A MODEL FOR THE INTEGRATION OF PRIMARY HEALTH CARE SERVICES IN KWAZULU-NATAL, SOUTH AFRICA

BY

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DECLARATION

I, Maureen Nokuthula Sibiya, do hereby declare that this thesis is representative of my own work. Where the work of others was used, it has been acknowledged in the text.

…… ……..

Signature of student Date of signature

APPROVED FOR FINAL SUBMISSION

…… ……..

Professor NS Gwele Date of signature

RN, RM, M Sc, PhD

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LIST OF ABBREVIATIONS

AIDS	: Acquired immune Deficiency Syndrome
ANC	: African National Congress
CHC	: Community Health Centre
CHW	: Community Health Worker
DHP	: District Health Planning
DHS	: District Health System
DHIS	: District Health Information System
EMRS	: Emergency Medical Rescue Services
EPI	: Expanded Programme for Immunization
FP	: Family Planning
GDP	: Gross Domestic Product
GDPR	: Gross Domestic Product per Region
HIV	: Human Immune Deficiency Syndrome
IMCI	: Integrated Management of Childhood Illnesses
IPHC	: Integrated Primary Health Care
KZN	: KwaZulu-Natal
MCWH	: Maternal, Child and Women's Health
MDG	: Millennium Development Goal
MVA	: Motor Vehicle Accident
NQF	: National Qualifications Framework
OSD	: Occupation Specific Dispensation
PHC	: Primary Health Care
RDP	: Reconstruction and Development Programme
SADC	: Southern African Development Community
SANC	: South African Nursing Council
SAQA	: South African Qualifications Authority
STI	: Sexually Transmitted Infection
TB	: Tuberculosis
UNICEF	: United Nations Children's Fund
WHO	: World Health Organization

DEDICATION

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ABSTRACT

BACKGROUND

In South Africa, Integration of Services Policy was enacted in 1996 with the aim of increasing health service utilization by increasing the accessibility of all services at Primary Health Care (PHC) level. However, the problem with the policy arises in the implementation of integrated PHC (IPHC) as there is no agreed upon understanding of what this phenomenon means in the South African context. Hence, there is a need for shared views on this phenomenon.

METHODS

A cross-sectional study, using a qualitative approach was employed in this study in order to analyze IPHC in KwaZulu-Natal (KZN). A grounded theory approach was selected as it is a method known for its ability to make the greatest contribution in areas where little research has been done and when new viewpoints are needed to describe the familiar phenomenon that is not clearly understood. Policy makers and co-ordinators of PHC at national, provincial and district levels as well as PHC nurses at functional level participated in the study. The data was collected by means of observations and interviews. The sample size for interviews was comprised of 38 participants.

RESULTS

It emerged that there were three core categories that were used by the participants as discriminatory dimensions of IPHC in South Africa. These core categories were (a) comprehensive health care, (b) supermarket approach and (c) one stop shop. Based on the findings of the study, it was concluded that the phenomenon, IPHC meant different things in different contexts.

CHAPTER 1

OVERVIEW AND RATIONALE OF THE STUDY

1.1 BACKGROUND TO THE STUDY

By the 1970's health care throughout the world was in turmoil with fragmented health systems. The trend at that time was expensive treatment for a few ill people rather than promotive and basic health care for many. These inequalities were found in both developed and developing countries world-wide. In response to the international sense of despair at inadequate health care, an international conference on Primary Health Care (PHC) was jointly sponsored by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF). It was hosted by the government of the USSR at Alma Ata from 6 to 12 September 1978. The PHC philosophy was introduced at this conference and was endorsed with enthusiasm by the participating nations. It was seen as a means of achieving 'Health for All by the year 2000' (Dennil, King and Swanepoel, 1999: 2).

The concept of PHC as determined at Alma Ata is:

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

The essential care aspect of PHC consists of eight basic components, sometimes referred to as elements. These are listed under section VII of the

Declaration of Alma Ata, which states that any PHC programme should include at least these components:

1. Education about prevailing health problems and methods of preventing and controlling them
2. The promotion of food supply and proper nutrition
3. An adequate supply of safe water and basic sanitation
4. Maternal and child care, including family planning and care of high-risk groups
5. Immunization against the major infectious diseases
6. Prevention and control of locally endemic diseases
7. Appropriate treatment of common diseases and injuries
8. The provision of essential drugs (Dennil et al., 1999: 3).

Roemer and Montoya-Aguilar (1988: 18) argue that the simultaneous provision of all these elements in a comprehensive programme may create a superficial handling of some of them hence quality assessment and assurance are all the more important. According to the PHC package for South Africa, the national task is to define what services are required to best meet the health needs of the nation. It is for the provinces and local government to decide, in the light of local circumstances, how these services are to be provided (Department of Health, 2001b: 7). In South Africa, the Strategic Priorities for the National Health System 2004-2009 proposes that the national and provincial departments need to find ways of supporting service delivery at local level in ways that strengthen integration (Department of Health (2004: 18). Despite the demarcation of boundaries and appointment of some personnel at district level, there was slow progress in integrating the health system. The ideal in a fully functional District Health System (DHS) is to have all workers employed by a single employer under the same conditions of service.

The first level of contact is the fundamental basis for health care system development. This is where primary preventive and promotive health care is provided. It is a first level entry to the health care system. Basic programmes provided at this level would include immunization, sexual and reproductive health, communicable diseases, health promotion and/or health education, pharmaceutical services, clinic disease management, medical services, mental health, nutrition, minor ailments, diagnostic services, school health, maternal, women's and child health, referral services, and emergency medical services. The current situation in South Africa is that these services are provided in a fragmented fashion. Local authorities provide part of the package while the provincial authority provides virtually all the components of the PHC package. This is where programme integration could be more effective and the benefits of this integration could impact on financial resource allocation.

The Alma Ata formulation of PHC came under attack almost from its inception. Within a year of the publication of the Alma Ata Declaration, Julia A Walsh and Kenneth S Warren of the Rockefeller Foundation published an article on Selective Primary Health Care (SPHC), which marked a radical shift away from the principles of Alma Ata Declaration (Walsh and Warren, 1979). The article argued for the postponement of comprehensive PHC on the grounds that it was too costly to implement. There were not enough resources available, especially in developing countries. If health statistics were to be improved, they argued, high risk groups must be targeted with carefully selected, cost effective interventions. This new, narrower approach became known as Selective Primary Health Care. (See Table 1 for a comparison of comprehensive PHC and selective PHC). SPHC was an interim strategy for disease control in developing countries. This demand-driven approach emphasized cost-effectiveness for everyone and measurable, short-term outcomes. SPHC focuses on providing packaged interventions to cater for avoidable health problems that account for large burdens of suffering, and not the provision of basic care for the whole nation (Peterson and Swart, 2002).

Different authors have identified the following differences between comprehensive PHC and SPHC:

Table 1: Differences between comprehensive PHC and selective PHC

COMPREHENSIVE PHC	SELECTIVE PHC
It is community oriented	It is problem oriented
Lifelong programme	Short-term programme
Too costly to implement	Low cost
Not attractive to funders - expensive	Programme attractive to funders
It targets all age groups	It targets only children under the age of three and women of child bearing age
Concept of health broadly defined	Health defined as absence of a disease
Focus on community development to enable health care personnel to facilitate relevant care	Focus on specific age group and diseases
It focuses on promotive, preventive, curative and rehabilitative aspects of care	It focuses on palliative approach, dealing with identified health care problems only
Community participation is essential	It is top down and it uses an authoritarian approach
Horizontal health care programme	Vertical health care programme
Focuses on comprehensive health care principles	Rejects some of the principles of PHC e.g. equity and intersectoral co-operation
Deals with health macroscopically	Deals with health microscopically
Deals with all health problems at first level	Deals with pre-identified health problems
Expenditure spread over all	High costs on a small group

(Dennil et al., 1999; McKenzie 1989; Walsh and Warren, 1979).

Although SPHC was quickly embraced by national governments, ministries of health and many of the larger, mainstream international organizations, it generated considerable controversy. According to Werner and Sanders (1997: 23) this new approach stripped PHC of many of its key concepts. The emphasis on overall social and economic development was removed. They further argued that the keystone of involving communities in the planning, implementation and control of PHC no longer existed. This selective, politically sanitized version of PHC was thus reduced to a few high priority technological interventions, determined, not by communities, but by international health experts. The Italian Global Health Watch support this argument in that SPHC is contrary to the Alma Ata Declaration. They argue that it had inevitably led to a vertical approach to health interventions, by which international donor agencies selected interventions on the basis of measurable outcomes and cost-effectiveness.

The semi-autonomous vertical programmes were established with specialized infrastructure, alongside a general health infrastructure providing curative services and a variable range of preventive services. Vertical programmes are those programmes that are free-standing at all levels, or that are run through regional level or higher, completely separately from other services on the ground (Schierhout and Fonn, 1999: 29). Walley, Lawn, Tinker, Francisco, Chopra, Rudan, Bhutta, and Black (2008) argue that interventions are implemented vertically when systems are weak or when the time frame is short. These authors further state that this approach can be implemented either to achieve important benefits at scale in as short time as possible or because donors are focused on short-term goals. Vertical approaches use planning, staffing, management and financing systems that are separate from other services, whereas horizontal approaches work through existing health system structures (Travis, Bennett, Haines, Pang, Bhutta, Hyder, Pielemeier, Mills and Evans, 2004). However, even if the start is vertical, over time programmes should be integrated and delivered by coordinated cadres of multi-purpose and more specialized health workers within district

management systems and with participation from communities (Lawn, Rhode, Rifkin, Were, Paul and Chopra, 2008). The transition required in restructuring these vertical and basic health services programmes into an integrated infrastructure capable of providing adequate, cost-effective promotive, preventive, curative and reconstructive quality health care services to all the population involves all levels of available health care facilities and personnel as well as community and other health-related authorities.

Despite the ideals and enthusiasm after Alma Ata, the delivery of PHC services continues to face challenges. Some of these challenges could be attributed to national factors such as a lack of the necessary political decisions and recognition of the positive impact of integration on health resources utilization and on the ultimate outcome of the health system; an absence of shared objectives among health professionals and workers at different levels of health system; lack of staff motivation or personal incentives to contribute to an integrated approach and inadequate development of the health infrastructure (Al-Khawashky, 2000; Walley et al., 2008).

Major efforts have been undertaken by the international community to implement the PHC strategy, with numerous projects and vertical programmes. Yet, within a few years, most of these proved to be inefficient, non-sustainable, and in some cases even counter-productive to the efficiency of the local horizontal health services. Finally, it became clear that SPHC resulted in short-term successes only. SPHC was unable to ensure the sustainable implementation of the PHC strategy. The concept of PHC calls for services to cover the entire spectrum of preventive and curative medicine. It has been claimed that this can only be provided within the framework of an integrated health care system, an objective that cannot be achieved overnight, but offers far more sustainability than any fast-track programme (Gorgen, Kirsch-Woik and Schmidt-Ehry, 2004).

According to the global report by the WHO (2003), there is evidence that in most countries, the implementation of PHC is incomplete, or it is not delivering the expected results in many countries. The report identifies the following problems related to the implementation of PHC:

- Inadequate resources and insufficient emphasis on sustainability
- Unrealistic expectations of PHC
- A lack of practical guidance on implementation
- Insufficient evidence on which to base local policy
- Poor leadership and insufficient political commitment
- Failure to address the demands, as well as the needs of populations.

However, such problems do not seem to undermine the strong commitment to PHC approach as a model for the delivery of the health care system. Comprehensive PHC was proposed as the vehicle for achieving progress in 1978, and despite 30 years of a largely dichotomized approach, there are encouraging signs of a shift towards embracing a more comprehensive menu of PHC service delivery in South Africa in the form of PHC service package (Department of Health, 2001a).

1.2 PROBLEM STATEMENT

The redirection of the health care system towards PHC along with the concomitant establishment of the DHS as a framework for PHC delivery and management has been the most significant transformation event in the public health sphere in South Africa since 1994. One of the foremost changes in the early years of the democratic government was the adoption of a district-based system, which is the principal instrument for the delivery of comprehensive integrated PHC services, in line with the Declaration of Alma Ata. The goal of the DHS was to achieve equity and improve access, effectiveness and efficiency of services through decentralized management services and localized service provision (Harrison, 1997: 4). On the other hand, this move towards transforming the health care system has been met with numerous impediments, flaws and failures, many of which have not yet been mastered, solved or ironed out. According to van Rensburg (2004: 451) the PHC service delivery system in South Africa is still seriously fragmented in respect to authority and service components. PHC remains a very far cry from both structural and functional integration, and thus also from the idealized unified or seamless public health service for South Africa. Secondly, the selective nature of PHC needs to be reiterated.

As equity and access to health care have been considered the key principle to steer the transformation of health services in South Africa since 1994, a mechanism was required to define parameters for service delivery, as well as to ensure comparability in the rendering of services. This mechanism was realized in the form comprehensive PHC service package that was introduced by the National Department of Health in 2001. Whereas in the past, the model of PHC delivery was strongly based on a vertical approach, the PHC package envisages an organization of services that allows for a one-stop approach. The comprehensive PHC service package aimed at defining services per level of facility as a way to maximize the integration of services (Department of Health, 2001a: 8).

Nevertheless, integration of PHC services continues to be seen as a pivotal strategy towards the achievement of the national goals of transformation of health services, and the attainment of a comprehensive and seamless public health system. Despite the popularity of the concept of integrated PHC (IPHC), there is comparatively little evaluative literature available, with a few exceptions (Toomey, 2000; Department of Health, 2001a; Pillay, 2002; Van Rensburg, 2004). Analysis of this literature reveals the absence of any standardized understanding of IPHC or agreed definition of the concept within the South African context. The problem, however, arises in the implementation of integrated PHC as there is no agreed upon understanding of what this phenomenon means in the South African context. To date no research studies have been carried out on the meaning of the integration of PHC services. Hence, there is a need for shared views on this phenomenon in order to facilitate an effective implementation of this approach. The following questions, therefore, remain:

- What is integrated PHC in the South African context?
- What causal and/or intervening conditions must be in place in order for integrated PHC to occur?
- What are the consequences of integrated PHC for service delivery as viewed by practitioners and policy makers?

1.3 SIGNIFICANCE OF THE STUDY

The year 2008 marks the 60th anniversary of the WHO and the 30th anniversary of the Alma Ata Declaration advocating PHC as the main strategy for achieving Health for All by the year 2000. Over 30 years ago, integration of health programmes was first raised at the Alma Ata conference and was considered a way of achieving Health for All. The Alma Ata declaration promoted a comprehensive approach to improving health care with a strong emphasis on building health systems "from the bottom up" through PHC (WHO, 1978). With health system development, the sector-wide approach and decentralization, integration has once again been put at the foreground of current debates.

In South Africa, the Integration of Services Policy was enacted in 1996 with the aim of increasing health service utilization by increasing accessibility and availability of all health care services at PHC level (Tint, Fonn, Khuzwayo and Robertson, 2000: 15). The current integration debate in South Africa, particularly in KZN, includes a slightly different focus from the debate that is related to the fragmented nature of health services inherited by the democratically elected government in 1994. There has been a pressing need to co-ordinate local authority and provincial services, previously separately responsible for preventative and curative care respectively, and to bring together services offered through authorities in the former homelands, with new provincial and national structures. This type of integration is structural and has unique organizational requirements. The critical element that impacts on the provision of integrated services at the primary level relates to the interaction between the provincial and local spheres of government. This interaction is further complicated by the different capacities within the different municipalities (Department of Health, 2001a:3).

South Africa has three spheres of government namely National, Provincial and Local. Currently, because of differing conditions of service and legislative problems, it is difficult to for staff to move between local government and the public service. This is proving to be one of the major stumbling blocks in the way of establishing a functional DHS (Hall, Ford-Ngomane and Barron (2005). Mc Coy, Buch and Palmer (2000: 7) argue that the responsibility for the delivery of comprehensive PHC can never completely belong to one level of the health system. These authors further state that this requires a vertically integrated, tiered health care system where different levels of management and administration work together in a complementary manner.

