one actor (stakeholder) faces substantially higher costs than the other, the benefits to both outweigh these costs. The two entities have gained a higher rate of return through an increased ability to reach more clients / patients, increased overall resources, greater economies of scale, more efficient processes, and increased synergies. Therefore, by working together, WCG - DoH and the NPOs have increased their capabilities to provide home and community based care to communities throughout the district.

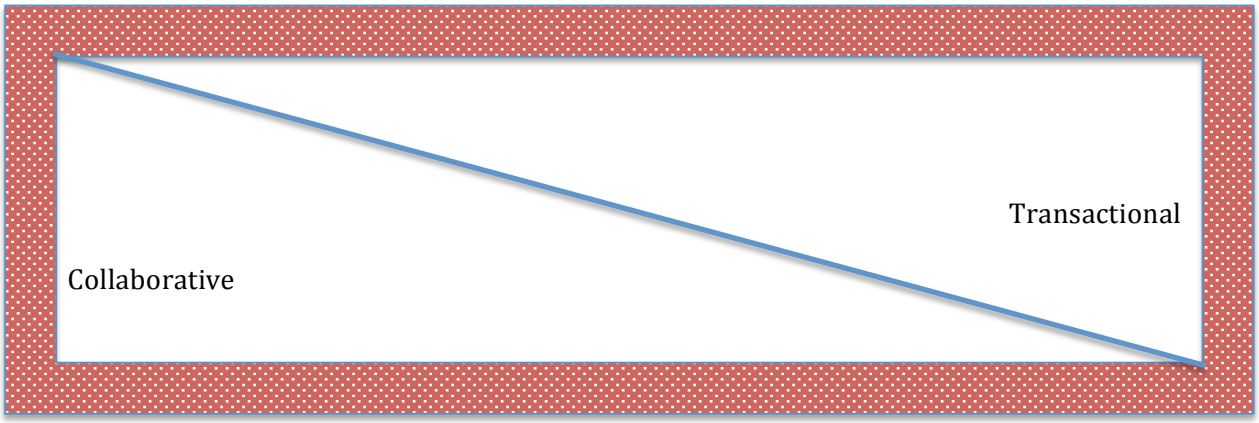

Figure 11: Transactional vs. Collaborative Balance along the Spectrum in Government (source: Author)

Ultimately, there is a level of mutual need within the collaboration that tempers the power imbalance and allows for cooperation on a local level. Above the local / sub-district level, collaboration is not practised (Figure 11) and therefore there is an almost tangible cut-off in the relationship. Although Nowell's (2009) study also postulates that network density is easier to achieve when the networks are smaller, the findings actually reveal the opposite. As the network gets scattered and smaller, collaboration becomes more difficult. Even though the network is smaller at the top, because of the physical distance and non-direct communication, collaboration is the weakest. This does not negate the significant challenges posed to NPOs by the power imbalance, even at a local / sub-district level. The WCG - Department of Health has the power of the purse and can revoke funding as it deems fit. The motivation for NPOs to then be subservient to the WCG – DoH's demands remains strong as the WCG - Department of Health funding is a vital component as part of their overall operations. It is often a difficult decision for an NPO to enter into a contract with the WCG - DoH, but NPOs have to be pragmatic, especially if they want to provide holistic health interventions in local communities. Once the

NPO enters into a formal agreement with the WCG - Department of Health to administer the HCBC programme, on a local / sub-district level, the two entities have to work together.

The common vision is articulated on a local level, in terms of a widespread sense that all the organisations want to work for the common good of the health needs of the community they are serving. The overall planning of procedures and policies may occur at a much higher level, and with little input from the local sector, but on the ground the day-to-day procedures are worked out in a collaborative process that is specific to the environment in which these organisations are working. Thomas and Perry (2006) point out that there is a significant difference along the continuum from coordination, to cooperation, to collaboration that eventually leads to establishing something innovative in a joint approach.

This movement along the spectrum points to the notion that power imbalances exist and continue to perpetuate a system that imposes one entity over the other. Nowell (2009) ultimately concludes, "that major changes that may threaten the status quo concerning power and decision-making require strong affective relationships" (p. 207). Although the relationships between the NPOs and WCG – DoH on a local level are stronger than the higher levels, they are not as yet strong enough to change the inherent status quo. Nowell's (2009) study of collaboration sums up the current challenges facing NPOs and WCG – DoH on a local level and indicates that, in order for significant change to take place, "strengthening the quality and connectedness of relationships among stakeholders may be an important lever for helping a collaborative to effectively make [such] a transition… to a more systems orientated goal" (p. 207). The quality of the relationship on the local level remains tenuous, resulting in the on-going challenges facing the various stakeholders. Finally, of note is that the two entities do not have a shared philosophy, which Nowell (2009) sees as of critical importance for systems change. Shared philosophy "directly relates to how stakeholders *think* about the target issue" (Nowell, 2009, p. 207). These different philosophies between the two entities eventually hinder more effective collaboration.

Ultimately, the counterpoint to not collaborating can be seen in the recent Life Esidimeni debacle in Gauteng with the death of 143 mental health patients. In a critical document, the Health Ombudsman (Makgoba, 2017) found that the termination by the Gauteng Department of Health of their chronic psychiatric care service provider, Life Esidimeni, led to about 2000 mental health patients being sent to their families and NGOs, who were then unable to provide any real level of care. This was done, according to the Gauteng Department of Health, to save

money and decentralise the system (which was theoretically policy, but should have occurred over a number of years). All of the 27 NGOs the patients were transferred to did not have valid licences. Subsequently, 143 patients died under unlawful circumstances. The report categorically states "available evidence by the Expert Panel and the Ombud showed that a 'high-level decision' to terminate the LE contract precipitously was taken, followed by a "programme of action" with disastrous outcomes/consequences including the deaths of Assisted MCHUs" (Makgoba, 2017, p. 1).

The Gauteng Department of Health was warned on numerous occasions about the threat posed with implementation of a policy to end the Gauteng DoH's relationship with LE. Recommendations had been made in the past concerning the placement of mentally ill patients in facilities that were not suitable. The various stakeholders were not listened to when they met with the Gauteng Department of Health. Although the Gauteng DoH had indicated they would not do anything further without consulting with the families and relevant stakeholders, the Gauteng Department of Health made the final decision to move the patients without any such subsequent consultation.

This represents an extreme case of negligence by the Gauteng DoH, but serves as an example of how disastrous things can become if all the stakeholders are not consulted and heard. If a similar scenario is to be avoided in the Western Cape, it is imperative that the recommendations in this study be scrutinised and prioritized for implementation. The relationships between the WCG – DoH and the NPO service providers are fundamental to the efficient and effective implementation of the HCBC programme in order to meet the basic health needs of communities in the Eden District and support the primary health care services of the Western Cape Government – Department of Health.

4.10 Reflexivity

The author spent a considerable amount of time reflecting on his point of view (positionality) within the HCBC system and the research in general. The author has worked in the district for more than a decade and has, as a funder and manager, interacted with many of the interviewees. The Isisombululo Programme to one extent or another has funded almost all the NPOs in the Eden District involved with community-based services. The WCG – Department of Health has also received significant funding from the IP in the Eden District. In addition, the author helped to found and develop one of the NPO service providers, Ithemba Lobomi, in the study. Therefore, the author's positionality has to been seen as crucial in the research process. The

author fully understood his bias as an advocate for the NPO service providers within the HCBC programme, but sought to minimise bias through continual reflection and self-assessment, as well in discussions with the author's supervisor. This does not negate the possibility of social desirability bias, i.e. that some interviewees expressed views they felt the author support. Fortunately, most of the interviewees have many years of experience in the CBS environment and are very open to stating their opinions without fear or favour.

The author, while cognisant of his view that the inherent power balance lay with the WCG – Department of Health, was also able to recognise the immense pressures faced by government in providing health services. Substantially, the author was also an advocate and supporter of funding for WCG – Health services in the Eden District. Therefore, although the opinions of the author have been influenced greatly by his positionality in the system, having a foot in both government and NPO sectors allows for a greater understanding of their distinct characteristics.

As an insider, the author, through on-going observations, has seen substantial dialogue and relationship building on a sub-district level. Regular (weekly / monthly) meetings are held between the two entities in order to insure optimal operational implementations. Both the clinic and NPO service provider staff are able to discuss issues as they arise, and the relevant stakeholders then find tangible solutions, which can be implemented rapidly and monitored over time. Standard Operating Procedures (SOPs) have been drawn up in order to document the process and to ensure communality in the process.

Ultimately, the author used his positionality to understand the two entities better, and gain a more detailed perspective on their assets and challenges within the HCBC system. The author's position within the system was not static, but supported both the WCG – Department of Health and the NPO service providers, based on the specific projects being funded and managed. Depending on the specific funded project, the author's positionality moved from being embedded closer to the NPO service provider, to being embedded within the WCG – DoH framework. His position in the district and system allowed access to the key stakeholders in the CBS system. While the total elimination of bias is impossible, the author strove to understand his place in the system and let the data lead the research process.

4.11 Research Limitations

The researcher has accounted for the limitations that have arisen during the research, which include the number of participants sampled. The author did not interview all the NPOs

operating throughout the Eden District, due to the geographical distance, logistical and time constraints associated with the study. The participating NPOs, however, represent a cross-section of those contracted to the WCG – DoH for HCBC services from small, to medium, to large, in a geographically diverse area.

The Eden District has it own set of unique features which have the potential to affect the research. Although the geographical region is large, there is, however, only a limited number of staff who work in the HCBC sector. In addition, staff frequently rotate backwards and forwards between employment at a NPO or WCG – DoH. People generally know each other well, and can potentially have many allegiances. Any study in the region must recognise that the opinions of an individual often reflect their current position, but might change if they enter government or the NPO sector later. Personal interactions may also cloud the responses to the questions, but, since so much of the work is personal relationships, this has validity for the study as well.

The findings reflect the viewpoint of participants from the Eden District and cannot therefore be generalised or transferred outside of the district. Additional studies utilising the research tool (semi-structured interviews and focus group) would be able to assure dependability of the methodology. The author has throughout the study attempted to keep the authenticity of the interview participants by understanding biases and dampen any preconceived ideas, while ensuring that the findings were based strictly on the data attained through the research.

5. Research Conclusions / Recommendations

5.1 Conclusion

By utilising their distinct strengths, the two entities have been able to provide a splintered, yet serviceable level of care in the community on a local level. They see some value and motivation to buy-in to the system, albeit sometimes only after a long period of dialogue and debate.

At the higher levels, the relationship cannot be classified as collaboration, but rather operates in a transactional (contractual) manner within a top-down bureaucratic environment. Ultimately, the relationship at the district and provincial levels, while not adversarial, is cooperative at best and distorted (transactional) as the norm, mitigated by the development of social capital. At the local / sub-district level a measure of collaboration is occurring under the pressures of a continuingly distorted power imbalance. Significant progress has been made within specific sub-districts on operational aspects of the HCBC programme and the district has become more responsive to the NPOs' needs, yet, a disconnect remains at the higher levels.

5.2 Recommendations

If there is to be a significant increase in the level of collaboration between the WCG – Department of Health and the NPOs contracted to provide the HCBC services in the various communities in the Eden District in order to improve service delivery, it is vital that a number of substantive issues are addressed between the two entities. While "business as usual" may provide an adequate level of service provision, it continues to place stress on both the WCG Department of Health and NPOs on a local level, and also to hinder service delivery. Immense pressures pervade the health system in South Africa, and therefore it is vital that all the role-players work in the most effective manner with each other. The relationship between the two entities needs to be prioritised. The utilisation of the distinct capabilities of the WCG – Health and NPOs to their fullest would result in greater outputs and increased impact on the ground. This has been accomplished, to some degree, within the George sub-district where a model of consultation, discussion, debate, and mentorship has been implemented between the various stakeholders resulting in a more balanced relationship between the various entities and more efficient service. These positive endeavours, however, are often overshadowed by the bureaucratic, top-down approach from the district and/or province.

This is not to say that challenges and stresses would not still arise, but, a stronger relationship between the WCG – Health and NPOs would provide greater resilience over time for the two entities. The following recommendations are an attempt to strengthen the relationship without incurring costs that outweigh the benefits (value) of proposed intervention. It is hoped that the recommendations will also initiate a dialogue between the WCG – Health and their contracted NPOs. The recommendations encompass the following:

NPO

- A cohort should be established (could be labelled a committee, association, HCBC Advisory Team, or forum), which would be constituted in order to build a collaborative framework for the planning and discussion of operational aspects of the HCBC programme from an NPO perspective. The cohort would include senior management [responsible for the HCBC programme] at the NPOs, which would be composed of the NPO Project Manager, NPO Coordinator, NPO Supervisor, and 2 - 3 CHWs per NPO.
- Quarterly meetings need to be held in the district that would bring together the various NPO service providers as described above in order to allow for open dialogue on the

HCBC programme, develop policy & advocacy frameworks, identify areas of challenge, and provide tangible, manageable, measurable solutions.

- There needs to be a unified, cohesive approach to working with the WCG – Department of Health on the HCBC programme.

Sub-District / Clinic

- An integrated dialogue (communication) structure is essential encompassing daily / weekly / monthly meetings between the various role-players (clinic, NPO, sub-district staff) on a local level, governed by the mechanics of the various processes. This has been accomplished to a degree in the George sub-district, but also across the Knysna & Bitou districts.
- A SOP should be developed laying out the communication protocols between the clinic, NPO, sub-district, district and province (note: this has been done to a certain degree in terms of the referral process at the George sub-district).
- The roles and responsibilities of each of the role-players need to be documented and respected. It is imperative that the staff of a NPO do not feel that they serve two masters. NPO staff operates under the management of that NPO, as they are not employees of WCG – Department of Health. NPO staff should feel welcome and supported in WCG – Health facilities and an atmosphere of collaboration should be fostered.

District

- Biannual meetings should be held in the district that would bring together the cohort including NPO and WCG – Health at a district level to allow for open dialogue on the HCBC programme, identify areas of challenge, and to provide tangible, manageable, measurable solutions.
- As part of these quarterly meetings, there is a need to plan and draw-up SOPs for the programme and monitor them over time. Outcomes (including the viewpoints of the NPOs) of these meetings should then be communicated to WCG – Health at a provincial level.
- A forum is needed that represents the community health workers within a district (this could entail representatives from each NPO in the district or all CHWs as a whole). The role of this forum would be to provide care and support for the CHWs, as well as allow for the CHWs to express their needs in a unified manner.

Province

- Hold annual meetings encompassing all role players (including the cohorts discussed above) to plan and strategise the HCBC programme on a macro level. Full "buy-in" and participation by all the stakeholders as partners is vital. This event should also include the CEOs of the various contracted NPOs and top-level management of the CBS / PHC programmes at the WCG – Department of Health. An agreed draft strategic plan should be a tangible outcome of the workshop.
- A framework should be provided for the development and dissemination of innovative and best practices of the various role-players in order to create more efficient systems and enhance the overall impact of the HCBC programme. Innovative practices could enhance communication (between NPO & clinics), patient/CHW/Nurse interactions, referrals, health systems, human resource and budgeting capabilities, relational issues, as well as advocacy tools.
- Province should hold meetings with each NPO before the signing of the next round of contracts in the district to gain a better understanding on the ground in the different areas and engage with the NPOs more fully.
- Set-up a joint rapid appraisal (situational analysis) conducted before development of the final SOPs and signing of the contracts between the two entities. This will allow for a more collaborative process and a more impactful service rendered.
- Ensure that the NPOs have a voice in the planning of all training activities (including curriculum, logistics, and language of instruction) associated with the HCBC programme. An understanding of the varied educational backgrounds of the community health workers is vital as training (in-class and practicals) can be a significant challenge given the language and skills requirements.
- The WCG – Health should endeavour to ensure that the "voice" of NPOs is heard, respected, and responded to in a timely, constructive manner.

National

- Also important is to develop a comprehensive national CBS/HCBC framework in collaboration with all the stakeholders.
- A salary and compensation package must be provided for the community health workers that reflect their level of work and responsibilities.

5.3 Future Research Directions

Given that the study focused on the Eden District, which is considered a 'rural' environment, it would be of value to better understand the nature of collaboration between the WCG – Department of Health and their HCBC service providers (NPOs) operating in the Cape Metro. The findings from a study in the Metro would potentially have considerable differences to those of the Eden District, but might reveal valuable insights into how the relationship between WCG – Health and the NPOs is able to sustain collaboration (if it exists). In addition, there might be innovations in the Metro that could be transposed in the Eden District, which would help the WCG Health – NPO relationship.

Another avenue for potential research is to study a similar environment to that of the Eden District, potentially the Overberg region that is also a rural locality, to ascertain whether the findings from the Eden District are similar. If the two regions were found to have similar findings, a study of the implementation of the recommendations in a comparable area would build on the work of this study. A study in an analogous area on the relationship between government and NPOs within the HCBC programme might also suggest innovations that could be applied in the Eden District.

Because so much value in terms of relationships resides in personalities, additional studies focusing on the effect of interpersonal relationships (social capital) between the various role-players impacts on delivery would build on this study. A final component for future research is to gain an understanding of how the transactional (contractual) nature of "bureaucracy" that enters into any relationship (or collaboration) between government and civil society affects the overall effectiveness of the process. Bureaucracy can sometimes hinder relationship building, but, it is a central component of any system. Researching the streamlining of bureaucracy in the provision of health services and relationship building has the potential to build greater knowledge and awareness.