PHC is an approach which has the potential to achieve both the Millenium Development Goals (MDGs) and the wider goal of universal access to health through acceptable, accessible, appropriate and affordable health care (Walley et al., 2008). However, there is a growing consensus that a primary bottleneck to achieving the MDGs in low-income countries is health systems that are too fragile and fragmented to deliver the volume and quality of services to those in need (Travis et al., 2004). Thus PHC, if implemented, would advance health equity in all countries rich and poor and, as a result, promote human and national development (Walley et al., 2008). Integration, however, remains a difficult concept to define uniformly, but is in general expected to improve the efficiency of health service delivery. This study should bring a shared meaning of the phenomenon of integrated PHC in South Africa and thus advance theoretical propositions to guide policy formulation and implementation as the country continues in its efforts to achieve a comprehensive and seamless PHC delivery system.

1.4 PURPOSE OF THE STUDY

The purpose of the study was to analyze IPHC within a DHS in South Africa and thus the shared meaning of the phenomenon. Ultimately the aim was to develop a model for the integration of PHC services in KZN.

1.5 OBJECTIVES OF THE STUDY

The objectives of the study were to:

- Analyze the phenomenon IPHC and the meaning attached to it at different levels of health system
- Identify and describe the causal conditions, the context, intervening conditions and consequences where IPHC services occur
- Describe the action/interaction strategies involved in IPHC services
- Advance propositional statements leading to a middle range theory of IPHC services

CHAPTER 2

RELATED LITERATURE REVIEW

2.1 INTRODUCTION

This chapter will present only the selected literature to give background to the study. According to Strauss and Corbin (1990: 50) selected literature review is done so that "the researcher will come to the research situation with some background in the technical reading". This is supported by Smith as cited by Hunter, Har, Egbu and Kelly (2005: 59) who states that the researcher is able, therefore, to approach the subject with some background knowledge, but it is important that the reading is not too extensive as the theories should evolve from the data itself, producing a grounded theory. Further to this, Burns and Grove (1999: 108) state that this review is only a means of making the researcher aware of what studies have been conducted, but the information from these studies is not used to direct data collection or theory development. Chenitz and Swanson (1986: 149) argue that a lengthy review in grounded theory study can in fact, reflect overdependence on existing knowledge. These authors further state that a review of existing literature can show gaps or systematic bias in existing knowledge, thus provide rationale for launching a grounded theory study.

According to Strauss and Corbin (1990: 50) selective sampling of the second body of literature review should be woven into the emerging theory during the third stage on grounded theory induction. This chapter starts by reviewing the DHS as the vehicle for the delivery of PHC approach. The subsequent headings include globalization trends in health; health system in Africa; health care in South Africa; national health care system typologies and PHC in South Africa.

2.2 THE DISTRICT HEALTH SYSTEM AND PHC DELIVERY

The DHS is an organizational framework for a country's health care system. It is accepted worldwide as the most appropriate vehicle for the delivery of the PHC approach. National health policy for a DHS was first set in the early 1990s through the African National Congress (ANC) Health Plan (ANC, 1994a). The DHS provides a framework for the development of comprehensive health programmes that can be tailored according to the needs of the people. As noted by Hall, et al. (2005: 45) within a DHS, the health district becomes a vehicle through which PHC services are offered to a specific population, residing in a clearly demarcated geographic area, through a variety of health care structures that aim to be involved in all aspects of community life that affect health. The following definition of the DHS was adopted by the WHO Global Programme Committee in 1986:

> "A health system based on PHC that is more or less a self-contained segment of the national health system. It comprises first and foremost of a well-defined population, living within a clearly delineated administrative and geographical area, whether urban or rural. It includes all institutions and individuals providing health care in the district, whether governmental, social security, non-governmental, private or traditional. A DHS, therefore, consists of a large variety of interrelated elements that contribute to health in homes, schools, work places, and communities through the health and other related sectors" (WHO, 1988).

McCoy and Engelbrecht (1999: 1) stress the point that DHS is the "core building block of the entire health system and that the PHC approach and the DHS model apply to the whole of the health system and at all levels of health care delivery". According to the White Paper for the Transformation of the Health System in South Africa, there are twelve principles with which planners must comply in the development of DHS. These are overcoming fragmentation, equity, comprehensive services, effectiveness, efficiency, quality, access to services, local accountability, community participation, decentralization, developmental and intersectoral approach and sustainability (Republic of South Africa, 1997: 15). PHC and DHS have been combined in what has come to be known as the district-based PHC system. By adopting

the district-based PHC system as the model for health care provision, numerous changes were necessary both in the organization and in the contents of the health care system (van Rensburg, 2004). Hall et al. (2005: 46) further state that the DHS provides the health sector with a management framework that can deliver health care in a cost-effective and integrated manner. The DHS is coupled with a decentralization process of moving health care management away from the central to peripheral levels of government.

Van Rensburg (2004: 134) identifies five considerations for the rationale for the introduction of the district-based PHC system in South Africa – all aimed at redressing the notorious deficiencies of the previous dispensation:

- Firstly, to meet the health care needs of everybody including those in underserved and understaffed areas, in a way that people want to receive their care
- Secondly, to provide a simple, integrated and logical service and thus to overcome the inefficiencies in service delivery caused by undue fragmentation of the system
- Thirdly, to ensure that local decisions are made locally, in terms of local needs, and by the very people who have to implement and be affected by the decisions
- Fourthly, to involve those people who use the health services in planning and designing their own services by means of fully representative community health bodies
- Finally, to shift the focus from administering health services towards improving health and the quality of care at the local level.

The vision for the KZN Department of Health is to achieve optimal health status for all persons in KZN and the mission statement is to develop a sustainable, co-ordinated, integrated and comprehensive system based on the PHC approach through the DHS (KZN Department of Health, 2007). The question that still remains is: Has the district-based PHC model managed to

integrate the health services in South Africa, particularly in KZN? According to the report on PHC progress by the Department of Health (2000: 13), progress towards a DHS is at different stages of development in the provinces. The report states that most provinces encountered difficulties in the integration of health district boundaries due to the lack of a legal framework. The Municipal Structures Act of 1998 states that the metropolitan areas and the district municipalities are responsible for delivering municipal health services. However, at the moment there is no legal definition for these services (Republic of South Africa, 1998). Hall, Haynes and McCoy (2002: 4) argue that the danger of fragmenting a single national health system is minimized where there are policies and systems. The rationale of devolving PHC functions from provincial health departments to local authorities is that local authorities have clear and legally recognized geographical boundaries over which they exercise authority and within which they are accountable to the public they serve.

According to the strategic priorities for the national health system 2004-2009, information sharing is poorly co-ordinated throughout the health system and it is inadequately cascaded to the different levels within provinces. However, at present, all provinces are involved in developing strategies for information collection. The Department of Health further states in its strategic priorities that the challenges with respect to PHC and DHS include among others, the elimination of fragmented services provided by provinces and municipalities and the strengthening of the quality of care at PHC level (Department of Health, 2004: 18).

2.3 ESTABLISHMENT OF NEW MUNICIPALITIES IN SOUTH AFRICA

South Africa now has municipalities with new boundaries and categories as stated in the Local Government: Municipal Structures Act No. 117 of 1998 and new powers and duties as stated in the Local Government: Municipal Systems Act No. 32 of 2000 (Republic of South Africa, 1998; Republic of South Africa, 2000) respectively. Fifty three health districts were established in line with the metropolitan and district municipal boundaries. The Constitution provides for three categories of municipalities (Republic of South Africa, 1996). Each has different powers and functions.

2.3.1 Category A: Metropolitan area

Category A is a municipality that has exclusive municipal executive and legislative authority in its area. There are six metropolitan areas in this country: Cape Town, Durban now known as eThekwini, East Rand, Johannesburg, Pretoria and Port Elizabeth.

2.3.2 Category B: Local municipality

Category B is a single local municipality. This municipality shares municipal executive and legislative authority in its area with a Category C municipality within whose area it falls. There are 232 of these Category B municipalities in South Africa.

2.3.3 Category C: District municipality

Category C municipality is a municipality that has municipal executive and legislative authority in an area that includes more than one municipality. Section 29 of the National Health Act of 2003 stipulates that the boundaries of the health district should coincide with the district and metropolitan municipal boundaries (Republic of South Africa, 2004: 38).

2.4 SPHERES OF GOVERNMENT AND HEALTH SERVICES

In terms of the Constitution of the country, all the spheres namely National, Provincial and Local have concurrent powers for the health sector (Republic of South Africa, 1996). Thus, all spheres are envisaged as having some responsibility for health services, but for different aspects. National government is primarily responsible for policy development and overall health sector co-ordination. Provinces are responsible for service provision. Local government has been traditionally responsible for the provision of preventive PHC services.

The system of government in this country is going through massive changes. With the finalization of the new municipal boundaries and the passing of the Municipal Structures Act No. 117 of 1998 and Municipal Systems Act No 32 of 2000, local government is set to play a far more significant role in future than it has in the past. Local government is the second or third tier of government deliberately created to bring government to the grassroots population, as well as to give its members a sense of involvement in the political process that controls their basic life.

In South Africa's political circumstances as a country of almost 40 million, constituted of heterogeneous cultural and political groups, the need for effective decentralized democratic local government as a vehicle for development and national integration is imperative (Reddy and Sabelo, 1997). The national government has made a policy decision to have strong local government in South Africa that will be responsible for among many things, delivering municipal health services (Nicholson, 2001: 1). According to the National Health Act of 2003 every metropolitan and district municipality must ensure that appropriate municipal health services are effectively and equitably provided in their respective areas. It further provides that formal service agreements between provinces and councils will be the basis for future development of PHC (Republic of South Africa, 2004: 42).

As far as health care is concerned, there are some very broad guidelines for local government but little clarity on the details. The Constitution of the Republic of South Africa, Act 2000 of 1993 (as amended by Act 2 and 3 of 1994) states that the municipal health services are the responsibility of local government. The Municipal Structures Act together with its Amendment Act states that municipal health services are the responsibility of metropolitan and district municipalities, not local municipalities (Republic of South Africa, 1998: 34). The constitution also states that health services generally, are one of the matters that can be handed over from a national or provincial government to a municipality if the municipality has the capacity to take over responsibility. According to South African Yearbook (2004/05: 352) local government is responsible for rendering preventive and promotive health care with some municipalities rendering curative care. It further states that many local authorities provide additional PHC services. In some instances, these are funded by provincial health authorities but in major metropolitan areas, the councils carry some of the costs.

There is no clear definition of either health services or municipal health services so there is no clarity about what health services local government will be responsible for. The interaction between the provincial and local spheres of government is the critical element impacting on the provision of integrated services at the primary level. This interaction is further complicated by the different capacities within the different municipalities. However, in order to govern effectively, local government needs to have a voice in the provincial and national governments where laws are made and where budgets are passed. The responsibility for the delivery of comprehensive PHC can never completely belong to one level of the health care system. According to McCoy et al. (2000: 7) this requires a vertically integrated, tiered health care system where different levels of management and administration work together in a complementary manner (See Figure 1).

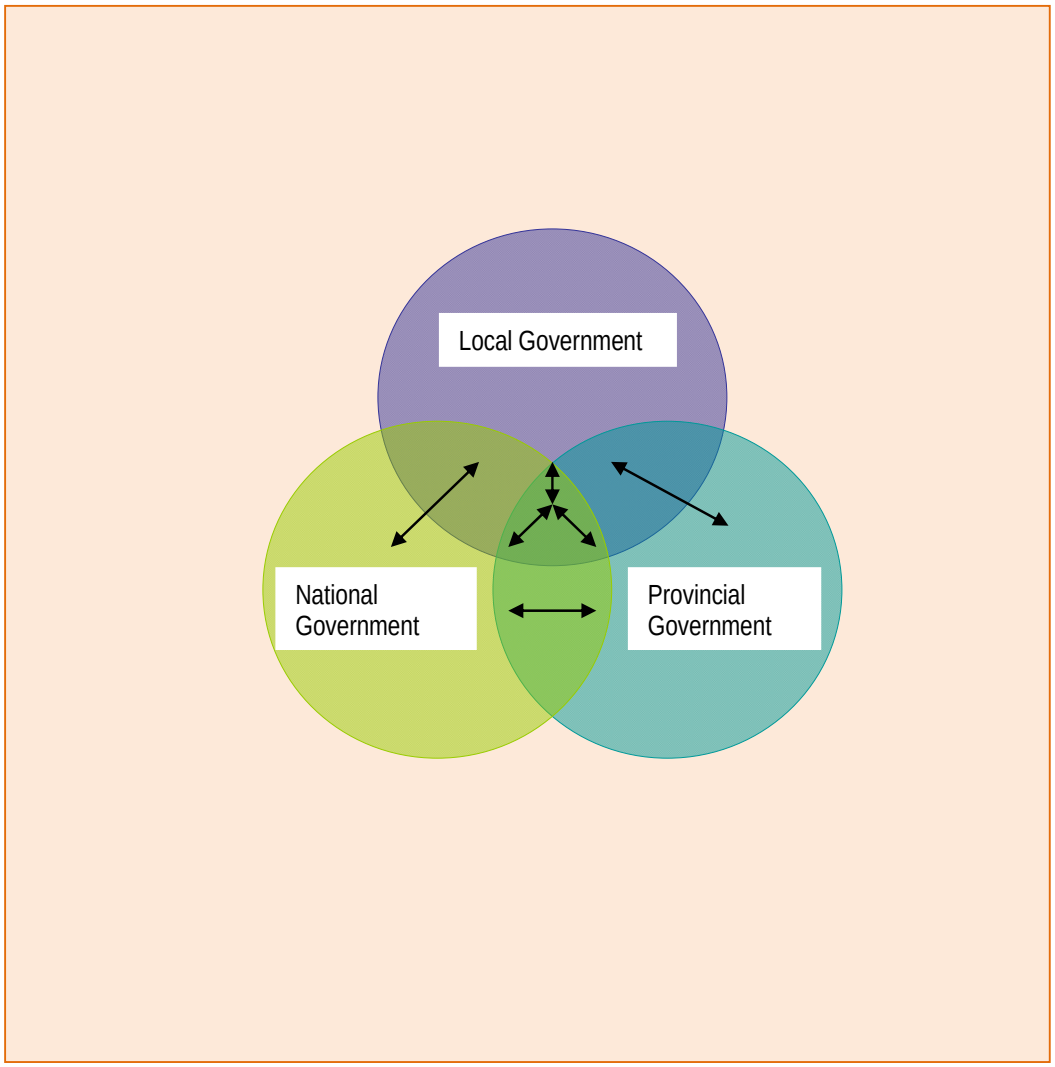


Figure 1: Spheres of government

2.5 INTERNATIONAL EXPERIENCE

As mentioned before, the DHS is an organizational framework that is accepted worldwide as the most appropriate vehicle for the delivery of PHC. Based on the PHC principles and approaches, and considering health as administratively and technically central and conditional to development, Al-Khawashky (2000) states that the DHS approach was introduced in about half of the Member States of the Eastern Mediterranean region. The author further states that DHS was introduced in Oman in the mid-eighties and by 1997 all the districts of the 10 regions of the Member States had an efficient DHS in place. Pillay, McCoy and Asia (2001) cite Philippines as the country where the strong political commitment was illustrated. The relationship between the Department of Health and local government in that country is cited as one of the reasons for the rapid decentralization. On the contrary, both in Mexico and Gambia, the major constraint to decentralization of health services was the reluctance by higher levels of authorities to give up control. Gilson et al. as cited by Pillay et al. (2001) state that a major obstacle to district development in Tanzania was the capacity of district managers working within a system which dis-empowered them because of the combined effect of an inflexible and ineffective resource allocation process, inadequate planning process, lack of clarity in terms of accountability and lack of management capacity and understanding within the district health management. In an effort to provide the district managers with the necessary skills in Tanzania, the District Action Research and Education (DARE) approach was used Barnett and Ndeki as cited by Pillay et al. (2001). These authors describe DARE as research that is conducted by people themselves that are experiencing problems with the aim of finding solutions to those problems and it also involves monitoring the implementation process of the solutions. Using DARE in Tanzania, within a year, district health management teams were able to identify problems and develop interventions and in addition, team spirit was enhanced during the process.

According to Tlabyane (2000: 29), most of the countries in Africa have been restructuring their national health systems towards the DHS. The majority of the countries are working on decentralizing PHC to local government. Ghana, for example, implemented the DHS as early as 1988. According to the report of Dangme West district by Agyepong as cited by Tlabyane (2000: 30), the integration of vertical programmes achieved better results than before. The report also affirmed the importance of integration with decentralized planning on the delivery of an efficient and effective health service.

2.6 THE RATIONALE FOR THE INTEGRATION OF PHC SERVICES IN SOUTH AFRICA

Since it came into power the aim of the government of national unity has been to reduce disparities and inequalities in health service delivery and to increase access to improved and integrated services. These services were to be based on the PHC approach as outlined at Alma Ata 1978 and the Reconstruction and Development Programmes (RDP) (ANC, 1994b: 48-49) in which the government created a framework for readdressing the imbalances, and rectifying the fragmented and inequitable health services in the country. This is re-iterated by the Constitution of the Republic of South Africa (1996), in the Bill of Rights Chapter 2 which pays special attention to, among others, the right to have access to health care services.

To create such a unified, district-based PHC system presupposes and requires bringing both authority over service components and resources (structural integration) and actual service delivery (functional integration) within the health district under one umbrella. The core challenge in developing a comprehensive PHC service for the district is therefore, to unite the different health authorities (often operating in isolation in the same district) and to integrate the different health services (often provided vertically or as free-standing programmes) into a united district health authority and into an integrated district health service (van Rensburg, 2004:144).

Tint et al. (2000: 15) define the term ‘comprehensive’ as the range of services available. These authors further state that comprehensive services in a PHC model simply mean that both preventive and curative services are given equal priority at PHC level.

It is often claimed that integrated programmes are better than the same services run vertically from the point of view of the users of services. According to the study that was done by Maharaj and Cleland (2005: 313), providers of PHC services were of the opinion that the integrated services served the needs of clients more efficiently and effectively than vertical programmes, and as a result, are more likely to contribute to greater client satisfaction. Another advantage of integration mentioned by several providers was enhanced confidentiality. In a single queue system, no one except the provider knows the purpose of the visit and thus the stigma attached to sexually transmitted infection (STI) patients or young unmarried family planning (FP) clients is reduced. This is further supported by Pillay (2002) who maintains that functional integration means structured co-operation and collaboration between provincial and local government health rendering authorities for the purpose of decreasing fragmentation and duplication, enhancing integrated service provision and increasing the efficiency and quality of PHC.

According to the study that was done by Coetzee, Hilderbrand, Goemaere, Mathys and Boelaert (2004) on the integration of tuberculosis (TB) and Human Immune Deficiency Virus (HIV) management, the available human and financial resources could be better used. The results of the study revealed that TB and HIV services function independently of each other and as a result, separate folders are kept in each service without exchange between caregivers. The clinicians in the different services are unaware of other treatments. Dually infected patients are seen at two different services and by different health staff, at different times and places and this results in missed opportunities for cotrimoxazole prophylaxis. In addition, a single

venue and a comprehensive consultation could result in less waiting time for patients.

There is a perception that PHC staff is being overburdened with new tasks, and not given adequate authority or support to fulfill these tasks (Schierhout and Fonn, 1999: 31). This is further supported by the Department of Health (2004: 18) who note that since the introduction of free PHC services, clinics are seeing more patients, while there are many instances where the movement of patients away from hospital outpatient departments to clinics has not been accompanied by a transfer of staff. Combined with the incomplete integration of curative and preventive health services in clinics, the Department of Health further argues that the increase in patient loads in clinics has led to some degree of compromise in the quality of care at that level.

Furthermore, some research studies that have been conducted in South Africa on the effectiveness of integration indicate that there are problems related to the integration of PHC services. According to the study conducted by Maharaj and Cleland (2005: 313), the results indicated that providers reported that they were initially resistant to integration because they had to cope with their existing workload as well as with new activities. Results further indicate that most of the resistance to integration came from providers who were accustomed to providing specialist services and as a result, associated themselves with specific activities, for example, family planning. Effective implementation of a more active mode of integrated services was also hindered by a host of logistical problems. The common complaints by staff included insufficient space, high case loads, lack of adequate staff preparation and training, shortage of equipment and poor infrastructure. Other technical issues raised by providers include the inability to conduct group health education for particular group of users for example, ante natal, child health due to the fact that all users come every day and anytime; and drug wastage in immunization as some vaccines have to be discarded after

few hours once they are opened (Tint et al., 2000). Organizational problems included the lack of co-ordination between personnel appointments and transfers and the training problem, problems with routine drug supplies and problems with the referral system to other levels of care (Schierhout and Fonn, 1999: 32).

Senior managers understood integration of services and its implementation differently. Managers' views on the practicality of integration imply that it is not feasible to implement integration within the existing PHC structure. For successful implementation of integration, they believe that more resources must be in place prior to any attempt at integration. According to the study that was done by Lush and Makoala (1999: 21) on HIV/STI services, they identified major communication gaps that inhibit effective implementation. These authors state that gaps were strongly related to status, where staff was of different levels in the hierarchy, there were difficulties in communicating either formally or informally to achieve programme objectives, such as the dissemination of the new technical guidelines or recruiting for training sessions. Communication between line managers within programmes was far stronger than outside programmes. They further argue that there should be clear communication channels and procedures for how the joint senior management structure will communicate with clinic level teams. It should be noted that all these studies explored the integration of two vertical programmes. This is further supported by a study that was done in Gauteng by Mashazi (2002: 80) on the integration of provincial and local authority nurses rendering primary health services. The results revealed that the local and provincial authority nurses were integrated without proper consultation and as a result, this integration was rejected. A number of studies maintain that building and maintaining good communication at all levels of the management and staff of the two authorities is a critical element of implementing functional integration (Toomey, 2000; Mashazi, 2002; Pillay, Leon, Wilson, Asia, Barron and Dudley, 2003).

2.7 INTEGRATION MODELS IN SOUTH AFRICA

There are three models of integration that are currently being addressed in South Africa. These are programme integration, functional integration and structural/ organizational integration.

2.7.1 Programme integration

Traditionally, health care programmes have been implemented as vertical programmes. With the escalation of health care costs as well as the introduction of the DHS, there was a need to reduce the number of vertical programmes implemented by specialized staff. The DHS model has been adopted internationally in a move towards civil service reform. In the South African context, programme integration is viewed as a subset of functional integration rather than as a separate entity (Tlabyane, 2000: 13).

2.7.2 Functional integration

Functional integration refers to service delivery. Pillay et al. (2003) further explain functional integration as the integration of provincial and local government health services for the purpose of decreasing fragmentation and duplication. It requires that the multiple health services and programmes rendered under multiple health authorities in the same district be brought into a seamless service (van Rensburg, 2004). According to Tlabyane (2000: 13) in this model, joint health resources planning between various service providers within a district exist to address issues of duplication and fragmentation. Functional integration is not only an important step in preparing for working together, it is also a vital step in securing the delivery of integrated comprehensive PHC services. Pillay (2002) identifies the following requirements for functional integration:

- Moving from an ‘us’ and ‘them’ attitude or relationship to one emphasizing the ‘we’
- Joint planning between the provincial and municipal health service rendering authorities
- Drafting a district health plan that clearly outlines the service delivery model
- Seconding health personnel from province to local government and vice versa
- Sharing of resources with a view to increasing efficiency
- Agreeing jointly on operating procedures.

2.7.3 Structural or organizational integration

This entails that the different health service rendering authorities within a district be ‘collapsed’ and integrated into one unified authority and administrative structure (McCoy, Harrison, Bamford, Donohue, Nxumalo and Radebe, 1998). Therefore, structural or organizational integration involves a change in policy framework. A legislative framework is required to ensure stability and sustainabilty of the new arrangement. Pillay (2002) states that structural integration goes hand in hand with functional integration. However, functional integration is a transitional measure or a first step that needs to take place before structural integration can be accomplished.

2.8 DESIRED OUTCOMES OF HEALTH CARE INTEGRATION

There are at least three desired outcomes to be achieved through health care integration:

- Cost control or expenditure regulation
- Increase in health provision efficiency
- Implementation of new patterns of health services, shifts in continuum of health care i.e. improving the patient’s satisfaction as well as quality of services and gains (Sobczak, 2002).

According to the WHO report on integration of health care delivery, an integrated service is firmly linked to the development of a DHS (WHO, 1996). Integration, therefore implies multi-purpose clinics; multi-purpose staff; planning of programmes that have many objectives and include other sectors and budgeting that reflects this; training courses that are general rather than specialized and supervisory visits that deal with all aspects of the service (Schierhout and Fonn, 1999: 4).

2.9 GLOBALIZATION TRENDS IN HEALTH

Converging trends in health care systems around the world inevitably hint at the globalization of health, health policy and health care. Globalization is one of the key challenges facing health policy makers and public health practitioners (Woodward, Drager, Beaglehole and Lipson, 2001). These authors argue that there is no consensus either on the pathways and mechanisms through which globalization affects the health of the populations or on the appropriate policy responses. According to the Southern African Regional Poverty Network (2006) the complex relationship between globalization and health occurs via effects of international governance and agreements; globalization's impact on economic, social, political and environmental conditions; exposure to health-damaging and health-benefiting commodities and conditions and access to health care.

One argument that has been used in support of globalization and trade liberalization, de-regulation and privatization is that it will reduce poverty and improve services, and thereby improve health. Globalization is characterized by the circulation of goods and services between countries in response to criteria of efficiency. Such multilateral agreements between countries as argued by Segouin, Hodges and Brechat (2005: 277), often function to the detriment of the countries with less developed economies. There is greater inequality between and within countries now than there was 20 years ago. For example, the movement of professionals in general tends to be

detrimental to poorer countries (Segouin et al., 2005). This raises the question of whether patterns of globalization have widened health differentials, and this observation has resulted in calls for more pro-poor sustainable development processes so that development has a positive impact where the health burden is greatest. The global threat and risks posed by emerging and re-emerging infectious diseases are accentuated by changes in human behaviour, changes in ecology and climate, in land use and patterns and economic development, as well as by tourism and migration (van Rensburg, 2004). Health systems of some sort have existed as long as people have deliberately tried to protect their health and treat diseases. Throughout the world, traditional practices based on herbal cures, often integrated with spiritual counselling and providing preventive and curative care, have existed for thousands of years, and often co-existed with modern medicine. Throughout the Third World, traditional healers have, for centuries been the major providers of health care. Even today, in many countries they still offer an alternative to Western medicine (Werner and Sanders, 1997: 14).

These authors further state that prior to the 19th century, public health activities were initiated either to combat the diseases that affected the European populations or as attempts to maintain a healthier work-force and so ensure healthy profits. By the end of the colonial period, the pattern of health care which had developed in most of the Third World was largely modelled on the system used in the industrialized countries. Towards the close of the 19th century, the Industrial Revolution was transforming the lives of people worldwide. At the same time societies began to recognize the huge toll of death, illness and disability occurring among work-forces whether from the infectious diseases or from industrial accidents and exposures (WHO, 2000). The emphasis was on expensive high technology and urban-based curative care in large hospitals and the services were almost wholly confined to the larger towns. The needs of people living in rural areas and urban slums were largely neglected. This situation continued with little change until the middle of the twentieth century (Werner and Sanders, 1997: 14).

According to the WHO (2000: 13) health care reforms during the 20th century have been characterized by three overlapping generations. During the 1940s and 1950s the first generation was characterized by an emphasis on hospital-based care in both high and low-income countries. This system was found to be inefficient and inaccessible.

According to Southern African Regional Poverty Network (2006) in 1999, the average life expectancy at birth was 49, 2 years in the least developed countries, 61, 4 for all developing countries and 75, 2 for developed countries. These gaps highlight the increased disease burden in the absence of sustainable development in the least developed and developing countries. The chances of a woman dying in childbirth in sub-Saharan Africa range from 1 in 11 in Eastern Africa to 1 in 65 in Southern Africa compared to 1 in 1100 in Eastern Europe and 1 in 5000 in Southern Europe. According to UNAIDS (2008: 30), sub-Saharan Africa remains the region most heavily affected by HIV, accounting for 67% of all people living with HIV and for 75% of AIDS death in 2007. Life expectancy in the most severely affected countries in sub-Saharan Africa has been reduced by almost a third, from about 60 years to 43. The state of the health systems has played a part in the dramatic rise in life expectancy that occurred during the 20th century. They have contributed enormously to better health and influenced the lives of people around the world. Enormous gaps remain, however, between the potential of health systems and their actual performance, and there is much variation in outcomes among countries which seem to have the same resources and possibilities. In today's complex world, it is difficult to say exactly what a health system is, what it consists of and where it begins and ends. The WHO report's (2000) definition of a health system includes all activities whose primary purpose is to promote, restore or maintain health. On the other hand, Kleczkowski, Elling and Smith (1984: 5) broadly define a health system as the coherent whole of many interrelated component parts, both sectoral and intersectoral, as well as the community itself, which produce a combined effect on the health of a population. Kleczkowski et al. (1984) further argue

that there should be one unified health system encompassing promotive, preventive, curative and rehabilitative measures.

The WHO report (2000: 22) identified three goals of a health system: a) better health as the primary goal of a health system; b) fairness financial contribution; and c) responsiveness to people's expectations in regard to non-health matters. The health system as a social system differs from the education system in two ways which make the goals of fair financing and responsiveness particularly significant. One is that health care can be catastrophically costly and the other peculiarity of health is that illness itself, and the resultant medical care, can threaten people's dignity and their ability to control what happens to them more than most other events to which they are exposed. A breakthrough in global health rights took place at the International Conference on PHC in 1978 in Alma Ata, USSR. Prior to Alma Ata, the trend was towards expensive treatment for a few sick people, rather than promotive and basic health care for many (WHO, 1978).

2.10 HEALTH SYSTEMS IN AFRICA

The health care systems of African countries cannot always be categorized as neatly or easily as those in industrialized countries (van Rensburg, 2004). Van Rensburg further argues that in Africa, health care systems vary with prevailing political-economic systems, spanning the entire spectrum from predominantly socialist (Angola, Mozambique and Tanzania) through socialized (Kenya), to strongly inclined free-market dispensations (South Africa). Dr Sambo, Regional Director for Health, Africa argues that "most African countries are challenged by a double crisis of fragile health systems and weak human resources, the latter being an essential component of effective service delivery" (WHO Regional Office for Africa, 2007). Africa has 14% of the world population, habours 25% of global disease burden and has only 1, 3% of global health workers. There would be a need for 2, 5 health workers per 1000 inhabitants to achieve the MDGs. However, the current

health worker: population in Africa is only 2, 3 health workers per 1000 inhabitants (WHO Regional Office for Africa, 2007). According to the World Health Report (2006) there are 57 countries that face crippling health workforce shortages and of these, 36 are located in Africa (WHO, 2006b). WHO estimates that over 4 million health workers are needed to fill the gap and the global deficit of doctors, nurses and midwives in particular is no less than 2, 4 million.