5.4 Postscript

Subsequent to the completion of this research, both the Knysna Hospice and PlettAID (for various reasons) ended their participation in the HCBC Programme with the WCG – Department of Health. The path Knysna Hospice took to ending their relationship with the WCG – DoH in terms of the HCBC Programme is illustrative of what happens when NPOs are not heard and generally concurs with the findings in this study.

Knysna Hospice has been contractually tied to the WCG – DoH Home Based Care Programme since 2002. When the HBC Programme first started, the programme was a full-day service, providing holistic care to the community. After several years, the WCG – DoH mandated the programme would become half-day and the salaries were then halved. The organisation was given double the numbers of Home Based Carers, but at the reduced hours and salaries. Consequently, the organisation then faced significant retention and service challenges.

In 2015 / 2016, the organisation was informed that a new framework of community care would be proscribed by the WCG – DoH under the *Health Care 2030* strategy. Approximately 90% of CHWs time would be spent on health promotion / prevention and 10% on sick care in households. While this was in stark contrast to the vision / objectives of Knysna Hospice, the decision was made to continue with WCG - Health and discuss with them the protocols going forward. Meetings were held at a district level, where it was tentatively agreed that the organisation would work 50% of the time on health promotion / prevention and 50% on sick care in the households. Shortly after this, it was indicated by province that this was impossible and the original protocol should be reinstated.

The Board and management of Knysna Hospice then decided to make the painful decision to end the contractual relationship in 2016 with the WCG – Department of Health. All HCBC staff were transferred to another NPO, Lifeline in Knysna. As can be expected, this has had a substantial impact on the quality of care, as Knysna Hospice had provided an excellent, holistic set of services to their clients for almost two decades. On a local level, however, Knysna Hospice continues to work well with the WCG – DoH and is funded by them for intermediate care at the Knysna Hospital. Neverless, both the community and Knysna Hospice were severely impacted by the outcome.

While it is understandable that the WCG – Department of Health has its own protocols, a lack of on-going consultations with NPO service providers has severely affected services being delivered and the NPO / WCG - DoH relationship. In addition, to Knysna Hospice, two other hospices in the Western Cape ended their contractual relationship with the HCBC Programme (WCG –DoH) because of similar reasons and concerns. It is therefore, vital in the future to retain NPO service providers that have the capacity to deliver quality, holistic care in the communities. Only through broad, tangible dialogue and collaboration can this be achieved.

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Appendix A

Business Prototype and Plan

Introduction

A requirement of the Graduate School of Business – University of Cape Town for the MPHIL degree in Inclusive Innovation is a business prototype and plan. As per the GSB guidelines, this component includes: 1) problem identification; 2) brainstorm and develop a solution; 3) create and test a prototype; 4) attractiveness of the business concept; 5) quality of the business planning process; and 6) a business (implementation) plan. As the nature of this study is within the health (non-profit) environment, the narrative has been tailored to fit within the more "entrepreneurial" type situation envisioned by the GSB - UCT. The author utilised the development of a prototype referral tool between the local clinics and NPO service providers, as part of the HCBC programme, to meet the requirement of the GSB - UCT. A focus group was utilised for this component of the research and placed as part of the appendix as per the GSB – UCT MPHIL dissertation guidelines for the dissertation.

Problem Identification

There has been an on-going (over several years) challenge with the patient referral system (Figure 12) between local clinics and the community health workers (CHWs) and HCBC Nurse Coordinators working in the NPO service providers. As discussed in the research findings, there has been a significant gap in the referral process that has lead to a severe impairment in community-based health services. Central to this problem is that when a patient was referred to a CCW in the community, from a local clinic, the clinic often did not know what happened to the patient once they were released from the clinic. Secondly, if a CHW or HCBC Nurse Coordinator referred a patient back to the clinic, they also did not know what happened to that patient (Figure 13). It remained uncertain as to whether they did go to the clinic, and what was the result. Closing the gaps then became vital for an efficient health system on a community care level. Over several years, there have been numerous attempts to rectify the patient referral system, with varying degrees of success (or lack thereof).

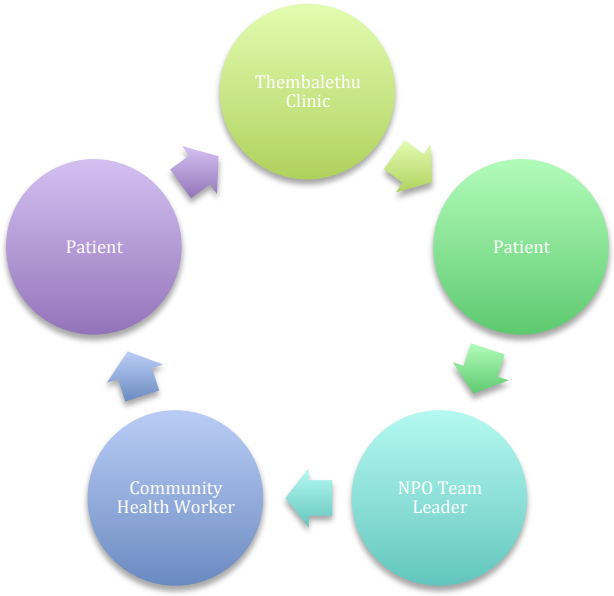

Figure 12: HCBC Referral Process – Overview (source: Author)

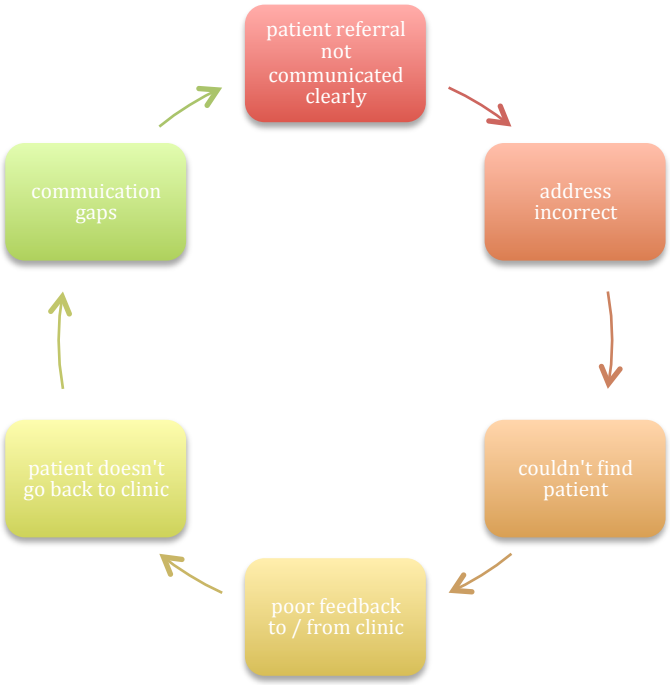

Figure 13: The Gaps in the HCBC System (source: Author)

The author, in his role as funder and Programme Manager, has been part of the process to gain a better understand of the situation and the many constraints that lead to gaps in the patient referral process. It was also easy to identify that there was a major challenge with the patient referral process, as the numbers of referrals from local clinics to the community-based NPOs remained very low. In speaking at that time with the nurses based at these clinics, there was

anecdotal evidence that the nurses were not referring because they felt they would lose "control" of their patients and did not know what happened to them once they were discharged back into the community. Therefore, they held onto the patients and refused to refer as necessary. These facility-based nurses often ultimately had little or no faith in the patient referral system. A similar perception prevailed among the NPO service providers based in the community, although they felt they were not getting sufficient communication back from clinics about patients referred back by them to the local health facilities. This atmosphere of discord then pervaded the entire referral process.

Brainstorming and Solution Development

As a partner with the WCG - Department of Health and a funder of the home and community based care programme for a number of years, the author attended numerous meetings were held to identify the gaps and develop a solution for the problem. The author, in his role as Programme Manager for the Isisombululo Programme in the Eden District, sought to bring a level of collaboration between clinics and the local NPO service providers, through the generation of an effective patient referral system.

The author helped to catalyse, rather than lead, the brainstorming and solution process, in order for the various stakeholders to take ownership of the solution and bring a level of sustainability to the process. Consequently, in an attempt to gain greater 'stickiness' for the solution, the various stakeholders had to understand and develop solutions on their own, in order to provide as end-users a protocol that was accepted and viable for all. This process took about six to nine months, commencing in September 2015. Numerous meetings were held to understand the current system at that time and brainstorm a viable solution. It was also beneficial that the new *Health Care 2030* strategic framework was being developed and rolled-out at the same time, as it allowed the two implementations to run concurrently.

Create and Test Prototype

It must be stated that the final protocols (prototype) for the updated patient referral system were ultimately designed and agreed upon by the WCG - Department of Health and the community-based NPOs. Given the nature of the problem, and the author's desire for a tool that had the support and feasibility of the various stakeholders through a collaborative process, it was essential that the stakeholders develop a solution organically through an on-going refinement

process. The author played a bridging (network) role in bringing together the various role players.

The final Standard Operative Procedure protocols (Appendixes C & D) were documented and a briefing session was held to roll out the new initiative in April, 2016. The new HCBC referral SOP endeavoured to finally close the gaps through a number of new components centred around new procedures, documentation, communication, meetings, and staff training.

The referral process from the NPO to the PHC facility commences with the community health worker doing a screening in the household and identifying a patient (client) needing to be referred back to the PHC facility (Figure 14). The CHW will write-up a referral letter with a date / time for the patient to visit the PHC facility and be seen through the appropriate fast lane. The patient takes the referral letter on the appropriate date and time with them to the clinic. The CHW keeps a list of all the clients referred and submits a copy, which is placed in the HCBC referral file at the PHC facility. The patient gives the referral letter to the health professional who sees him/her at the PHC facility. On a weekly basis, the NPO Coordinator and the Operational Manager (OM) at the PHC facility meet to go over the list of referrals and insure that everyone who was referred from the community side has presented at the PHC facility. The NPO Coordinator returns all the referral forms at the end of the month to the OM and follows up with patients (clients) who have not presented themselves at the clinic.

The referral process from the PHC facility to the NPO service providers follows a similar process, but in reverse (Figure 15). The nurse at the PHC facility places in the HCBC file all the referrals for a particular day. Then, on a daily basis, the CHW or NPO Coordinator collects the referrals. The CHW and/or NPO Nurse sees the patient the following day and reports back to the PHC facility on the referred patients they have seen. A copy of the referral letter is put in the patient's file. Discussions on referred patients also occur on a daily / weekly basis. Reasons for referred patients not being seen by the CHW or NPO Nurse are communicated back to the OM for follow-up. Recalls (for lab results, TB results, Immunisations, and high risk TB & ARV defaulters) are given to the NPO Coordinator who distributes them amongst the community health workers. Feedback is also given at weekly meetings.

The referral process relies on effective communication and documentation to ensure its effectiveness. Therefore, it represents a model of collaboration between the PHC facilities and the NPO service providers in order to implement the referral system. The SOP for the referral system has the support of all the stakeholders as they participated from the outset in its planning

and development, and subsequent implementation and monitoring of its effectiveness. While the system is not perfect, all the stakeholders work to ensure its viability and overcome any challenges with the appropriate solution(s).

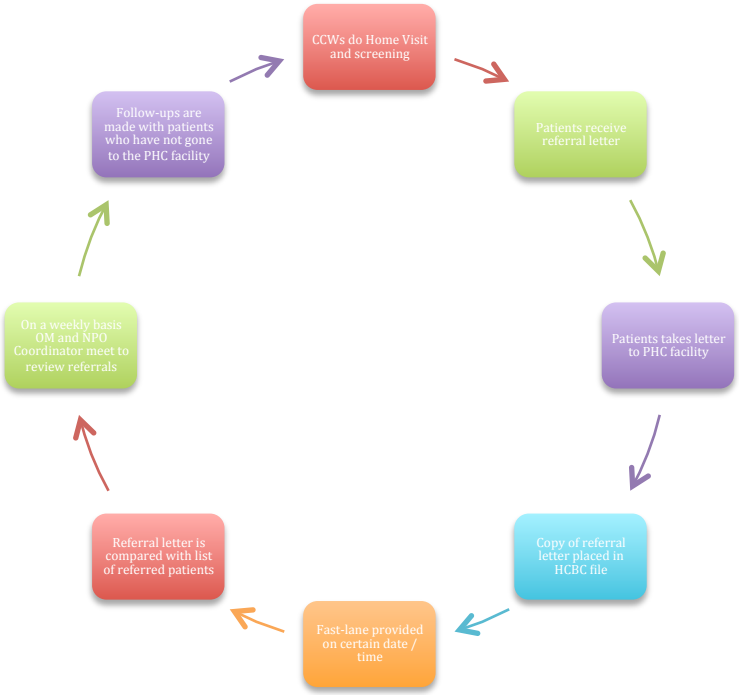

Figure 14: NPO to PHC facility referral. New HCBC SOP (source: Author)

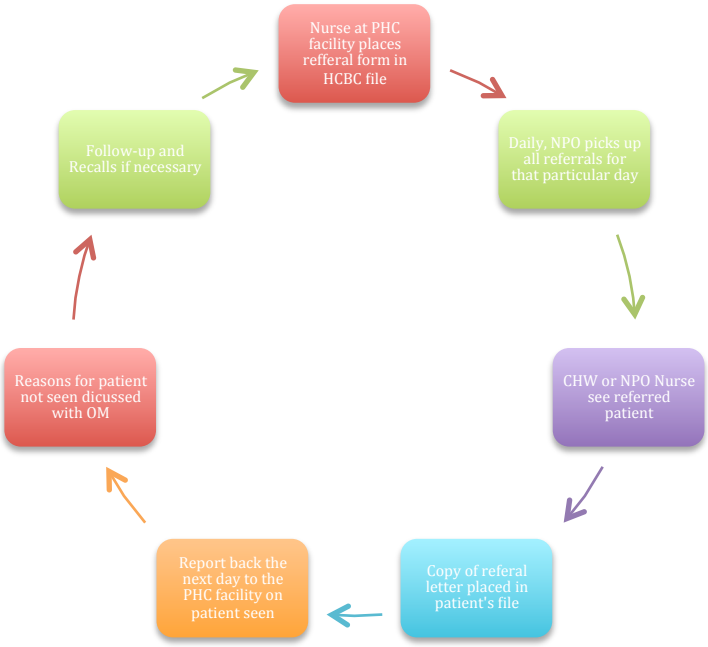

Figure 15: From PHC facility to NPO referral. New HCBC SOP (source: Author)

Given that the new protocols were only implemented in May, 2016 and the research for this study was finalised in July, 2016, it was a relatively short period of time to provide a viable test within an experimental design; however, anecdotal evidence through the use of a focus group

has proven that SOP is generally well received. The focus group was held in June, 2016 giving some feedback from implementation of the new protocols over a two month period of time. The focus group contained the following participants:

Organisation	Title / Function
Bethesda / CMSR	HCBC Coordinator
Western Cape Government Health	CBS Coordinator: George Sub-District
Western Cape Government Health	Facility-Supervisor: Thembalethu Clinic

Table 9: List of focus group participants

Attractiveness of the Business Concept

The focus group revealed a general consensus on the merits of the revised Standard Operating Procedures. A NPO interviewee states her hope for the SOP:

> *"For now, it is very good because what we do now, if we have a problem in the community, the home based carers come to us and [afterward] we go to the house and assess the situation and then we do referral to the clinic and then the clinic gives us back what we refer for them. Also if they pick up something for example, if there is basic care that needs to be done, it is where the clinic refer clients to us, so the referral system for now, it is sorted"(NPO).*

Another NPO interviewee concurs and is excited about the way the new referral programme is working.

> *"But, the interesting part is that we do get people at their houses and talk to them one on one getting the information that we need for the referral to the clinic because sometimes the clients are walking with an ailment and walking and walking. They know if they go to the clinic they will have to wait for long hours, and now they've got the paper so the outcome is a bit better. In previous years we would say, no go to the clinic without anything go and check out with the Sister and see is she can help you. By now they know they've got the letter and there's a fast lane for them, not in a sense that they will be helped immediately, but they know they will be helped they won't be sent back" (NPO).*

All staff members have been trained on the new SOP and now know their roles and responsibilities. Communication has been prioritised and specific meeting dates have been set. Feedback has been streamlined to provide the necessary information to close the gap between the local clinics and NPO service providers.

Quality of the Business Planning Process

The constraints of this research entail a small sample size for the focus group and the period being discussed in terms of the rollout was only two months. A larger set of focus groups held 9 to 12 months after the commencement of the new SOP would probably reveal greater validity on the topic.

The WCG – Department of Health has designated an "evaluator" of the HCBC patient referral system to ascertain whether the model is operating optimally (closing the gaps and ensuring that patients who are referred to or from the clinics are not lost within the process).

A suggestion for future evaluation of the referral process would be to acquire a random sample of patients referred either by the clinic or NPO service provider and follow that cohort through the referral SOP process. This would provide a rigorous, valid evaluation of the referral procedures and ascertain whether the system is working efficiently and if the previous gaps in the system have been overcome.

Appendix B

Implementation Plan

Executive Summary

The referral process for the home and community based care (HCBC) programme has been consistently challenging. The clinic was hesitant to refer patients to the community health workers (CHWs) because they did not know what happened once the patient was decanted from the clinic back to their homes. An additional gap was that once the patient was acquired by the CHW, it was again difficult for either the CHW or WCG – Health nurse to follow-up with patients referred back to the clinic. The whole referral cycles had major gaps and lead both entities to lack confidence in the process. This had a significant impact on the number of referrals, which always remained low, and was counterproductive to the goal of the referral system, which is ultimately to reduce the strain on the health facilities by increasing patient referrals.