According to Machiphisa (2005) there are clear indications of growing inequities in health and health care in Africa. According to Africa Focus Bulletin, (2004) one of the criticisms of PHC as a route to achieving the affordable universal coverage, the goal of Health for All, is that it provides little attention to people's demands for health care, says Nyazema who is the co-ordinator for Consumers International Regional Office for Africa. Nyazema notes that as a result of this neglect, health programmes in Africa have concentrated almost exclusively on the perceived needs of grassroots people. The human resource shortage is one of the key structural obstacles facing not only the war against AIDS pandemic, but also the more general health crisis of which it is the most visible indicator. The human resource problem in the health sector in sub-Saharan Africa has reached crisis proportions in many countries. Although the gravity of the problem varies across the region, the situation in some countries is so grave that urgent action is needed (Academy for Educational Development, 2003). This is further supported by a speech delivered by a WHO Regional Director for Africa, Dr Luis Sambo in a message to mark World Health Day observed worldwide on the 7 April 2006 that *"Little attention has been paid to the people who actually deliver health care in our region. For too long, the health workforce has been ignored, left to toil and struggle in silence. This cannot continue."* (WHO/AFRO, 2006). The Regional Director attributed the crisis of human resources in the health sector in the region to several factors, including inadequate financing arrangements, weak planning and the widespread migration of African health workers, especially to the developed world.

Health systems in Africa are being drained by an exodus of health personnel to wealthy countries. According to WHO/AFRO (2006) the outflow of skilled health personnel from Africa has reached rate that there are more health workers from African countries overseas than in their countries of origin. Rates of health worker migration range from 8% to as high as 60% in some African countries. Many health workers are un-motivated to stay because they are poorly paid, poorly equipped, infrequently supervised and informed, and have limited career opportunities within the civil service. The health of people in sub-Saharan Africa is being compromised by the disaster, while the health systems of the subcontinent are not responding adequately and effectively to this predicament.

2.11 HEALTH CARE IN SOUTH AFRICA

Prior to 1994 the South African health system was built on apartheid ideology and characterized by racial and geographic disparities, fragmentation and duplication and hospi-centreicism with lip service paid to the PHC approach. There were 14 departments of health, each with its own objectives. The national department of health provided a portion of the vertical programmes while the provincial administration and local authorities duplicated primary health care services in their areas of jurisdiction. Access to health care for rural communities, especially those classified as 'black' was difficult. Many rural clinics had very limited access to medical doctors and medicines were expensive and not always available at public health facilities and expensive (Department of Health, 1999: 5; Tlabyane, 2000: 1).

Over the past few years, the country has been through an exciting process of transformation. A series of changes have been made, but these have been largely cosmetic and until there are major political changes to redress inequalities, it is unlikely that this costly and ineffective system will alter significantly. The problems with the South African health care system have been summarized by van Rensburg (2004) as follows:

- A lack of co-ordination of health services
- Shortage of both health personnel and facilities, particularly for blacks in both urban and rural areas
- The problem of private practice where health services were not equally available and accessible to all sectors of the population
- An inordinate emphasis on cure, curative services and institutional care with not enough focus on either the prevention of disease or community-based care.

There is therefore, there is a need to re-organize the South African health system so that it addresses the problems of the past. This is supported by the current mission and vision statement of the National Health Act of 2003 which states that: “The vision is a caring and humane society in which all South Africans have access to affordable, good quality health care. The mission is to consolidate and build on the achievements of the past five years in improving access to health care for all and reducing inequity, and to focus on working in partnership with other stakeholders to improve the quality of care of all levels of the health care system, especially preventive and promotive health, and to improve the overall efficiency of the health care delivery system” (Republic of South Africa, 2004).

South Africa’s health system consists of a large public sector and a smaller, but fast-growing private sector. The public sector is under-resourced and over-used, while the mushrooming private sector runs largely on commercial lines and attracts most of the country’s health professionals. Although the state contributes 40% of all expenditure on health, the public health sector is under pressure to deliver to about 80% of the population. Despite this, most resources are concentrated in the private health sector, which sees to the health needs of the remaining 20% of the population. Public health sector consumes around 11% of the government’s total budget, which is allocated and spent by the nine provinces. How these resources are allocated, and the standard of health care delivered, varies from province to province. With less

resources and more poor people, cash-strapped provinces like the Eastern Cape face greater health challenges than wealthier provinces like Gauteng and the Western Cape (South Africa Info, 2007a). There are large inequities in funding across districts (Blecher, Day, Dove and Cairns, 2008). According to the South African Yearbook (2007/08: 2) the provincial estimates showed that KZN had the largest share of the South African population at 21% of the total followed by Gauteng with 20, 2% and the Eastern Cape with 14, 4%. However, the Gross Domestic Product per Region (GDPR) of KZN is the second largest in the country after Gauteng (South African Yearbook 2007/08:13).

2.12 NATIONAL HEALTH CARE SYSTEM TYPOLOGIES

Health care has become a major focus of international concern and primary political, social and economic issues in nearly every country. The resources required to meet public demand for high quality and high technology services are substantial, especially since the average expectancy life is increasing in most countries with consequent higher per capita expenditures. Some countries rely on government-sponsored and managed health care, whereas at the other extreme, private enterprise provides the care. Most countries are located somewhere on a continuum between these extremes. According to van Rensburg, Fourie and Pretorius (1992: 21) health care systems of countries are not static, unchangeable entities. They are highly dynamic and highly changeable systems which are particularly sensitive to changes in the external environment, for example, to an altered political economy, changing morbidity and mortality patterns, or technological developments. There are many different ways of categorizing the types of health care systems in countries. Different national health care typologies are discussed below:

2.12.1 Typology based on national economic levels and degree of health systems organization

Table 2: Typology based on national economic levels and degree of health system organization

	*Degree of health system organization		
National economic level	Modestly organized	Moderately organized	Highly organized
Developed (affluent)	1	2	3
Developing (transitional)	4	5	6
Least developed (poor)	7	8	9

Source: Kleczkowski et al. (1984: 9)

On the basis of estimates of their economic and socio-political characteristics, the health systems of every country may be situated within a matrix. A conceptual matrix of the characteristics of national health systems based on these two factors i.e. the national economic level and the health system's degree of organization is presented in Table 2. Theoretically, every national health system in the world could be placed in one of these nine categories. In some categories there would be many health systems and in others only a few. Moreover, the economic and sociopolitical characteristics of countries and health systems are continually changing, which means that a system might be in one category now and in another five years hence. Subject to this possibility, Table 1 may offer general guidance for the development of strategies to re-shape national health systems. The amplitude of health resources is bound to be much greater in categories 1, 2 and 3 for example, than in categories 7, 8 and 9 and re-orientation strategies should obviously

take this into account. Similarly, the role of the private sector in financing health services is much greater in categories 3, 6 and 9 and this must obviously influence the planning of any system changes. It is likely that most of the world's national systems do not belong in the extreme categories (1, 3, 7 and 9) but rather in the intermediate zone (2, 4, 5 6 and 8). National health systems that are rather loosely structured (modestly organized) but highly efficient may have the optimum effect on the health of their populations. On the other hand, some highly organized but resource- or structure-oriented systems could have a less than optimum effect on health because of organizational rigidity or inadequate financial support.

2.12.2 Roemer's fourfold typology of national health care systems

Table 3: Roemer's fourfold typology of national health care systems

ECONOMIC LEVEL (GNP) per capita	HEALTH SYSTEM POLICY (market intervention)			
	Entrepreneurial & permissive	Welfare-oriented	Universal & comprehensive	Socialist & centrally planned
Affluent & industrialised	United States 1	West Germany Canada 2	Great Britain New Zealand Norway 3	Soviet Union Czechoslovakia 4
Developing & transitional	Thailand Philippines South Africa 5	Brazil Egypt Malaysia 6	Israel Nicaragua 7	Cuba North Korea 8
Very poor	Ghana Bangladesh Nepal 9	India Burma 10	Sri Lanka Tanzania 11	China Vietnam 12
Resource rich	13	Libya Gabon 14	Kuwait Saudi Arabia 15	16

Source: Roemer as cited by van Rensburg (2004: 13)

This typology reflects the global situation of health care systems in the late 1980s and 1990s. Roemer designates these respectively as entrepreneurial, welfare-oriented, comprehensive and socialist systems. He qualifies these general trends according to developed and developing countries: *"In the industrialized countries, there seems to be a trend towards increasing use of social insurance mechanisms, while in the developing countries, the trend is toward greater use of governmental revenues to finance health services"* (Roemer as cited by Van Rensburg, 2004:13). Entrepreneurial and permissive health systems are very common. The health care system of the USA is one of the few systems which leans strongly in that direction. In this type of a system, the development and use of health care resources occur in a predominantly free-market system. There is minimal intervention by the state regarding the supply, demand and price of health services. Private and local initiatives play a decisive role in the provision of services. According to

Lasley, Lasley and Jinks (1997) the US health care system is the most expensive in the world in terms of per capita cost and proportion of Gross Domestic Product (GDP) expended for health care. US spend 15% of GDP on health care. The public health system is decentralized and varies in comprehensiveness and quality from state to state and among communities. Smaller rural communities tend to have much more limited services than larger and wealthier urban communities. South Africa is classified as a developing and transitional country under an entrepreneurial and permissive health system. According to Goudge (1999: 70) South Africa had one of the most expensive and ineffective health care systems in the past regime. In 1992/93 the country was spending 8, 4% of its GDP on health care proportion, yet South Africa ranked below 60th in terms of the health status indicators. This was attributed to the fact that the private sector spent over 60% of the total spending on a beneficiary population of less that 20% of the country's total. The remaining 80% of the population were dependent on the public health services, which were spending the remaining 40% of the resources. Health care expenditure in South Africa was approximately R107 billion in 2003/04. This is equivalent to 8, 7% of GDP in that year which is relatively high by international standards (Department of Health, 2006a: 14). While total health care expenditure in South Africa in 2005 was just over R100 billion (or 6, 7%of GDP), a single tier system for hospital and ambulatory services at private sector cost levels would require expenditure levels of R318 billion (or 20, 8% of GDP). This is considerably more than high income countries which generally spend 8-10% of GDP on health care (McIntyre, 2007).

When looking at the above typologies, South Africa is grouped as a middle-income country along with countries such as Brazil and Argentina, but in terms of health status, South Africa is not on a par with these countries. The main reason for the currently low health status of South African population, according to Bradshaw et al. as cited by van Rensburg (2004: 226) is the triple burden of a disease from a combination of poverty related diseases, emerging chronic diseases and injuries. HIV/AIDS further contributes to the

poor health status of the country as a result of increased child and young adult mortality and reduced life expectancy. Health, more often than not, is a reflection of the overall socio-economic conditions within a society and is also indicative of discrepancies between groups of different socio-economic status. This is even more so the case in South Africa where living standards, social development and access to health care are not equally distributed. Unequal distribution of health care resources is still noted even during the post apartheid era. For example, according to the National Human Resources Plan for Health, private sector contribution as a share of GDP is 5, 2% catering for a population of 7 million people, whilst public sector share is 3, 5% providing for 35 million people (Department of Health, 2006a: 14). A nation's health is, therefore, undoubtedly affected by factors external to individuals or groups where the health conditions are observed. Given this maldistribution of resources, monitoring health expenditure by the source of finance and by beneficiary type is vital. The skewed distribution of human resources between the public and private sectors poses a fundamental challenge to harnessing the pool of resources within the health sector to address the broader health system imperatives of meeting the MDGs. Wadee and Khan (2007) argue that the multiple data sets make it difficult to quantify the exodus of human resources from the public sector to the private sector. As a result, these authors recommend the creation of national human resources for health data base that would allow both the public and private sectors to progress together towards the goal of strengthening and unifying the health system.

2.12.3 Field's typology of national health care systems

The characteristics, underlying principles and differences of these types, as well as the countries in which these different health care systems are found, are represented in Table 4.

Table 4: Field's typology of national health systems

	Type 1 Emergent	Type 2 Pluralistic	Table 3 Insurance / Social Security	Type 4 National Health Service	Type 5 Socialised
General definition	Health care as item of personal consumption	Health care as pre-dominantly a consumer good or service	Health care as an insured / guaranteed consumer good or service	Health care as a state-supported consumer good or service	Health care as a state-provided public service
Position of the physician	Solo entrepreneur	Solo entrepreneur and member of variety of groups / organizations	Solo entrepreneur and member of medical organization	Solo entrepreneur and member of medical organization	State employee and member of medical organizations
Role of professional associations	Powerful	Very strong	Fairly strong	Fairly strong	Weak or non-existent
Ownership of facilities	Private	Private and public	Private and public	Mostly public	Entirely public
Payments	Direct	Direct and indirect	Mostly indirect	Indirect	Entirely indirect
Role of politics	Minimal	Residual/ indirect	Central/ indirect	Central/ direct	Total
Prototypes	Russia, USA, Western Europe in 19th century	South Africa, Switzerland, USA in 20th century	Canada, France, Italy, Japan, Spain, Sweden, West Germany in 20th century	Australia, Great Britain in 20th century	Cuba, Eastern, Europe, Soviet Russia in 20th century

Source: Field as cited by van Rensburg (2004: 11)

2.12.4 The typology of William Cockerham

Table 5: The typology of William Cockerham: Fourfold classification

Type	Definition	Characteristics	Country examples
Free-market medicine	Free-market medicine is primary based on wider free-market principles, particularly private financing by fee-for-service, private initiative and ownership, and least state or third-party intervention. Such systems are characterized by a two-track system of financing and of health care delivery, i.e., a private track (based on individual purchasing power) and a public track (based on welfare provision)	Free-market medical systems Have both private and public systems of financing and organization of health care services Have providers which are mainly private entrepreneurs Have facilities which are privately and state owned Do not guarantee equal access to the general population and are mostly highly inequitable Encourage (even enforce) private care for patients who are able to pay for such services	United States of America Switzerland South Africa
Socialized medicine The Beveridge model	Socialized medicine refers to a system of health care delivery in which health care is provided in the form of a state-supported consumer service financed by taxation. That is, health care is purchased but the buyer is the government, which makes the services available at little or no additional cost to the consumer. There are several different forms of socialized medicine.	In socialized medical systems, the government Directly controls the financing and organization of health care services in a capitalist economy Directly pays providers Owns most of the facilities (Canada is an exception) Guarantees equal access to the general population Allows some private care for patients willing to be responsible for their own expenses	Great Britain Canada Nordic countries Italy Spain Saudi Arabia Kenya
Decentralized national health programmes This Bismarck model	Decentralized national health programmes differ from systems of socialized medicine in that government control and management of health care delivery is more indirect. Government acts primarily to regulate the system not operate it. Often government functions in the role of a third party mediating and coordinating health care delivery between providers and organizations involved in the financing of services.	In decentralized national health programmes, the government Indirectly controls the financing and organization of health services in a capitalist economy Regulates payments to providers Own some of the facilities Guarantees equal access to the general population Allows some private care to patients willing to be responsible for their own expenses	Germany Japan France The Netherlands Mexico Belgium Austria Switzerland Luxembourg
Socialist medicine The Semashko model	Socialist medicine is a system in which health care is a state-provided public service. The state controls, organizes, finances and allocates health care directly to all citizens free of charge. No third-party organizations or insurance companies are interposed between health care providers and patients. The state owns all facilities and pays salary to all health care workers.	In socialist medical systems, the government Directly controls the financing and organization of health services in a socialist (communal) economy Pays providers directly Owns all facilities Guarantees equal access Bans/restricts private care	Former Soviet Union and eastern Europe – Hungary, Poland, Russia, People's Republic of China, Cuba

Source: Field as cited by van Rensburg, 2004: 14)

2.13 PRIMARY HEALTH CARE IN SOUTH AFRICA

PHC was formally introduced in South Africa from April 1994 as the driving principle for health care provision with the implementation of two policies, “free health for pregnant mothers and children under the age of six years” as well as the “universal access to PHC for all South Africans”. This gives special emphasis to the development of clinics and basic health care programmes such as safe motherhood, child health and nutrition, expanded immunization, management of communicable diseases and the treatment of chronic ailments (Department of Health, 2000: 3). In 1994 the newly elected African National Congress (ANC) government was faced with the daunting challenge of transforming a fragmented and discriminatory health care system into one with the capability of delivering health care to all citizens, particularly those previously disadvantaged under apartheid legislation. One of the most notable changes was the creation of a single National Department of Health, which is responsible for strategic policy development and technical guidance. At the same time, according to the White Paper for the Transformation of the Health Care System, nine provincial health departments were created and tasked with the responsibility for ensuring effective implementation of national policy (Republic of South Africa, 1997). Public sector PHC services are the backbone of health care. Therefore, ensuring equity, effectiveness and efficiency in the provision of these services is critical to the functioning of the entire system (Ntuli and Day, 2004).

One of the foremost changes in the early years of the democratic government was the adoption of a district based system, which is the principal instrument for the delivery of comprehensive integrated PHC services in line with the Declaration of Alma Ata. The goal of the DHS was to achieve equity and improve access, effectiveness and efficiency of services through decentralized management services and localized service provision. According to McCoy and Engelbrecht, (1999) DHS is more than just a structure or form of organization; it is the manifestation of a set of activities

such as community involvement, an integrated, holistic health care delivery system and intersectoral approach to planning, policy development and management. The DHS builds on the principle of comprehensive care across a continuum, ranging from home and community care to specialized tertiary health care, with an efficient referral network at each level (Department of Health, 2002). Under the ANC government, commitment to delivering an integrated system of service delivery and management is strong and explicit moves to integration have taken place, for example, Maternal, Child and Women's Health (MCWH). The pursuit of optimum health for mothers, women and children is one of the principal goals of the National Health Plan and the RDP (ANC, 1994a; ANC, 1994b) respectively. The key programmes of MCWH include:

- Political support for international conventions
- Free health care for pregnant women and children under the age of six years, immunization
- Reduction of morbidity and mortality for common diseases, improved nutrition
- Health education for priority issues, increased and enhanced reproductive health services
- Development of comprehensive women's health care services
- Effective measures against HIV/ AIDS, and sexually transmitted diseases
- Protection against abuse and violence
- Enactment of appropriate legislation and finally, redirected training, and
- Education for health workers (Department of Health, 2001a: 30).

According to the Strategic Plan 2006/07-2008/09 the DHS was strengthened during 2005/06 (Department of Health, 2006b: 8). Key to this was the need to clearly define the roles of provinces and municipalities with respect to service delivery and to ensure that functional integration was achieved so that patients experienced seamless access to PHC services, regardless of which authority provided the service. It further stated that the District Health

Planning (DHP) guidelines and their implementation were also revised to strengthen PHC services through a more systematic planning process, and by improving the implementation of plans and the monitoring of service delivery. Most health districts provide the full basket of PHC services but the challenge is to ensure that this also is a feature in all health sub-districts. Furthermore, according to data from the District Health Information System (DHIS) the use of PHC services has increased from 67 021 961 visits per year in 1998 to 98 633 210 in 2005 (Department of Health (2006b: 8). Since 1994, more than 700 clinics have been built or upgraded, 2 298 clinics have been upgraded and given new equipment, and 125 new mobile clinics have been introduced. There are now more than 3 500 clinics in the public sector (South Africa Info, 2007b).

2.14 A COMPREHENSIVE PHC SERVICE PACKAGE FOR SOUTH AFRICA

In 2001, the National Department of Health introduced a comprehensive PHC core package which represents the services that should be rendered for PHC services to be regarded as fully comprehensive (Department of Health, 2001a: 7). The package attempts to define services in terms of both level of care and approach. Services at the clinics were defined, not by size of the facility, but by the level of skills of the staff. As such, they include services which can be delivered by a professional nurse as part of the common package. Additional services could be delivered if regular visits by doctors or other specialists are organized. For the organization of clinics, the comprehensive PHC core package suggests three service points, namely children, adults and fast queue/repeat, although local clinics may choose different types of organization (Department of Health, 2001a: 9). The interventions that can be delivered together are clustered in the PHC package in an effort to make the service congruent with the infrastructure and the model of care functioning at the district level (See Figure 2). The PHC package helps to identify shortcomings in both equipment and training needs. It serves as a planning

and prioritization tool focusing on equity, efficiency and cost-effectiveness. In terms of the PHC service package, the following ten core norms are applicable to all PHC facilities:

- The clinic renders comprehensive integrated PHC services using a one-stop approach for at least 8 hours a day, five days a week
- Access as measured by the proportion of people living within 5km of a clinic, is improved
- The clinic receives a supportive monitoring visit at least once a month to support personnel, monitor the quality of service and identify needs and priorities
- The clinic has at least one member of staff who has completed a recognized PHC course
- Doctors and other specialized professionals are accessible for consultation, support and referral and provide periodic visits
- Clinic managers receive training in facilitation skills and PHC management
- There is an annual evaluation of the provision of the PHC services to reduce the gap between needs and service provision using a situation analysis of the community's health needs and the regular health information data collected at the clinic
- There is annual plan based on this evaluation
- The clinic has a mechanism for monitoring services and quality assurance and at least one annual service audit
- Community perception of services is tested at least twice a year through patient interviews or anonymous patient questionnaires (Department of Health, 2001b:12).

The core standards for PHC service provisioning amount to the presence of the following (Department of Health, 2001b:12-14):

- References, prints and educational materials
- List of equipment that should be available in a PHC setting
- Medicines and supplies as per the essential drug list for PHC as well as measures for ordering and control of supplies
- Competencies of health staff, amongst others the ability to organize and run the facility and to reduce patients' waiting time
- Patient education where the emphasis is on community participation to improve health awareness
- Records specifically related to an integrated standard health information system that facilitates the collecting and utilization of data
- Community and home base activities where the emphasis is on involvement of community stakeholders for support
- Referral of patients to the next level of care
- Collaboration with other sectors to enhance the promotion of health.

The main framework for the implementation of the package is the DHS within which fixed and mobile clinics constitute the basis for service delivery. Due to resource and capacity constraints, it is taken into account that not all districts and local municipalities will be in a position to provide the entire package immediately. The intention was to implement the package incrementally in all provinces, with 2004 being set as the target for full provision and availability of the package in all PHC facilities. However, it soon turned out that the dates set for the implementation of core programmes of the package were unrealistic and overambitious and as a result, materialized only partially. This is further supported by the eThekwini District Health Plan which states the utilization of clinics in the district is lower than expected and that clinics will be monitored to ensure a 70% implementation of the PHC package (KZN Health, 2006a: 9).

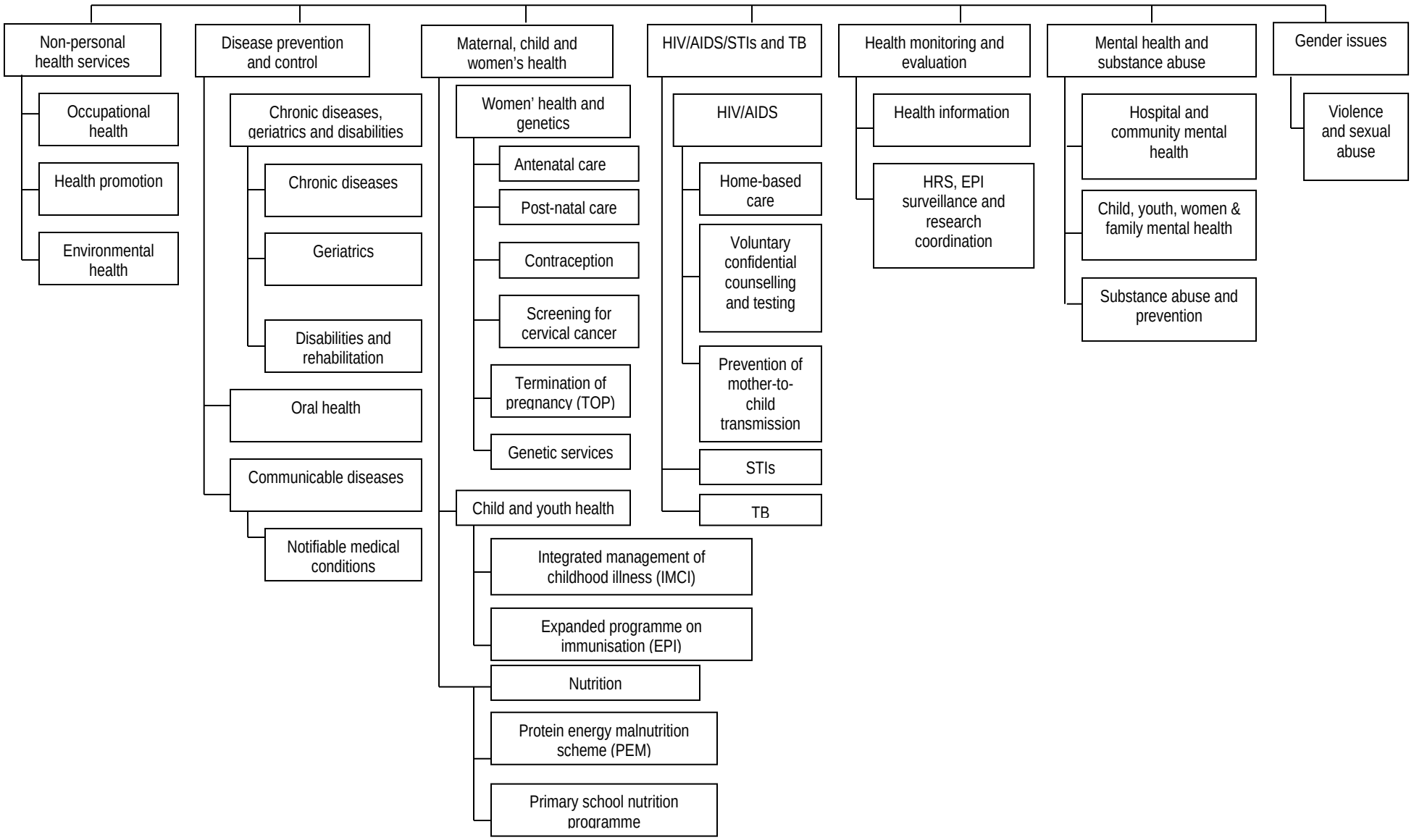


Figure 2: The core PHC programmes and clusters of programmes

2.15 CONCLUSION

This chapter traces the development of IPHC internationally, regionally and nationally in South Africa. Reviewed related literature revealed limited empirical data on integrated services, hence a need for this study.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 DESIGN

A cross-sectional study, using a qualitative approach was conducted in order to develop an operational framework for the integration of PHC services in South Africa. It is crucial that the method chosen is one that is most likely to yield a framework grounded within the South African health systems context. A cross-sectional study involves the collection of data at one point in time (Polit and Beck, 2004: 166). Cross-sectional studies are appropriate for describing the status of the phenomena at a fixed point in time. Qualitative research in this study was considered the most appropriate method to gain an in-depth understanding of the contextual factors and/or phenomena that characterize PHC integration in South Africa. Although a number of views and/or opinions have been advanced regarding PHC and its state of delivery in the country, very little or no research has been done to examine the meaning of PHC integration within the South African context and as such, develop a common frame of reference for policy development, implementation and evaluation. Hence, the grounded theory approach was selected as the most appropriate approach for a study aimed at developing a context-driven framework for PHC integration.

3.2 GROUNDED THEORY APPROACH

A grounded theory approach is appropriate for this study as it is a method known for its ability to make the greatest contribution in areas where little research has been done and when new viewpoints are needed to describe a familiar phenomenon that is not clearly understood (Chenitz and Swanson, 1986: 7). The researcher was interested in developing a theory which explains the meaning of IPHC as applied in the delivery of PHC services within the DHS in

South Africa. Strauss and Corbin (1990: 23) define a grounded theory as “one that is inductively derived from the study of the phenomenon it represents”. That is, it is discovered, developed, and provisionally verified through systematic data collection and analysis pertaining to that phenomenon. Therefore, data collection, analysis and theory exist in a reciprocal relationship with each other. The emphasis of grounded theory is on new theory generation. A theory, according to Strauss and Corbin (1998: 15) is “a set of well developed categories that are systematically interrelated through statements of relationship to form a theoretical framework that explains some relevant social, psychological, educational, nursing or other phenomenon”. These authors further state that the theory that is derived from the data is more likely to resemble what is actually going on than if it were assembled from putting together a series of concepts based on experience or through speculation.

3.3 THE BACKGROUND OF THE GROUNDED THEORY

Grounded theory has its roots in Sociology in the 1960s and as a formal methodology, grounded theory was first presented by Glaser and Strauss in their 1967 book, *The Discovery of Grounded Theory.* Glaser and Strauss first described the method of grounded theory in 1967 as a means of enabling the systematic discovery of theory from the data of social research (Glaser and Strauss, 1967: 3). The book was premised on a strong intellectual justification for using qualitative research to develop theoretical analysis. Glaser and Strauss (1967) developed grounded theory as both a research methodology derived from the assumptions and theoretical underpinnings of symbolic interactionism and a method for systematically deriving empirically based theories of human behaviour and the social world through an ongoing process of comparative analysis (Kendall, 1999: 745). Since its origin, grounded theory as a method has experienced some diffusion and variation in its application. The current debate regarding grounded theory has occurred since the publication in 1990, of *Basics of Qualitative Research,* by Strauss and Corbin (1990). Strauss and Corbin

published this book to help grounded theorists, especially beginners, learn to construct in-depth research studies in a consistent manner. They, therefore, perceived a need to fill the gap in the methodology literature on the processes involved in generating meaningful grounded theories from qualitative data.

Since then two different approaches have emerged; the Glaserian (after Barney Glaser) and the Straussian (after Anselm Strauss). The root of the difference between Glaser and Strauss lies in the diverse philosophical stances held by the two researchers and their consequential ontological, epistemological and methodological implications (Annells, 1996: 387). They differ in how they view the procedures and processes of grounded theory. Glaser left teaching and went into business, leaving Strauss to answer the multiple charges laid against grounded theory. Glaser's approach remained faithful to the original joint description of the grounded theory method. In response to Strauss and Corbin's (1990) publication, Glaser published *Emergence vs Forcing: Basics of grounded theory analysis* in 1992, which denounced Strauss and Corbin's approach for being more about conceptual description than emergent theory. Glaser and Strauss have different views in the following aspects: (a) sources of research question, (b) the use of technical literature and personal and professional experiences in grounded theory, (c) data analysis, and (d) verification and validation of the emerging theory and hypothesis.

According to Strauss and Corbin (1990: 38) the research question is developed as early as the beginning of the study. The rationale provided by these authors is that in grounded theory a research question "is a statement that identifies a phenomenon to be studied" (1990: 38). It is oriented towards action and process. In other words "the original research question is a directive that leads the researcher immediately to examine a specific performance, the site where events are occurring, documents, people acting, or informants to be interviewed. It gets the researcher started and helps him or her stay focused throughout the research project" (Strauss and Corbin, 1990: 39). These authors further argue

that having a research question at the beginning of the study sets the boundaries on what will be studied because it is impossible to cover all aspects of a phenomenon. The research question narrows the study field to a researchable size.

Glaser, on the other hand, is not in favour of having a research question from the beginning of the study. According to him the grounded theory researcher starts with an area of interest, not a professionally preconceived problem, but often an area containing a life cycle of interest. "The grounded theorist has no preconceived view of what problems they may encounter in the research or how the participants resolve their problem. He lets the problems and continued resolving emerge" (Glaser, 1998: 118). He states that grounded theory requires a suspension of knowledge about the problem. Glaser felt that having a research question from the initial phase of the study is limiting in that the developed theory may not naturally develop from the data, but will be shaped by the research question. He believes that the research problem and question are only discovered when coding begins (Glaser, 1998: 123).

Glaser and Strauss also have different views on the use of technical literature and personal and professional experiences in grounded theory. Strauss and Corbin (1990: 23) allow for priority theory, technical and non-technical literature and personal as well as professional experience to enter the field of research. They further state that all kinds of literature can be used before the research study is begun and during the study itself. Strauss and Corbin warn that the previous knowledge should not be taken as a given, testable framework on how to explain a phenomena. Instead it should serve as a source of inspiration. They further argue that selective sampling of the second body of literature review should be woven into the emerging theory during the third stage on grounded theory induction, the stage that is termed 'concept development'. This is supported by Smith as cited by Hunter et al. (2005: 59) in suggesting that general reading of literature may be carried out to obtain a feel for the issues at work in

the subject area, and to identify any gaps to be filled using grounded theory. He further states that the researcher is able, therefore, to approach the subject with some background knowledge, but it is important that the reading is not too extensive as the theories should evolve from the data itself, producing a grounded theory.