Through a collaborative process, the various stakeholders were able to develop a set of standard operating procedures (SOPs) to create a more effective patient referral process. The SOPs were developed at the same time, as the new HCBC programme was rolled out in April of 2016. It was vital that all parties agreed to and accepted the procedures in order to increase the patient referral numbers and ensure patients weren't lost in the system. The new SOPs have been in place for the last three months and have generally had a positive affect on patient referral numbers and attendance in the clinics and support in the communities.

Health Sector: Community Based Services

The health sector in the Eden District, Western Cape, South Africa is influenced by the immense [infectious / non-infectious] disease burden in local communities. At the heart of the health system is the primary healthcare (PHC) model, which has been adopted to provide health services under extremely challenging forces. For the last two decades the health system (including the PHC system) has faced the affects of the twin infectious disease complications of HIV / AIDS and TB.

A primary component of the primary healthcare system in South Africa since the 1990s is community-based services (CBS) including the home based care (HBC) Programme, which

provided care in the home for patients discharged from the health facilities. Recently, the HBC programme has evolved as part of the *Healthcare 2030* initiative of the Western Cape Government Department of Health. The current home and community-based care (HCBC) programme provides a wellness-centred approach focusing on prevention, awareness, and support in a household-based model of care. Since the inception of community based services, government has been unable to provide all the health services as it lacked internal capacity. A model was therefore developed to utilise the numerous non-profit organisations (NPOs) to support the CBS programmes, by the development of a contractual relationship between WCG – Health and the NPOs, where the WCG - Department of Health provided the budget and protocols, and the NPOs carried out the intervention, utilising staff employed (retained) at the NPOs. All administrative / operational functions were carried out by the NPOs, while the WCG – Department of Health was left only with the overall oversight and management of the programme. This contractual system continues today, with very little change.

Regional Segmentation

The current home and community based care programme operates through distinct policies and procedures in the Western Cape between the metro (around Cape Town) and the rural areas running north and east along the cost and into the Karoo. This implementation plan provides support for the rural environment of the George Sub-District, Eden District in the Western Cape. While the referral tool may be supportive in other rural areas, it has not yet been tested as of yet, and therefore, all recommendations only apply to the greater part of the Eden District.

Referral System

The referral system is the cornerstone of the HCBC programme. Without a sound referral process, the link between the clinic and the community, and back to the clinic would be broken, leading to a much less effective provision of health services. For many years, under the original HBC system, there were many gaps in the referral circle, which lead to only a small number of patients being discharged from the health facilities back into the community as the PHC nurses lacked confidence in the system viability to adequately track their patients after they were discharged back into the community. The NPO HBC Nurse Coordinators, similarly mistrusted the referral system, as they too saw the gaps in the system and were concerned that potential patients found in the community and referred onwards to the health facilities would never actually get there. Patients falling out of the system were ultimately the main concern of the two

roll players in the HBC programme through a lack of a basic referral framework and faulty communication between WCG – DoH and their NPO service providers.

With the advent and planning for the new HCBC programme towards the end of 2015, it was evident that the referral process had to be re-engineered as well. Additionally, although the WCG – DoH and their NPO service providers had worked in a top-down, centralised approach in the past, it was crucial that a level of collaboration be developed to plan and implement a sustainable, viable referral process.

Development of the Referral Tool

The development of the Standard Operating Procedures (SOPs) for patient referrals occurred over an extended period of time. While the underlying need to address the gaps in the patient referral system has been known for some time, it has taken successive interactions to reach the creation of a viable referral tool. The process of developing a SOP began with meetings between the various stake holders (WCG – Department of Health and community based health providers – NPOs) to map out the referral process. Gaps were ascertained and addressed as necessary. By placing everyone in the same room and discussing the challenges of the patient referral system in an open exchange of frustrations, concerns, and solutions the group was able to formulate a viable patient referral system.

Once a SOP has been developed and agreed to by all the stakeholders, it was piloted in the clinics and evaluated over time to assess its efficiency. At subsequent meetings of the stakeholders, group successes were discussed and challenges and solutions were proposed. A trial and error process led to the development of a final patient referral SOP document (Appendixes C & D). On-going meetings on the SOP will continue to address any challenges to the system.

Recommendations

Based on the process to develop a final patient referral SOP and the successes and challenges gained from the exercise, the following recommendations are suggested:

- Ensure all stakeholders are included in the process from the beginning.
- Ensure that all stakeholders are on an equal footing and feel free to voice their opinions, concerns, and ideas.
- Map out the original process, ensuring all the gaps are identified.

- Map out the new process, safeguarding that the process flows effectively and all gaps are appropriately dealt with to make sure patients are kept in the system.
- Write-up the process into a document, which should be distributed to the entire group for their review and feedback.
- Continue regular meetings to gain feedback (monitoring) on the effectiveness of the process and to deal with any challenges that arise.
- Provide support and resources as necessary to enable the referral system continues to function efficiently.
- Update and review the SOP regularly to ensure sustainability of the entire process.

Appendix C

Western Cape DoH Standard Operating Procedure

Dr Hannelie Louw
Manager Medical Services
Harry Comay Hospital, Uniondale Hospital
George Primary Health Care
Hannelie.Louw@westerncape.gov.za

STANDARD OPERATING PROCEDURE

TITLE	Referrals between PHC Clinics, George Hospital, Harry Comay Hospital, Uniondale Hospital and Home Community Based Care.
INSTITUTION	George Sub-district
ISSUE DATE	6 October 2015
NUMBER OF PAGES	6
ISSUED BY	Dr H Louw
AUTHORS OF SOP	H Louw, W Fortuin, V Vertenten, M Cillie, M Williams, S Hendricks
AMENDED:	Amended May 2016

Objectives:

- To ensure quality Community based care services and strengthen the relationship between the PHC Clinics, Harry Comay Hospital, George Hospital and the NPO's delivering HCBC services.
- To ensure functional and timeous referrals to HCBC to decrease defaulter rates.

The CBS services in George are rendered by the following organisations:

Organisation	**Bethesda**	**Ithemba-lobomi**
No of CCW's	George: 44	45

	Uniondale area: 23	
Nurse Coordinator Allocated Clinics Nurse Coordinator Allocated Clinics Nurse Coordinator Allocated Clinics	E-mail referrals to: projects@bethesdageorge.org.za Uniondale: Amcummin@westerncape.gov.za Sr Veronica Vertenten 044 8758088 0833830331 • Rosemoor • Conville • Blanco • George Central • Herold • Mobiles: Wilderness, Waboomskraal Sr Jolene Van Rensburg 044 875 8088 0833677726 Lawaaikamp Parkdene Staff Nurse Stander (Uniondale) 044 7521068 0727110770 • Uniondale • Haarlem • Avontuur • Mobiles CHW Supervisor: George-Vacant CHW Supervisor: Uniondale: S Maart	Referrals: nurseco@outlook.com Sr Mercia Williams 044 8801032 0833172066 • Thembalethu • Kuyasa Sr Brink 044 8801032 • Pacaltsdorp • Touwsranten CHW's Supervisor N Siganagana

Schedule of meetings:

1. 2 Monthly JPI meeting
    a. Meeting with NPO's and other Government Departments to align services.
    b. NPO Coordinators to give feedback on Community Projects and involvement in DOH activities.
    c. Meeting on Wednesday @ 08h30.

2. Monthly CBS Operational Meeting
    a. All NPO Coordinators, Operational Managers, PHC Manager and Assistant PHC Managers to attend.
    b. NPO to present statistics.
    c. Challenges and achievements for discussion.
    d. Meeting on Wednesday @ 08h00.

3. 2 Monthly CBS- NPO Management Meeting Quarterly Finance Meeting
    a. All NPO CEO's, Project Coordinators and NPO Nurse Coordinators, Finance officials, Project Managers, PHC Manager and CBS Coordinator.
    b. Operation of NPO's
    c. Challenges and achievements for discussion.
    d. Meeting on Wednesday @ 08h00

4. Weekly Clinic Meeting
    a. NPO Coordinator and Operational Manager
    b. Feedback of referrals from NPO Coordinator
    c. Feedback from OM with regard to referrals.
    d. Discuss challenges and planning.

Meeting Times for Clinics:

Clinic	**Day& Time**	**Clinic**	**Day& Time**
Lawaaikamp	**Wednesday-08h30**	*Thembalethu*	Friday- 11h00
Conville	**Tuesday-08h30**	Kuyasa	Friday- 09h00
Parkdene	**Friday- 09h00**	Pacaltsdorp	**Monday-09h00**
Rosemoor	**Monday -08h15**	Touwsranten	**Friday-09h00**

Blanco	**Thursday-08h15**		
George Central	**Thursday- 09h00**		
Herold Waboomskraal	**Wednesday-12h00**		
Uniondale Haarlem Avontuur	**Daily**		

CHW Functions:

1. Community Screening
2. Manage patient referrals from PHC, HCH and GH
    a. Basic care (selective)
    b. Wound care
    c. Adherence support (selective)
3. Off-sites support
4. School Health program support with HPV and Dental programs
5. Crèche Screening

Roles and Responsibilities.