On the contrary, Glaser objects to previous knowledge entering the field of research, especially during the analysis. Glaser (1992) maintains that literature should not be reviewed in the substantive area of study so as not to contaminate, constrain or impede the emerging categories, their properties and theoretical codes. Glaser believes in pure methodology that completely refrains from drawing on any kind of previous knowledge, because he believes that any previous knowledge would guide the intentions of the researcher in specific ways. He is concerned that in supplementing external signs with personal experience, Strauss promotes movement away from groundedness and towards subjectivity and dogmatism. Glaser proposes that to the extent that this drift occurs, it restores the rational approach to theorizing that the grounded theory method was designed to offset. Glaser (1998: 8) argues that all is data. He further states that the researcher would perhaps be unwise to carry out reading that provides him with anything more than a partial framework of local concepts, which designate a few principal or gross features of the situations that he/she will study. Glaser believes that the literature should be used to gain an overall picture of the research problem and afterwards to confirm the theory. Glaser's theory involves induction initially followed by deduction once the theory emerges. Glaser (1998: 67) maintains that literature review should not be done in the substantive area and related areas where the research is to be done. He further states that when grounded theory is nearly completed, that is during the sorting and writing up, then the literature search in the substantive area can be accomplished and woven into the theory as more data for constant comparison. Strauss's approach involves using the literature to identify phenomenon. In essence, it would appear that Glaser views grounded theory as situated in post-

positivist paradigm of enquiry while Strauss has been developing grounded theory from a constructive stance (Annells, 1996: 389).

The difference between Glaser and Strauss continues on the process of data analysis. Each of them describes coding as an essential aspect of transforming raw data into theoretical constructs of a social process, but the types of coding processes differ. Glaser's process is characterized by two coding processes: substantive and theoretical coding. Substantive codes conceptualize the empirical substance of the area of research whereas the theoretical codes conceptualize how the substantive codes may relate to each other as hypotheses to be integrated into the theory (Glaser, 1978: 55). On the other hand, open coding, axial coding and selective coding using the paradigm model characterize Strauss and Corbin's process (1990: 61) and this will be discussed later in detail. The main controversy involves Strauss and Corbin's addition of an intermediary set of coding procedures, called axial coding. Strauss and Corbin (1990: 111) claim that the use of the paradigm model to construct a grounded theory allows one to use thinking processes that are natural to most people, thereby helping researchers "capture as much of the complexity and movement in the real world that is possible". Glaser (1978) insists that the codes used, in fact, the actual labels placed on the codes should be driven by conceptual interests that have emerged from the data and not "forced" into any particular scheme, such as the paradigm model. Strauss recommends that data analysis is conducted predominantly through deduction. This has been criticized by Glaser who suggests that the researcher would be making assumptions about what is in the data as opposed to what actually exists.

Glaser (1992) makes theory generation versus theory verification a central theme in his text in his criticism of Strauss and Corbin's approach. According to Strauss and Corbin (1990: 109) verification and validation are important when developing a theory. Verification is important during axial coding, where the researcher verifies the hypotheses against actual data. If the researcher has questions

about certain categories, he or she has to return to the data and look for evidence, incidents and events that support or refute the question. On the contrary, Glaser believes in constant comparative analysis so as to develop a theory that is grounded on data. He does not favour verification and validation like Strauss, as in his view, verification and validation fall outside the parameters of grounded theory. He believes in emergence. On the other hand, Strauss and Corbin (1990: 133) believe that validating one's theory against the data completes its grounding. Validation is conducted by laying out the theory in memos either diagrammatically or narratively. Then the statements regarding the category relationships under varying contextual conditions are developed and finally validated against the data. The statements are checked against each case to determine whether they fit or not. The researcher looks at whether they fit in a general sense and whether they fit in most cases, not necessarily in every case. Modifications and changes can be made in the statements until a general match is made. Glaser is against the validation process because it forces the data to fit into preset categories. Glaser continues to argue in favour of being true to the original belief that the theory should emerge from the data and claims that Strauss and Corbin's approach means, not a grounded theory but a "forced" description (Glaser, 1998: 104). Strauss and Corbin reject this, saying the data "are not being forced; they are being allowed to speak" (Strauss and Corbin, 1990: 119).

As a result of these divergences, it is incumbent on every researcher using grounded theory to indicate which implementation of the methodology they are using. Though acknowledging and recognizing the spirit of Glaser's original version, this study employed Strauss and Corbin's approach. Strauss and Corbin's approach is more appropriate for this study because the researcher had to review literature on PHC within a district health system and this allowed the researcher to approach the subject with some background knowledge that enabled her to develop a theory based on the emerging concepts and categories. Secondly, the researcher herself embarked on this study with knowledge and

previous experience of PHC as an educator of the subject. Strauss and Corbin argue that the researcher's prior experiential data, basically their personal and professional experience, is supportive of theory building and contributes to theoretical sensitivity, the ability to understand the data's important elements and how they contribute to theory. Thirdly, the researcher used Strauss and Corbin's approach for data analysis because it provides a concrete, structured and clear way to analyze grounded theory data.

3.4 SETTING

Qualitative researchers collect their data in real world, in other words in a naturalistic setting (Polit and Beck, 2004: 248). In grounded theory the selection of settings is directed by theoretically relevant concepts. Therefore, the researcher selected only those districts where integrated PHC was implemented. In line with the DHS, there are four levels of care in the KZN province, namely 554 clinics; 17 community health centres (CHCs); 41 district hospitals; 18 specialized hospitals; 10 regional hospitals and three tertiary hospitals. The study took place in selected health districts in KwaZulu-Natal (KZN) province to enable the researcher to undertake an in-depth study to analyze the PHC delivery within the DHS. There are 11 health districts in KZN. They are Ugu (DC 21), uMgungundlovu (DC 22), Uthukela (DC 23), Umzinyathi (DC 24), Amajuba (DC 25), Zululand (DC 26), Umkhanyakude (DC 27), Uthungulu (DC 28), Ilembe (DC 29), Sisonke (DC 43) and eThekwini (Durban). The map showing health districts in KwaZulu-Natal is indicated in Figure 3. As discussed earlier in Chapter 2, the boundaries of the health district coincide with the district and metropolitan municipal boundaries (Department of Health, 2004). According to census statistics for 2003, out of nine provinces in South Africa, KZN has the highest population of 9, 5 million out of a population of 45 million that is served by these 11 health districts.

3.5 BACKGROUND OF SELECTED KZN HEALTH DISTRICTS

3.5.1 Health district A

Health district A is in a metropolitan area. According to the District Health Plan 2007-2008, the total area of this district is only 1, 4% of the total area of the province and it contains over a third of the population of KZN and 60% of its economy activity (KZN Department of Health, 2006a). This district has a population of 3 388 835, which is 33, 9% of the total population of the Province's 9 700 000. Only 35% of the municipal area is predominantly urban and the remainder is rural to semi-rural. The District Health budget for the 2006/2007 financial years was R3 215 776 (30, 9%) of the provincial's budget's R10 379 202 allocation (KZN Department of Health, 2006a: 10). PHC services in this district are jointly provided by the Provincial Department of Health and the Local Government Authority, with the former contributing 60% and the latter 40%. Provincial facilities within the eThekwini District are distributed as follows: eight CHCs and 47 PHC clinics. On the other hand the Municipality has 77 PHC clinics and 15 mobile units, with one CHC shared by both authorities. According to KZN Department of Health (2006a: 9) health district A is in the process of devolving PHC services to local government in order to integrate provincial PHC services within the context of the overall city plan and this has not yet been realized. The catchment population ratio per clinic is 1:22570 which is above the national norm of 1:150000.

3.5.2 Health district B

Health district B is located in the midlands of the KZN Province. The district consists of seven local municipalities (KZN Department of Health, 2006b: 8). According to the District Health Plan 2007-2008, health district B has a population of 996 342 (KZN Department of Health, 2006b: 8). The district has 48 fixed clinics, 17 mobile clinics, four CHCs and nine hospitals (KZN Department of

Health, 2007). Out of 48 fixed clinics, 22 are provincial clinics, 17 local government clinics, eight satellite clinics and two state aided clinics (KZN Department of Health, 2006b: 21). 75% of the identified clinics are open 24 hours a day and 53% offer services over extended hours.

3.5.3 Health district C

Health district C is located in the south of KZN Province. Health district C has a population of 704 141 and comprises six local authority areas. The district has three district hospitals, one regional hospital, one state-aided hospital, 47 fixed clinics and 15 mobile clinics with 214 visiting points. There are also 10 local authority clinics in the district (KZN Department of Health, 2007). It is currently estimated to serve 88% of the districts' population, 12% of the population is considered to have Medical Aid and visit private health facilities (KwaZulu-Natal Department of Health, 2006c: 4). According to the District Health Plan 2007/08, 84% of the population is rural and communities are characterized by poor access to services, lack of roads and other communication infrastructure and a relatively low level of access to social, education and health services.

3.5.4 Health district D

Health district D is located in the northern eastern part of KZN Province. According to the District Health Plan (2007-2008), this district is 90% rural (KZN, Department of Health, 2006d: 9). Health district D has a population of 872 932 and comprises five local authority areas. The district has five district hospitals, two specialized hospitals, three state-aided hospitals, 58 fixed clinics and 11 mobile clinics with 215 visiting points. The district also has two local authority clinics (KZN Department of Health, 2007). This district is the biggest geographically and as a result, health facilities are far apart. The poor condition of the roads in the district hinders access to health care services and make recruitment and retention of staff difficult.

Figure 3: The map showing health districts in KwaZulu-Natal (KZN Department of Health, 2007)

3.6 SELECTING CASES

Polit, Beck and Hungler (2001: 234) define sampling as the process of selecting a portion of the population to represent the entire population. An essential feature of grounded theory research is the continuous cycle of collecting and analyzing data. Theoretical sampling is generally accepted as a critical feature of grounded theory. Glaser and Strauss (1967: 45) define theoretical sampling as "the process of data collection for generating a theory whereby the researcher jointly collects, codes and analyses data and decides what data to collect next and where to find them in order to develop a theory as it emerges". In addition to theoretical sampling, a fundamental feature of grounded theory is the application of the constant comparative method. As the name implies, this involves comparing like with like, to look for emerging patterns and themes. Through constantly comparing new data, old data and emerging categories, its aim is to generate categories, the properties of which form the basis of the theory being produced. In other words, data analysis informs subsequent data collection and sampling. Therefore, sampling strategy is not pre-determined before the grounded theory began but is directed by the emerging theory (Glaser, 1978: 36).

In terms of obtaining a suitable size in grounded theory, the grounded theorist does not decide on the size of the sample population before the study begins. Sample size is deemed to be satisfactory only when the key concepts that have been identified from the collected data have reached saturation point: in other words, when no new data emerges (Glaser and Strauss, 1967: 61). These authors further state that in research carried out for discovering theory, the researcher cannot cite the number and types of groups from which he/she collected data until the research is complete.

The basic criterion governing the selection of comparison groups for discovering theory is their theoretical relevance for furthering the development of emerging categories. The researcher chooses any group that will help generate, to the

fullest extent, as many properties of the categories as possible and that will help relate categories to each other and their properties (Glaser and Strauss, 1967: 49). Participants selected in grounded theory should be rich in information. As has been stated before, participants are selected on the basis of their ability to contribute to the development of theory. More importantly, grounded theory requires an interactive process of data collection, coding, analysis and planning what to do next (Strauss and Corbin, 1998: 101-105). Therefore, a three stage selection plan was applied to select a sample from the accessible population. The first stage of the selection involved the theoretical sampling of those health districts that purported to have implemented integrated PHC in KZN. The researcher then purposively selected regions according to their geographical location since the boundaries of the health district coincide with the district and metropolitan municipal boundaries. These districts are central (Health district A), midlands (Health district B), south (Health district C) and north (Health district D). Health districts A and B are situated in urban areas and Health districts C and D are situated in rural areas. It is often assumed that urban health services are better resourced than rural services; therefore, it is important to analyze one of each in order to investigate differences in PHC delivery within the DHS. There are 61 municipalities in KZN: 1 metropolitan area (Category A); 50 local municipalities (Category B) and 10 district municipalities (Category C) (KZN Department of Health, 2007). Health district A falls under category A and health districts B, C and D fall under category C.

The second stage of the selection involved the theoretical selection of clinics located within these four districts to collect data on integrated PHC. As mentioned before, some of these clinics fall under the local authority and some under the provincial services. When selecting the clinics, the sample consisted of the clinics under the local authority and provincial services. The third stage involved the theoretical selection of policy makers at the district, provincial and national levels that were involved with PHC co-ordination. Selection of participants at the various clinics continued until data saturation had occurred.

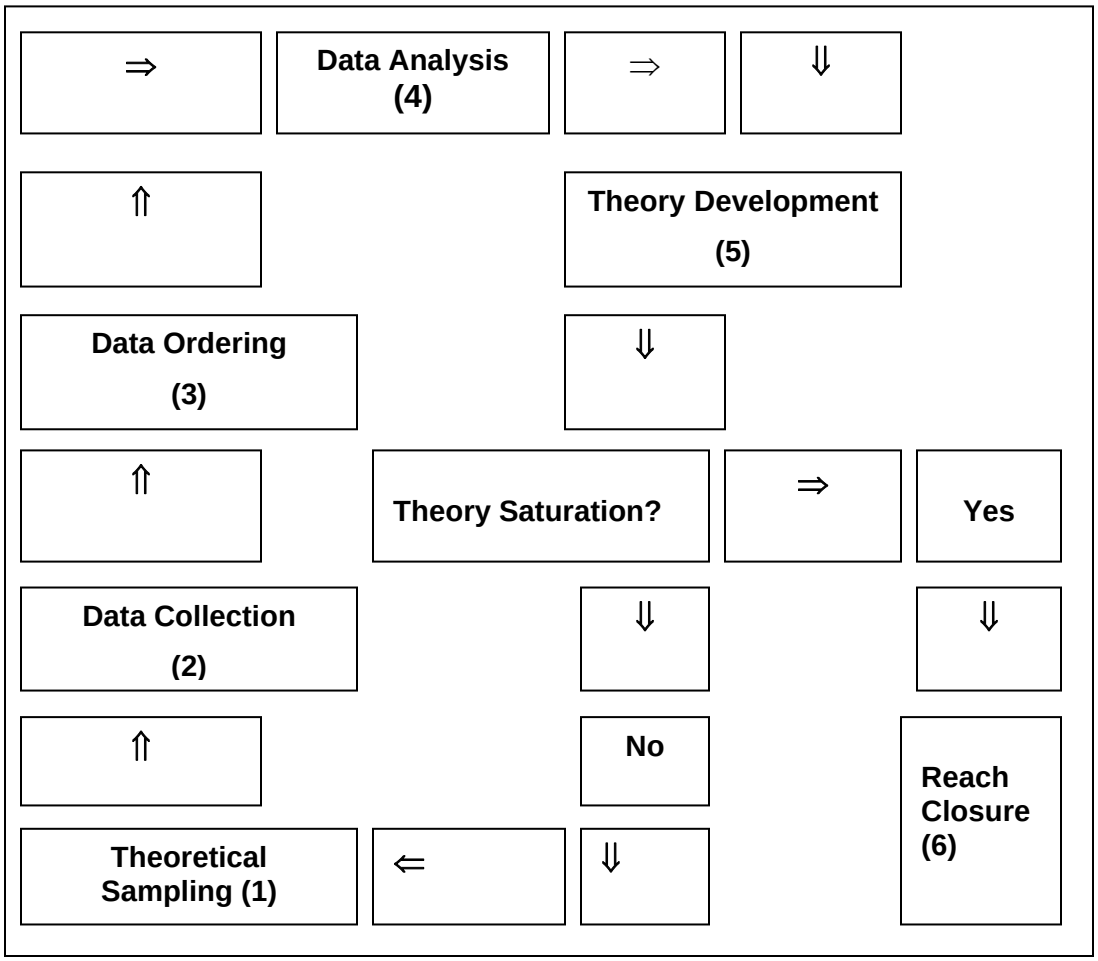
3.7 SAMPLE DESCRIPTION

The sample consisted of PHC policy makers at National, Provincial and District levels. The Provincial and National Deputy Directors for PHC and District Programmes Managers were interviewed. At a functional level, observations were done at one clinic per municipality and thereafter a person-in-charge or his/her deputy in case where the charge nurse was not available, was interviewed. Theoretical sampling continued until the stage where saturation was reached. Saturation was decided by the completeness of all codes when no new conceptual information was available to indicate new codes or the expansion of new codes. According to Glaser (1978: 36), theoretical sampling on any code ceases when it is saturated, elaborated and integrated into the emerging theory. The researcher ultimately achieved a sense of closure by repeatedly checking and asking questions to contrast and compare the emerging conceptual framework as indicated by Glaser (1978: 39).

To be exact, observations were done in 32 clinics. Out of 32 clinics, 53% (N=17) were located in urban areas and 47% (N=15) in rural areas. The sample size for interviews comprised 38 participants. Of these, one was the National Deputy Director and one Provincial Deputy Director for PHC, there were four Programmes Managers from the four districts who participated in the study in order to establish what IPHC meant to them as policy makers. From each sampled clinic per municipality, a professional nurse-in-charge or the deputy in case the person-in-charge was not available, was interviewed. Therefore, at functional level, 28 professional nurses-in-charge and four deputy professional nurses-in-charge were interviewed.

3.8 DATA COLLECTION AND ANALYSIS

Grounded theory does not start with a hypothesis, but rather collects and explores data to generate theories. As data collection proceeds, the inquiry becomes increasingly focused and emerging theoretical concerns and on core processes. In this approach, the process of data collection and analysis is not separable but is an integrated process as depicted in Figure 4. In relation to the purpose of the study, the grounded theory was used to guide the organization, analysis and interpretation of the results. Grounded theory emerges from direct involvement with the empirical world to enhance the collection of rich data. The collection of data was done in two phases and through the use of multiple sources of data in order to strengthen emerging theory and to enhance internal validity.



Source: (Pandit 1996: 7)

Figure 4: Interrelated processes of data collection, data ordering and data analysis to build grounded theory

3.8.1 Phase 1

The first phase of data collection entailed in-depth interviews with the district, provincial and national health officials that were involved with PHC co-ordination and policy making. In-depth interviews at this phase were informed by the emerging concepts, categories and propositional statements.

3.8.2 Phase 2

The second phase was directed towards analyzing the PHC delivery within the DHS. During this phase, data was collected by means of observations and interviews. The researcher began by observing how the services were offered from the time a patient arrives at the clinic until discharge. Observations included looking, listening and asking questions as they arose out of observations in order to offer insight into what was observed. Individual interviews were then conducted with one PHC nurse, preferably the person in charge at the clinic level after doing the observation. Interviews based on the data that emerged during observations were conducted. Glaser maintains that in grounded theory "there is no such thing as observation without interviews to give them meaning; the reverse is also true" (1998: 109). The intention was to do cross checking, filling of gaps and verification of categories and concepts that emerged from the data. This is supported by Chenitz and Swanson (1986: 88) who state that the use of observation and formal interviewing increases validity by decreasing reactivity of the subjects. They further argue that validity is increased since it assures that the truth in the observations is checked with the active questioning of the interview situation. The basic assumption is that the respondents are telling the truth. During this phase, the researcher spent a minimum of five days in each health district. Observations were planned in such a way that some were done when clinics were busy and some when they were nearly empty. This enabled the researcher to get a picture of what was happening during busy times and also during quiet times. Data collection continued concurrently with data

analysis. This procedure is used to constantly compare data that have already been gathered so that commonalities and variations can be determined.

In line with basic tenets of grounded theory, observational and document analysis instruments were developed based on data obtained from interviews. A tape recorder was used to back up the notes compiled during the interview sessions. Hand written notes were utilized to provide backup information throughout the process of data collection. The interviews were transcribed within 24 hours of being conducted and, together with the field notes, formed the database for the research. The two broad questions that were asked to facilitate the discussion were:

- What is the meaning of integrated PHC?
- What is the nature of events regarding the integration of PHC services?

Additional questions based on the outcome of the interviews were asked. See Table 6 for a summary of data collection methods and triangulation of data sources.

3.8.3 Data analysis

Analyzing data by the grounded theory method is an intricate process which reduces raw data into concepts that are designated to stand for categories (Chenitz and Swanson, 1986: 102). Therefore, memos and diagrams were used during data collection and analysis. Memos are written records of analysis and diagrams are visual devices that depict the relationships among concepts (Strauss and Corbin, 1998: 217). These authors state that memoing and diagramming should begin with initial analysis and continue throughout the research process so that the analysts will move from working with data to conceptualizing. Strauss and Corbin (1990: 10) maintain that writing memos is an integral part of doing grounded theory since the analyst cannot readily keep track of all the categories, properties, hypotheses and generative questions that evolve from the analytical process. This is further supported by Glaser who

maintains that the basic goal in memoing is to develop ideas with complete freedom into a memo fund that is highly sortible (1978:83).

The aim of using the grounded theory is the identification of core categories achieved by the grouping and integration of coded concepts under a single cover term. Grounded theory is a repetitive process because the analyst is required to return constantly to data sources to check aspects of the emerging interpretation and to gather a new data, when and where appropriate. As mentioned before, in this approach, the process of data collection and analysis is not separable but is an integrated process. Therefore, the researcher analyzed the data as she continued with data collection.

The researcher used Strauss and Corbin's process of data analysis. Coding methods were used to analyze data. Strauss and Corbin (1990: 57) define coding as the actual process through which the data are broken down, conceptualized and put back together in new ways into some form of theoretically meaningful structure. According to Strauss and Corbin (1990:61-117) at the heart of the grounded theory are the three coding procedures: open coding, axial coding and selective coding as illustrated in Figure 5. Open coding is the process of breaking down, examining, comparing, labelling and categorizing data. The product of labelling and categorizing are concepts – the basic building blocks of grounded theory construction. Out of open coding process evolve additional questions that need to be asked and data which needs to be examined until the stage where no new categories emerge from the process.

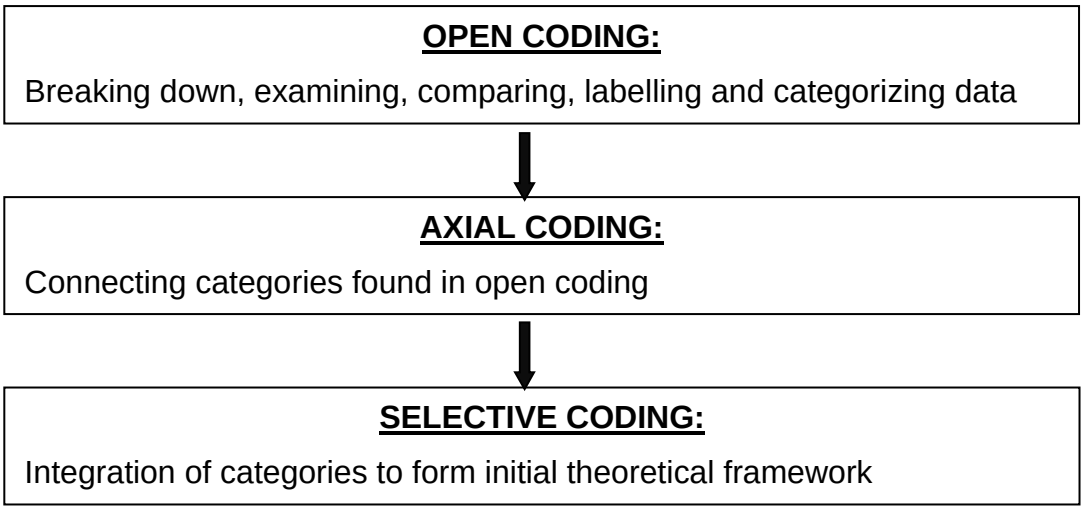
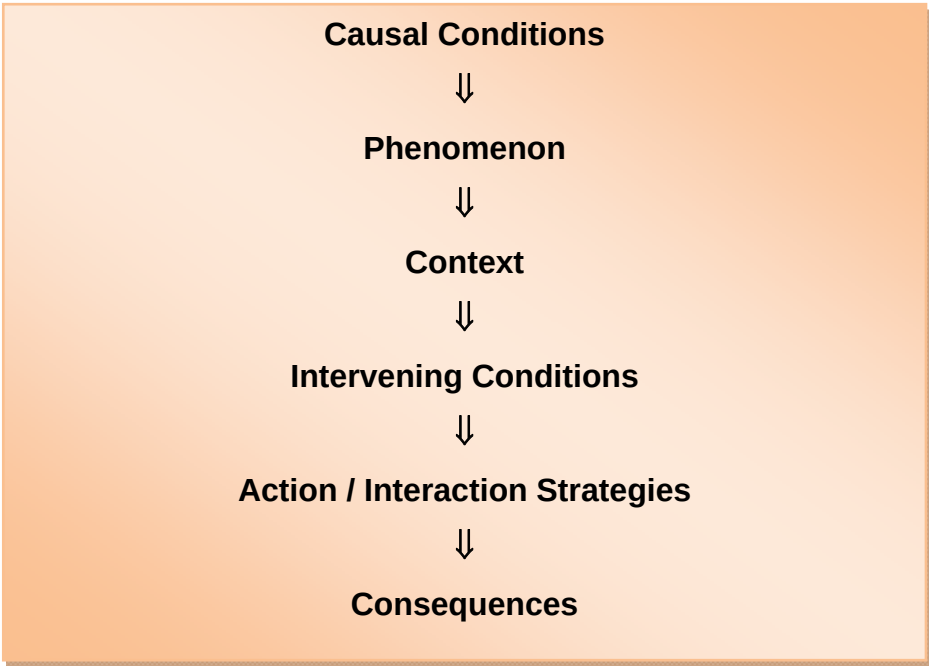


Figure 5: Strauss and Corbin's process of data analysis

Subsequently, data is being compared and similar incidents grouped together and given the same conceptual label. The process of grouping the concepts at a higher, more abstract level is termed categorizing (Strauss and Corbin, 1990: 61). The researcher uses using the microanalysis approach to generate the categories. Strauss and Corbin (1998: 57) define microanalysis as "the detailed line-by-line analysis necessary at the beginning of a study to generate initial categories and to suggest relationships among categories; a combination of open and axial coding". Whereas open coding fractures the data into concepts and categories, axial coding puts those back together in new ways by making connections between a category and its sub-categories. According to Strauss and Corbin (1990: 96) axial coding involves procedures for connecting categories found in open coding. Microanalysis, therefore, includes open and axial coding. This is done by utilizing a coding paradigm involving conditions, context, action/interactional strategies and consequences. Selective coding on the other hand is the process of selecting the core category and systematically relating it to other categories that need further refinement and development. Therefore, selecting coding involves the integration of the categories that have been developed to form the initial theoretical framework.

3.9 THE PARADIGM MODEL

In grounded theory, axial coding subcategories are linked to a category in a set of relationships according to the paradigm model, the basic purpose of which is to enable the researcher to think systematically about data and relate to them in complex ways. By answering the questions of who, when, where, why, how, and with what consequences, analysts are able to relate structure with process. Hence Strauss and Corbin (1998: 127) identify the paradigm which is an "analytic tool devised to help analysts integrate structure with process". This paradigm model is an organizing scheme that connects subcategories of data to central idea, or phenomenon, to help the researcher think systematically about the data and pose questions about how categories of data relate to each other (Strauss and Corbin, 1990: 99). The paradigm model denotes the causal conditions, phenomenon, context, intervening conditions, action/interactional strategies and consequences. The basic features of this model are depicted in Figure 6. According to Strauss and Corbin (1998: 130) phenomenon is a term that answers to the question "What is going on here?" It is the core category which is the central idea, repeated patterns of happenings, events or actions/ interactions that represent what people do or say, alone or together in response to the problems and situations in which they find themselves. Causal conditions are the events that lead to the development of the phenomena. Context refers to the particular set of conditions and intervening conditions, the broader set of conditions, in which the phenomena is managed. Contextual conditions have their source in causal (and intervening) conditions and are the product of how they crosscut to combine into various patterns dimensionally. Action/interactional strategies refer to the actions and responses that occur as the result of the phenomenon and the outcomes, both intended and unintended, of these actions are referred to as consequences.



Source: Pandit (1996: 7)

Figure 6: The Paradigm Model

3.10 CRITERIA FOR EVALUATING THE QUALITY OF A GROUNDED THEORY STUDY

There are no agreed upon criteria for evaluating the quality of research using the grounded theory. The criteria currently thought of as the gold standard for qualitative researchers are those outlined by Guba and Lincoln (1985). These researchers have suggested four criteria for establishing the trustworthiness of qualitative data: credibility, dependability, confirmability and transferability. How a grounded theory is presented offers a number of challenges to the researcher in terms of structure, level of detail included and how the data are portrayed to display evidence for the emergent categories. Strauss and Corbin's grounded theory suggest that good grounded theory should initially be judged on criteria related to the process of generating theory. Firstly, the data needs to be valid,

reliable and credible. Secondly, the research process should be adequate. Thirdly, the research findings should be empirically grounded (1990: 253-257).

3.10.1 Ensuring good data is obtained

Grounded theory research can make use of a wide variety and combination of data collection methods (Strauss and Corbin, 1990: 55). Therefore, to ensure the richness and depth of data as well as to enhance the credibility of this study, triangulation is implemented by using multiple sources of data. These sources included the managers and PHC nurses. For method triangulation, different methods of data collection are used and these include in-depth interviews and observations. Multiple data collection methods provide an opportunity to evaluate the extent to which an internally consistent picture of the phenomenon emerges (Polit and Beck, 2004: 432).

3.10.2 Ensuring rigour in the research process

Theories should be traceable to the data that gave rise to them (Strauss and Corbin (1994: 274). Strauss and Corbin (1990: 253) provide seven criteria in question form that can be used to evaluate the research process:

1. How was the original sample selected? On what grounds?
2. What major categories emerged?
3. What were some of the events, incidents, actions and so on (as indicators) that pointed to some of these major categories?
4. On the basis of what categories did theoretical sampling proceed? That is, how did theoretical formulations guide some of the data collection? After the theoretical sampling was done, how representative did these categories prove to be?
5. What were some of the hypotheses pertaining to conceptual relations (that is among categories), and on what grounds were they formulated and tested?

6. Were there instances when hypotheses did not hold up against what was actually seen and how were these discrepancies accounted for?
7. How and why was the core category selected? Was this collection sudden or gradual, difficult or easy? On what grounds were the final analytic decisions made?

3.10.3 Ensuring empirical grounding in grounded theory research findings

Strauss and Corbin (1990: 254-257) provide seven criteria in question form that can be used to evaluate empirical grounding in research findings:

1. Are concepts generated?
2. Are the concepts systematically related?
3. Are there many conceptual linkages, and are the categories well developed?
4. Is much variation built into the theory?
5. Are the broader conditions that affect the phenomenon under study built into its explanation?
6. Has the process been taken into account?
7. Do the theoretical findings seem significant, and to what extent are they significant?

3.10.4 Evaluating the theory

Glaser and Strauss (1967: 237-249) identify four central criteria for judging the applicability of the theory to a phenomenon, namely fitness, understanding, generality and control. The criterion of fitness requires that the theory must fit the substantive area and correspond to the data. Data should not be forced or selected to fit pre-conceived or pre-existent categories or discarded in favour of keeping an extant theory intact (Glaser, 1978: 4). Understandability implies that the theory must make sense to all the participants in the study. Generality implies that the theory is abstract enough to have a wider application without

losing its relevance. The criterion of control requires that the theory should enable the person, who uses it to fully understand and analyze the situations, be able to predict change and its consequences, and be capable of revising his/her actions and act appropriately.