Activity	**Responsibilities of CHW's and NPO Coordinator**	**PHC Responsibilities**
Community Screening and referrals to PHC	CHW screen client in community CHW complete daily activity form CHW complete referral form CHW keeps list of all clients referred. NPO Co keep register of all referrals to Clinic NPO Co Meets weekly with OM and receives referral letters. NPO Co ensures follow up of	Fast lane exists for CBS referrals. See Clinic HCBC Fast lane program below. Clerk keeps client list of referred patients. Clinician sees client and indicate visit on daily tally sheet. Clinician complete feedback part of referral form. Clinician makes copies of

	clients referred that did not present to the Clinic. NPO Coordinator returns all the referral forms to OM at month end.	referral forms at the end of the day. 1 copy gets filed in the patient's file and other copy is handed to OM. OM gives referral letters with the feedback part completed to NPO Coordinator at weekly meeting. OM files all referral forms received monthly from the NPO Co in the CBS file.
PHC Referrals to CBS Priority areas: (Selective) • TB • Child Health • Wound care • Basic care • Adherence support • Teenage mothers	CHW/NPO Co collect referrals daily from OM. (Rural: weekly) CHW give daily feedback on previous day's referrals. CHW complete NPO section of form: Patient listing – clients referred to HCBC form. Feedback details to also be completed on the General Referral/Transfer letter for patient form.	OM prioritises clients and selective referral is done. Clinician/ OM Complete referral form (General Referral/Transfer letter for patient) OM negotiates with NPO Co with regard to workload of CHW's. OM to complete: Patient listing – clients referred to HCBC form. Discuss referral daily and weekly with CHW and NPO Co. File referral letter back in Patient file
HCH referrals to HCBC • Adherence support • Contact screening	CHW's will support patient and ensure that patient reports to Clinic. CHW do contact screening in home. NPO Co collects referrals weekly from ward clerk. NPO Co gives weekly feedback	OM refer high risk patients to HCBC OM refers patient contacts for screening. OM to complete: Patient listing – clients referred to HCBC form. Discuss referral daily and

	on previous day's referrals. NPO Co completes NPO section of form: Patient listing – clients referred to HCBC form. Feedback details to also be completed on the General Referral/Transfer letter for patient form.	weekly with CHW and NPO Co. File referral letter back in Patient file and into CBS File.
George Hospital referrals to HCBC	NPO Co receives referral via fax/ e-mail and follow up patient. Fax/e-mail feedback to referring clinician. If urgent feedback then contact telephonically.	Clinician contact NPO Co directly for urgent referrals. Complete referral form and fax/ e-mail to NPO.
Uniondale Hospital referrals to HCBC	NPO Co receives referral and follow up patient. Give feedback to referring clinician. If urgent feedback then contact telephonically.	Clinician contact NPO Co directly for urgent referrals. Complete referral form and give to NPO Co/ PHC Coordinator.
Off-sites support	Level 2 -4 CHW's will support off-site weekly	OM to coordinate off-site and liaise with NPO Co.
School Health Program	Level 2-4 CHW's will support campaigns	CBS Co will coordinate campaigns between SH PN and NPO Co's.
Crèche Screening	CHW's screen children at all crèches regularly. Crèches assigned to a specific CHW Assist with consent forms prior to outreach from PHC Refer to PHC clinic or outreach team	Outreach teams to respond to referrals from CHW's

The expectation is that a CCW's will visit the Clinics on a daily basis to ensure good communication. This is however not possible for rural Clinics. The NPO Coordinator will visit all the facilities weekly and ensure improved referrals and communication. All referrals from and to Herold and Mobile Clinics must be posted in Bethesda's pigeon hole at Harry Comay Hospital. NPO Coordinator will collect referrals weekly. Urgent referrals must be done telephonically. Feedback and requests for referrals will be posted by NPO Coordinator into the pigeon holes for Herold and the Mobiles.

PHC Clinics HCBC Fastlane Schedule.

The PHC Clinics will ensure a Fastlane for HCBC service referrals according to the following schedule. CHW's to ensure that referrals are done according to the schedule to ensure efficient management of patients.

Clinic	**Program**	**Days/Times**
Blanco	Child Health Women's Health All other	Monday/ Friday: 1st and 3rd Thursday: 16:00 – 18:00 Daily
George Central	Family Planning and Cervical Screening All other	Thursday: 14:00 – 18:00 Everyday
Conville CDC	Child Health Women's Health HAST Chronic	Tuesday/Thursday: 14:00 – 15:00 Everyday: 8:00 – 10:00 or Wednesday: late clinic. Everyday Monday to Thursday: 14:00 – 15:00
Lawaaikamp	Women's Health All other	Thursday: 16:00 – 18:00 Wednesday and Friday: 8:00 – 11:00
Parkdene	Child Health Women's Health	Monday Wednesday
Rosemoor	Child Health	Wednesday: 12:00 – 15:30 Women's Health: 12:00 – 15:30

Kuyasa	All	Wednesday: 7:30 – 13:00
Thembalethu CDC	All	Everyday Cervical Screening only afternoons.
Touwsranten	All	Everyday
Pacaltsdorp	Child Health Ante-natal Cervical screening and Family Planning HAST	Wednesday: 13:00 Tuesday: 7:30 Thursday: 13:00 Everyday
Uniondale/ Haarlem	All	Everyday

Appendix D

Western Cape DoH Standard Operating Procedure (amended)

Dr Hannelie Louw
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Harry Comay Hospital, Uniondale Hospital
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    b. NPO to present statistics.
    c. Challenges and achievements for discussion.
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    a. All NPO CEO's, Project Coordinators and NPO Nurse Coordinators, Finance officials, Project Managers, PHC Manager and CBS Coordinator.
    b. Operation of NPO's
    c. Challenges and achievements for discussion.
    d. Meeting on Wednesday @ 08h00

8. Weekly Clinic Meeting
    a. NPO Coordinator and Operational Manager/other designated person
    b. Feedback of referrals from NPO Coordinator
    c. Feedback from OM with regard to referrals.
    d. Discuss challenges and planning.

Meeting Times for Clinics:

Clinic	**Day& Time**	**Clinic**	**Day& Time**
Lawaaikamp	**Wednesday-08h30**	*Thembalethu*	Friday- 11h00
Conville	**Tuesday-08h30**	Kuyasa	Friday- 09h00
Parkdene	**Friday- 08h30**	Pacaltsdorp	**Monday-09h00**
Rosemoor	**Monday -08h15**	Touwsranten	**Friday-09h00**

Blanco	**Thursday-08h15**		
George Central	**Thursday- 09h00**		
Herold Waboomskraal	**Wednesday-12h00**		
Uniondale Haarlem Avontuur	**Daily**		

CHW Functions:

6. Community Screening and referrals to PHC
7. Manage patient referrals and recalls from PHC, HCH and GH.
8. Off-sites support
9. School Health program support with HPV and Dental programs
10. Crèche Screening and referrals to PHC

Roles and Responsibilities.

Activity	**Responsibilities of CHW's and NPO Coordinator**	**PHC Responsibilities**
Community Screening and referrals to PHC	CHW screen client in community CHW complete daily activity form CHW complete referral form if needed Write on top of referral form day&time according the fast line of the clinic and give it to the client Explain to the client the fastline days ,times of the clinic and to give the referral form to the Clinician who sees him/her CHW keeps list of all clients	Fast lane exists for CBS referrals. See Clinic HCBC Fast lane program below. Clerk keeps client list of referred patients. (Patient listing form for referral in) Clinician sees client and indicate visit on daily tally sheet. Clinician complete feedback part of referral form. Clinician makes copies of referral forms at the end of the

	referred.(weekly CHW referral list) NPO Co keep weekly CHW referral list in HCBC referral file NPO Co Meets weekly with OM and receives referral letters. NPO Co ensures follow up of clients referred that did not present to the Clinic. NPO Coordinator returns all the referral forms to OM at month end.	day. 1 copy gets filed in the patient's file and give the original CHW referral form to the OM OM gives original referral forms with the feedback part completed to NPO Coordinator at weekly meeting. The NPO Co will assess the outcomes recorded on the feedback and ensure follow up of client if necessary NPO Co keep all the referrals in HCBC referral file OM files all original CHW referral forms received monthly from the NPO Co in the HCBC/CBS file.
PHC Referrals to HCBC for Basic Care : Selective High risk patients eg: TB defaulters • Child Health: eg Children on NTP, PMTCT • Wound care • Chronic diseases and ARV's • Teenage mothers	CHW/NPO Co collect referrals daily from OM. (Rural: weekly) CHW give daily feedback on previous day's referrals. CHW complete NPO section of form: Patient listing – clients referred to HCBC form. Feedback details to also be completed on the General Referral/Transfer letter for patient form.	OM prioritises clients and selective referral is done. Clinician/ OM Complete referral form (General Referral/Transfer letter for patient) OM negotiates with NPO Co with regard to workload of CHW's. OM to complete: Patient listing – clients referred to HCBC form. Discuss referral daily and weekly with CHW and NPO Co. File referral letter back in

		Patient file Completed "Patient listing form for referrals out" to be filed in CBS file.
Recalls: Only to be used for the following indications: • Lab results • TB results (initial) • Immunisations • High risk: Mis appointments- ARV 6-21days TB less than 2months • High risk TB&ARV Defaulters	NPO Co /team leader collect recall form and allocate recalls to CHW's. Give feedback to OM daily and at weekly OM meetings.	OM/ Clinician complete "Patient listing form for recalls" and give to NPO Co daily /place in holder/box for daily collection /at weekly meeting.
HCH referrals to HCBC • Adherence support • Contact screening of family/household members	CHW's will support patient and ensure that patient reports to Clinic. CHW do contact screening in home. NPO Co collects referrals weekly from ward clerk. NPO Co gives weekly feedback on previous day's referrals. NPO Co completes NPO section of form: Patient listing – clients referred to HCBC form. Feedback details to also be completed on the General Referral/Transfer letter for patient form.	OM refer high risk patients to HCBC OM refers patient contacts for screening. OM to complete: Patient listing – clients referred to HCBC form. Discuss referral daily and weekly with CHW and NPO Co. File referral letter back in Patient file and into CBS File.

George Hospital referrals and recalls to HCBC	NPO Co receives referral via fax/ e-mail and follow up patient. Fax/e-mail feedback to referring clinician. If urgent feedback then contact telephonically.	Clinician contact NPO Co directly for urgent referrals. Complete referral form and fax/ e-mail to NPO.
Uniondale Hospital referrals to HCBC	NPO Co receives referral and follow up patient. Give feedback to referring clinician. If urgent feedback then contact telephonically.	Clinician contact NPO Co directly for urgent referrals. Complete referral form and give to NPO Co/ PHC Coordinator.
Off-sites support	Only Level 2 -4 CHW's will support CAS workers weekly	OM to liase with CAS Project Coordinator and liaise with NPO Co.
School Health Program	Level 2-4 CHW's will support HPV campaigns	CBS Co will coordinate campaigns between SH PN and NPO Co's.
Crèche Screening	CHW's screen children at all crèches regularly. Crèches assigned to a specific CHW Assist with consent forms prior to outreach from PHC Refer to PHC clinic or outreach team clinic on referral form.	Outreach teams to respond to referrals from CHW's

The expectation is that a CCW's will visit the Clinics on a daily basis to ensure good communication. This is however not possible for rural Clinics. The NPO Coordinator will visit all the facilities weekly and ensure improved referrals and communication. All referrals from and to Herold and Mobile Clinics must be posted in Bethesda's pigeon hole at Harry Comay Hospital. NPO Coordinator will collect referrals weekly. Urgent referrals must be done telephonically. Feedback and requests for referrals will be posted by NPO Coordinator into the pigeon holes for Herold and the Mobiles.

PHC Clinics HCBC Fastlane Schedule.

The PHC Clinics will ensure a Fastlane for HCBC service referrals according to the following schedule. CHW's to ensure that referrals are done according to the schedule to ensure efficient management of patients.

PLEASE NOTE: All patients arriving at the facility with a HCBC referral will be seen the same day, additional to the fast lane schedule.

Clinic	**Program**	**Days/Times**
Blanco	Child Health Women's Health All other	Monday/ Friday: 1st and 3rd Thursday: 16:00 – 18:00 Daily
George Central	Family Planning and Cervical Screening All other	Thursday: 14:00 – 18:00 Everyday
Conville CDC	Child Health Women's Health HAST Chronic	Tuesday/Thursday: 14:00 – 15:00 Everyday: 8:00 – 10:00 or Wednesday: late clinic. Everyday Monday to Thursday: 14:00 – 15:00
Lawaaikamp	Women's Health All other	Thursday: 16:00 – 18:00 Wednesday and Friday: 8:00 – 11:00
Parkdene	Child Health Women's Health	Monday Wednesday
Rosemoor	Child Health	Wednesday: 12:00 – 15:30 Women's Health: 12:00 – 15:30
Kuyasa	All	Wednesday: 7:30 – 13:00
Thembalethu CDC	All	Everyday Cervical Screening only afternoons.
Touwsranten	All	Everyday

Pacaltsdorp	Child Health Ante-natal Cervical screening and Family Planning HAST	Wednesday: 13:00 Tuesday: 7:30 Thursday: 13:00 Everyday
Uniondale/ Haarlem	All	Everyday

Appendix E

Semi–Structured Interview Guide: NPO Service Provider

INTRODUCTORY SECTION:
Welcome interviewee, introduce facilitator, briefly explain the research and the purpose of the interview, the duration of the interview, remind participant about consent and confidentiality issues.

***OVERVIEW OF HOME AND COMMUNITY-BASED CARE*:**

1. **What do you see as the role of Home and Community Based Care (HCBC)?**
   Probes:
   What is the underlying thought on the HCBC programme?
   Personal view of the HCBC system

Vital to get information on the current HBC system and how it is envisioned within the community-based service providers.

2. **How does the Home and Community Based Care (HCBC) system work?**
   Probes:
   Discussion on the various aspects of the HCBC system.

3. **What are the main components of the Home and Community Based Care (HCBC) system?**
   Probes:
   How does the individual components of the HCBC system work together in order to provide the overall service provision?

4. **In practical terms, how efficiently does the Home and Community-Based Care (HCBC) system work?**
   Probes:
   Is the HCBC system working in practice?
   Personal view of the effectiveness of the HCBC programme.

Need to understand how CBSP (interviewee) views the importance of the HCBC programme.

***POLCIY & PROTOCOLS*:**

5. **What are the main policy documents that proscribe the protocols of the Home and Community Based Care (HCBC) system?**
   Probes:
   Government documentation on the HCBC programme
   What is the Department of Health strategy on the HCBC programme?

6. **Has there been an evolution in the objectives/protocols of the Home and Community Based Care (HCBC) system?**

Probe:
How has the HCBC programme changed over time?
Where is the HCBC programme stratergy moving?

RELATIONSHIPS AND COLLABORATION:

7. **What is your view of the nature of the relationship between your organization and the Department of Health?**
   Probe:
   In-depth discussion on the relationship between two entities.
   How does CBSP understand the relationship with the Department of Health?

Crucial understandings on the relationship between the CBSP and the DoH.

8. **Do you believe that there is a level of collaboration between the two entities, and if so, to what level?**
   Probes:
   Gauge level of cooperation between the 2 entities
   Is collaboration understood to be part of the relationship?
   Is the relationship seen as a partnership?

What are the interviewees real feelings (bias) towards the Department of Health?

9. **Do you have examples of tangible collaboration between CBSP and the Department of Health?**
   Probes:
   Does the interviewee have an understanding of the value of collaboration through definite examples?
   Are there examples of the collaboration in the relationship?

10. **Do you believe the community-based service providers have their own voice in terms of delivery of service protocols for the DoH?**
    Probes:
    How does the interviewee (CBSP) gauge the current state of the nature of the relationship?
    Is the relationship seen as a partnership?
    Does the interviewee (CBSP) value the perspectives of their partners in the HCBC programme?

11. **Are the two entities able to work effectively together in practical terms?**
    Probes:
    Understand compatibility and partnerships between the 2 entities

***CHALLENGES & STRENGTHS OF HCBC SYSTEM*:**

12. **What are the challenges in the Home and Community Based Care (HCBC) system?**
    Probes:
    What is not working in the HCBC system?
    Is there an overarching obstacle(s) in the HCBC system?

What causes the interviewee's (CBSP) day-to-day frustrations with HCBC? What are the main weaknesses of the system?

13. **What are the challenges in the relationship between your organization and the Department of Health?**
    Probes:
    What is not working in the HCBC relationship?
    What are the negative aspects of the relationship?

14. **How could the relationship be strengthened between your organization and the Department of Health?**
    Probes:
    How could the relationship be made stronger?
    Is there a more effective way of working together?

Positive solutions – how to make things better within the HCBC system.

15. **How could the Home and Community Based Care (HCBC) system itself be strengthened?**
    Probes:
    How could the HCBC system be made stronger?
    What components of the HCBC needs to be enhanced or modified to builder a stronger overall model and how?

16. **How can the two entities collaborate together in order to ensure a more efficient Home and Community Based Care (HCBC) system?**
    Probes:
    Building a more collaborative approach
    Thinking about an ingrained collaboration approach

***FUTURE OF THE HCBC PROGRAMME*:**

17. **What will the change in objectives of the HCBC Programme (Wellness, health promotion and prevention of ill health) mean for the your organization?**
    Probes:
    What does the future hold for the HCBC programme?
    How does the change in the individual components of the HCBC system affect the overall framework and responsibilities of the various stakeholders?

18. **Has there been more collaboration over time with the new framework?**
    Probes:
    Were the new objectives put in place as part of a collaborative process?

19. **Finally, can you think of any other changes necessary to ensure an efficient HCBC system and a collaborative relationship?**
    Probes:
    Has anything been missed in the previous questions?
    Final thoughts and a means of acquiring additional thoughts on the relationship and tools for promoting collaboration.

Make sure all questions have been answered satisfactory; Full understanding of the views of the relationship between the 2 entities. **Thank the interviewee for their participation.**

Appendix F

Semi–Structured Interview Guide: WCG - Department of Health (DoH)

INTRODUCTORY SECTION:
Welcome interviewee, introduce myself, briefly explain the research and the purpose of the interview, the duration of the interview, remind participant about consent and confidentiality issues.

***OVERVIEW OF HOME AND COMMUNITY-BASED CARE*:**

18. What do you see as the role of Home and Community Based Care (HCBC)?
Probes:
What is the underlying thought on the HCBC programme?
Personal view of the HCBC system

Vital to get information on the current HBC system and how it is envisioned within the DoH and community-based service providers.

19. How does the Home and Community-Based Care (HCBC) programme fit within the Primary Health Care system?
Probes:
How does the HCBC programme fit into the overall PHC system?

20. How does the Home and Community Based Care (HCBC) system work?
Probes:
Discussion on the various aspects of the HCBC system.

21. What are the objectives of Home and Community Based Care (HCBC) within the PHC system today?
Probes:
The most important aspects of the HCBC programme within the PHC system
Key outputs of the HCBC programme

22. How has its objectives evolved over the last few years?
Probes:
The change in objectives / approach over the last couple years

23. Why was there a need to change the objectives?
Probes:
Why was policy modified over the last few years?
Where is the HCBC programme stratergy moving towards?

7. What will the change in objectives (Wellness, health promotion and prevention of ill health) mean for the various components of the Home and Community Based Care (HCBC) system?
Probes:
How does the change in the individual components of the HCBC system affect the overall framework and responsibilities of the various stakeholders?

8. **In practical terms, how efficiently does the Home and Community-Based Care (HCBC) system work?**
   Probes:
   Is the HCBC system working in practice?
   Personal view of the effectiveness of the HCBC programme.

Need to understand how DoH (interviewee) views the importance of the HCBC programme.

***POLCIY & PROTOCOLS*:**

9. **What are the main policy documents that proscribe the protocols of the Home and Community Based Care (HCBC) system?**
   Probes:
   Government documentation on the HCBC programme
   What is the Department of Health strategy on the HCBC programme?

10. **What was the original focus of the objectives/protocols of the Home and Community Based Care (HCBC) system in the past?**
    Probe:
    How has the HCBC programme changed over time?

RELATIONSHIPS AND COLLABORATION:

11. **What is your view of the nature of the relationship between the Department of Health and their proscribed community based service providers?**
    Probe:
    In-depth discussion on the relationship between two entities.
    How does DoH understand the relationship with the community based service providers?

Crucial understandings on the relationship between DoH and their service providers.

12. **Do you believe that there is a level of collaboration between the two entities, and if so, to what level?**
    Probes:
    Gauge level of cooperation between the 2 entities
    Is collaboration understood to be part of the relationship?
    Is the relationship seen as a partnership?

What is the interviewees real feelings (bias) towards the community-based service providers?

13. **Do you have examples of tangible collaboration between DoH and their community-based service providers?**
    Probes:
    Does the interviewee have an understanding of the value of collaboration through definite examples?
    Are there examples of the collaboration in the relationship?

14. **Do you believe the community-based service providers have their own voice in terms of delivery of service protocols for the DoH?**
    Probes:

How does the interviewee (DoH) see the viewpoint from the community-based service provider perspective?
How does the interviewee (DoH) gauge the current state of the nature of the relationship?
Is the relationship seen as a partnership?
Does the interviewee (DoH) value the perspectives of their partners in the HCBC programme?

15. Are the two entities able to work effectively together in practical terms?
Probes:
Understand compatibility and partnerships between the 2 entities

***CHALLENGES & STRENGTHS OF HCBC SYSTEM*:**

16. What are the challenges in the Home and Community Based Care (HCBC) system?
Probes:
What is not working in the HCBC system?
Is there an overarching obstacle(s) in the HCBC system?

What causes the interviewee's (DoH) day-to-day frustrations with HCBC? What are the main weaknesses of the system?

17. What are the challenges in the relationship between the Department of Health and their community-based service providers?
Probes:
What is not working in the HCBC relationship?
What are the negative aspects of the relationship?

18. How could the relationship be strengthened between the DoH and their community-based service providers?
Probes:
How could the relationship be made stronger?
Is there a more effective way of working together?

Positive solutions – how to make things better within the HCBC system.

19. How could the Home and Community Based Care (HCBC) system itself be strengthened?
Probes:
How could the HCBC system be made stronger?
What components of the HCBC needs to be enhanced or modified to builder a stronger overall model and how?

20. How can the two entities collaborate together in order to ensure a more efficient Home and Community Based Care (HCBC) system?
Probes:
Building a more collaborative approach
Thinking about an ingrained collaboration approach

***FUTURE OF THE HCBC PROGRAMME*:**

21. What does "Self-care supported through community-based interventions" mean to you and do you think it will prevent unplanned visits to health services?

Probes:

What is happening currently in the policy debate surrounding the HCBC programme?

How will it affect the various aspects of the partnership and relationships between the DoH and their community-based service providers?

22. How do you think it will affect the Home and Community Based Care (HCBC) system in the near term?

Probes:

What challenges will be placed on the service providers by the new HCBC objectives?

How is the HCBC system evolving?

What is the new thinking on the HCBC programme?

Make sure all questions have been answered satisfactory; Full understanding of the views of the relationship between the 2 entities.

Thank the interviewee for their participation.

Appendix G

Focus Group Discussion Guide (FGDG): WCG - DoH & NPOs

INTRODUCTORY SECTION:
Welcome interviewees, introduce facilitator, briefly explain the FGD and the purpose of the FGD, the duration of the FGD, remind participants about consent and confidentiality issues.

Ask all the participants to introduce themselves
Confirm with the group what terms you will use in the FGD to refer to home-based care (HBC) and the referral system.
Confirm the type of participants in the group to use as probes during questions.

***CURRENT PURPOSE OF THE REFERRAL SYSTEM*:**

1. **What do you see as the purpose of the current referral system?**
   Probes:
   How is it part of the clinic – community relationship?
   What function does it play?
   How does it fit into the overall HBC protocols?

Vital to get information on the current HBC system and how it is envisioned within the DoH and community-based service providers.

CURRENT WORKFLOW OF THE REFERRAL SYSTEM:

2. **Describe how the current workflow proceeds throughout the referral process.**
   Probes:
   Map out the process.
   Where are the gaps?

Vital to take the current model through a step-by-step process to map out the various aspects of the referral system and ascertain any/all gaps. Lay-out process on a white board.

3. **What is your role in the process? Do you think you have the ability to modify the system to make it work?**
   Probes:
   How do you fit into the system?
   Do you feel empowered in terms of having an affect on the process?

Gives a good understanding of the role of the individual and their buy-in to the process and their ability to modify the system.

4. **Is the referral system between the clinic and the HBC Nurse Coordinator and/or Home-Based Carer working effectively?**
   Probes:
   Is the system working to the level that is required to provide a cost effective, quality output?
   That there is an understanding that the model is not working effectively and there needs to be a radical modification to the process.

It is understood from preliminary discussions with stakeholders over a number of years, that the referral system is inherently defective and needs to be changed. Hopefully, this view will also be shared within the conversation.

5. **Let's think about why the system is not working to its full capacity. Why do you think this is the case?**
   Probes:
   Where are the bottle-necks?
   What are the ingrained perceptions that are creating barriers to effective implementation of an effective referral process?

6. **How could we transform the referral system?**
   Probes:
   Need to get substantial, tangible process changes.

A brainstorming, process driven transformative approach needs to attained from this question. Need to lay-out process on a white-board.

7. **Would this new model (SMS / Email system) fill in all the gaps from the prior system?**
   Probes:
   Does this new model complete the circle?
   Does this new model include the community in the process?

Make sure the process is holistic and includes some form of community participation

8. **Do you think this new referral model will make your work easier and more effective?**
   Probe:
   Would they own it and implement it?

9. **Is there anything else that would have an impact that we have discussed in terms of the referral process and your work?**
   Probe:
   Anything we have missed.

Lastly, ask the group if they have any questions for the facilitator(s) of the focus group.