3.11 ETHICAL CONSIDERATIONS

Permission to conduct the study was obtained from the KZN Department of Health. Authorities from the different institutions concerned were approached for consent to conduct a study. The rights of participants were safeguarded through written informed consent and confidentiality. Participants were assured that participation in the study would not in any manner affect their lives in the settings either as employees or consumers. Participants were informed that they were free to withdraw from the study at any time.

3.12 CONCLUSION

As stated before, it is incumbent on every researcher using grounded theory to indicate which form of the methodology they are using. One grounded theory approach is not necessarily superior to another, and the decision to use a particular approach depends on the goal of the research study, description or theory generation.

TABLE 6: Summary of data collection methods, triangulation of data sources – management and operational levels

Objectives	Data source	Methods	Questions
Analyze the term integration of PHC services	• National PHC directorate • Provincial PHC directorate • District Management • PHC nurses	• In-depth interviews	• What does the term IPHC mean to you?
Analyze PHC delivery within a DHS	• PHC clinics Role players: • National PHC directorate • Provincial PHC directorate • District management • PHC nurses	• Observation • In depth interviews	• Observe how IPHC is implemented • What are the major events that led to the development or implementation of IPHC? • What processes do you have in place to ensure that PHC services are offered in an integrated manner? • What makes this approach work in your clinic/ district? • What would you need to be in place in order for this approach to really work? • What has this approach done in terms of your service as it relates to patient outcome? • What are the challenges in offering your clinic services?

CHAPTER 4

PRESENTATION OF THE RESULTS

4.1 INTRODUCTION

According to Glaser and Strauss (1967: 65) in theoretical sampling, no one kind of data collection is necessarily appropriate. The findings presented in this chapter resulted from the 'slices of data' obtained during observations that were done at the PHC clinics and the results of the in depth interviews with the PHC nurses and policy makers at district and national levels. According to Strauss and Corbin (1990: 63) "theories can't be built with actual incidents or activities as observed or reported; that is, raw data. The incidents, events, happenings are taken as, or analyzed as, potential indicators of phenomena, which are thereby given conceptual labels". Therefore, conceptualizing data becomes the first step in analysis. Strauss and Corbin further state that once the particular phenomena in the data have been identified, the researcher can then begin to group concepts around them to reduce the number of units to work with. These authors refer to the process of grouping concepts that seem to pertain to the same phenomena, as categorizing (1990: 65). Hence, presentation of the results of the data in this study is therefore organized under the subheadings which were used in the paradigm model in Figure 6 which include the phenomenon, causal conditions, context, action/ interactional strategies and consequences.

Analysis began with open coding where transcribed interviews were read and coded line by line to identify descriptions of thoughts and actions. Substantive codes were developed and formulated in the words used by the participants themselves. As IPHC was the phenomenon of interest in this study, it became the core concept around which other concepts revolved. Through constant comparison of substantive codes, similar codes were uncovered and labelled. Substantive codes with same meaning were grouped into descriptive categories

and subcategories. Axial coding revealed concepts related to each other. This enabled the development of the core concept. All concepts were linked to the core concept via selective coding. Constant comparison between the categories continued until they were theoretically saturated.

The results are outlined in a manner which indicates how the objectives of the study were achieved. The outline is as follows: (a) the conceptualization of IPHC, (b) factors that contributed to the integration of PHC services (causal conditions), (c) the context within which IPHC is practiced, (d) the actualization and practice of IPHC (action/ interaction), (e) intervening conditions, and (f) intended and unintended outcomes of IPHC (consequences).

4.2 CONCEPTUALIZATION OF IPHC

All participants who were interviewed understood the IPHC services as the provision of all services in the clinic as stated in the comprehensive PHC core package. However, they expressed different views regarding the process of the provision of these services. The researcher noted that the participants used the terms ‘supermarket approach’ and ‘one stop shop’ interchangeably, yet their understanding of these two terms had different meanings. The following conceptual categories for understanding the integration of PHC services emerged from the data analysis process:

4.2.1 Comprehensive health care

Comprehensive health care as a strategy for ensuring the availability of a range of services was identified as a common theme among all interviewees. The participants understood IPHC as a comprehensive basket of services to be delivered at PHC level which may include preventive and promotive services including curative and rehabilitative services that seek to remove root causes of

the diseases. The following excerpts from the interviews with participants support this theme:

> ***I understand IPHC as a basket of services that must be available in the clinic in order to address all the needs of the community as stated in the comprehensive PHC package. In other words, the clinic must provide comprehensive services to the community.***
>
> ***We are providing daily services that are needed by the patients. We work from Monday to Sunday in order to be able to provide comprehensive health care services.***
>
> ***IPHC is stated in the policy document as a comprehensive health care service. You provide all the services everyday for everybody for everything.***
>
> ***IPHC is based on the comprehensive PHC service package which states the type of services that should be available in the clinic.***
>
> ***It has to do with the comprehensive services where you offer preventive, curative and rehabilitative services. All the services are interrelated, for example, if you treat a patient that is infected with HIV, you do not look at HIV only. You look at the opportunistic infections like tuberculosis as well as social aspects to ensure that the patient is managed holistically. If a patient has a sexually transmitted infection, you do not only look for this infection. You refer them for voluntary counselling and testing for HIV and you also do a Pap smear. In other words, it means rendering of all services that the patient needs comprehensively.***

4.2.2 Supermarket approach

The majority of the participants understood IPHC as the provision of all services within the same premises on the same day to increase the level of accessibility of the services to the community. During observation, the researcher noted that the services that were offered at the clinics were listed on the bill board at the entrance of the clinic. Patients moved from one consulting room to another for different services. The following excerpts from the interviews with the participants demonstrate this:

> ***IPHC is an approach where the nurses offer all the services that the patient wants under one roof. It does not necessarily mean that a patient will access all services in one consulting room but it means that the patient will get all other services in the clinic. All the services that are needed by the patient are available in the clinic. This includes ante natal care service, FP, mental health and other services. It is a supermarket service. It is like going to OK Bazaars. If you go to OK, whether you want needles or you want meat or you want mealie meal or hardware, it is there under one roof.***

> ***It is a supermarket type of an approach. The patient must be able to access all the services that she needs, and not to leave the clinic and go elsewhere. When you go to Shoprite, you get everything. There are items that are kept in the fridge; there are things that are kept in shelves. Everything is well organized. We think of the very same shop when we integrate services in PHC.***

> ***It is a supermarket approach where we do everything for the patient before she leaves the clinic. The patient will not be asked to come to the clinic on different days for different services.***

We are trying to provide all the services in one place so that the client can be treated for all symptoms in one place.

During the observation the researcher noted that in the clinics where supermarket approach was used, patients that required more than one service were seen by different nurses. Patients joined different queues in order to access different services. In those clinics where the consulting rooms had interleading doors, the professional nurse referred the patient to another nurse. In such cases, the patient did not join different queues. In some clinics, nurses informed the other nurse telephonically or through the intercom about the patient that needed more services to avoid any delays.

4.2.3 One stop shop

As noted earlier, some participants referred to IPHC as the provision of services to the patient by one nurse. The participants reported that this was done to avoid re-queuing if the patient presented with multiple problems. This decreased the waiting time in the clinic. Furthermore, interviewees reported that this was practiced to increase the level of accessibility of PHC services to the community. From the observations, too, the researcher noted that in these clinics, for patients who needed more than one service, all of these, except immunizations were provided by one nurse in her consulting room. The following extracts are a representation of some of the responses from the participants with regard to the understanding of IPHC:

The nurse does everything for the patient because we have our rooms packed with all the equipment and drugs needed to provide all the services so as to avoid delaying the patient. If I run out of drugs, I personally go out of my room to get the necessary treatment for the patient.

The nurse will do everything for the patient to avoid any delays. Our rooms are well equipped and we have drugs in our rooms. We serve a very poor community who is in a hurry to go back to the fields, so we do not want to delay them. Our staff members have developed a bond with their patients so we try to do everything for the patient so that the patient is comfortable to list all his/her ailments.

One professional nurse does everything for the patient who has multiple symptoms.

I will render all the services that the patient wants except immunization that will be prescribed and the child will be taken to another room for immunization.

4.3 CAUSAL CONDITIONS

Causal conditions are the events that lead to the development of the phenomena (Strauss and Corbin, 1990: 96). From the data sources, it emerged that the need for the integration of PHC services in South Africa arose as a response to (a) health needs of the community, (b) the shortage of staff and limited infrastructure and (c) the fragmentation of PHC services and (d) need for equity and redress.

4.3.1 Responding to the health needs of the community

Participants highlighted that IPHC was put in place to address the health needs of the community, particularly the needs of the poor communities and those from rural areas, as is indicated in the following excerpts from the interviewees' statements:

I think the approach is trying to make the services accessible to the patients and to avoid patients having to move from queue to queue and coming back to the clinic on different days for different services. We are dealing with poor communities and some are critically ill so they cannot afford coming to the clinic repeatedly. It is better to provide all the services at one time.

We want to satisfy the needs of the community at large. We wanted to do away with the situation where we had patients moving up and down and coming to the clinic on different days in a week. So, we wanted to save time and money since we are dealing with a poor community.

We wanted to increase the accessibility of the services because if patients are told to come back on certain days, they do not come back. Our clinic is located in a deep rural area and we serve the poorest of the poor. Some patients pay almost R10.00 for transport to take them to the clinic. So we want to make sure that they get all the services that they want.

It was to ensure easy access of services and to ensure that the patients are given total patient care. The aim was also to shorten the waiting time in the clinic as patients walk a long distance from home to the clinic. We serve a community that is located in a deep, deep, rural area and this community is very poor. There is no transport to take patients to the clinic.

Patients were complaining that they were chased away by nurses when they came for certain services on the wrong day.

4.3.2 Shortage of staff and limited infrastructure

The participants also indicated that IPHC was put in place to address the problem of shortage of staff and limited resources in PHC settings. Since the introduction of free PHC services and the addition of programmes due to the movement of patients from hospital outpatient departments to clinics, participants reported that they were seeing more patients. The following excerpts from the interviews with the participants demonstrate this:

> ***IPHC was put in place to overcome the problems of the shortage of staff and overcrowding in the clinics that resulted from free health service.***

> ***Programmes like the management of chronic conditions were moved from the hospital to the clinics but the nurses did not move with their patients to PHC setting.***

4.3.3 Fragmented PHC services

The participants reported that the main aim of integrating PHC services was to transform the fragmented services into comprehensive and integrated services. The following excerpts from the participants' statements illustrate the point:

> ***Before 1994, there were numerous vertical programmes in PHC clinics that were offered on different days of the week.***

> ***Before 1994, vertical programmes were offered on different days. You would find that a client would come for a service today and the following day for another service, and this resulted in missed opportunities especially with FP, immunization and chronic***

treatment. If patients came on the "wrong day", they would be sent back home.

The integration came about particularly after 1994 to do away with vertical services. Previously we had quite a number of vertical PHC services, for example, mental health clinic, chest clinic, family planning clinic and others and this led to the provision of fragmented health services.

4.3.4 Need for equity and redress

Some of the participants reported that by introducing IPHC, the government was aiming to reduce disparities and inequalities in PHC service delivery and to increase access to improved and integrated services and this was noted in the following excerpts:

IPHC is historical. It dates back to pre 1994 period during the apartheid system. There were different health systems from homelands and these formed part of the health system in South Africa. It was very costly to run these health systems. This resulted in different health services for different people. For example, well-resourced health services for a minority racial group within a bigger system. The management of these services was problematic due to the many authorities rendering services e.g. local authority, province and missionaries.

Post 1994, there was a move to have one health system for one country in order to address the legacy and impact of apartheid on health. As a result, there were elements of transformation that were put in place like streamlining of authority, comprehensive PHC core package. Since May 2006 with the implementation of Health Act,

Chapter 5 legislated DHS and PHC and the emphasis is on the integration of PHC services.

4.4 THE CONTEXT OF IPHC

Context refers to the particular set of conditions under which the phenomena is managed; that is the locations of events or incidents pertaining to a phenomenon along a dimensional range (Strauss and Corbin, 1990: 96). Contextual conditions have their source in causal (and intervening) conditions and are the product of how they crosscut to combine into various patterns dimensionally. In keeping with international trends, South African health policy is moving towards comprehensive PHC. The national health policies emanated as part of the context within which IPHC was introduced. The National Policy Framework that guided the National Department of Health in introducing IPHC includes the Constitution of the Republic of South Africa, the White Paper for the Transformation of Health System, and the Comprehensive PHC Service Package for South Africa.

4.4.1 The National Policy Framework that guided the introduction of IPHC

The drive behind the introduction of IPHC was to transform the health care system in South Africa by improving the accessibility of services to the community. According to the participants, IPHC was regarded as an effort by the government to reduce disparities and inequalities in health service delivery and to increase access to improved and integrated services. These services were to be based on the PHC approach in which the government created a framework for redressing the imbalances, and rectifying the fragmented and inequitable health services in the country.

The participants also cited the 1997 White Paper for the Transformation of the Health System in South Africa as the first pivotal health policy document that

guided the transformation in the health sector to overcome fragmentation of PHC services. They further mentioned that one of the policy measures was to unify the fragmented health services into a comprehensive and an integrated health system to address the legacy and impact of apartheid on health. According to the participants, the National Department of Health has introduced a comprehensive PHC core package which represents the services that should be rendered for PHC services to be regarded as fully comprehensive. They reported that the package was an important tool for monitoring the PHC delivery to ensure more equitable and comprehensive PHC that would be of better quality. The following participants' excerpts clearly demonstrate the National Policy Framework that IPHC was based on:

> ***The Constitution of the country, Section 27 refers to the right to health. It states that patients have a right to access health care services.***
>
> ***I think that the IPHC was put in place to respond to the country's Constitution which talks about rights of patients to access health services. Before 1994, the health system is South Africa was not accessible to everybody in terms of affordability and otherwise.***
>
> ***IPHC was introduced in order to respond to the National Policy of PHC which talks about the integration of services. The comprehensive PHC core package specifies the services that should be available in a PHC clinic.***
>
> ***Integration of PHC services is based on the principles of the DHS as well as the whole transformation of service delivery and I think it is provided for in the White Paper for the Transformation of Health System.***

4.5 ACTION/ INTERACTIONAL STRATEGIES

Action/interactional strategies refer to the actions and/ or strategies devised to manage, handle, carry out, or to respond to a phenomenon under a specific set of perceived conditions (Strauss and Corbin, 1990: 97). The main category that emerged under the action/ interactional strategies was organization of the clinic. The term clinic organization in this study will mean action/interactional strategies that focused mainly on setting up clinic activities in a manner that these ensured smooth running of the clinic. The participants listed the following strategies as means of ensuring smooth running of the clinic: (a) queuing systems, (b) special days for certain programmes, (c) dedicated staff members for certain programmes, (d) rotation of staff members, and (e) extension of hours of service.

4.5.1 Queuing systems

The participants reported that they were using different queuing systems to ensure less waiting time in the clinic. They cited the fast queue, walk through, numbering system and booking system as systems that were put in place to ensure the smooth running of the clinic.

4.5.1.1 Fast queue

Participants reported that they had fast queues for those patients that did not need a full physical examination. The participants used the terms fast queue and quick queue interchangeably. These were the patients that came to the clinic for TB treatment, family planning, mental health and chronic treatment. During observation, the researcher noted that there was only one professional nurse that was allocated for the fast queue and these services were offered mainly during the morning session. The participants explained fast queue as:

We have a quick service for tuberculosis, voluntary counselling and testing for HIV and family planning so as not to delay these patients since they do not need a full examination. One professional nurse is allocated for this queue.

We have two queues in our clinic. One is for patients who have come to collect their treatment for tuberculosis, family planning and chronic conditions. An enrolled nurse is allocated for TB patients and one professional nurse does family planning and chronic ailments. The second one is for patients with acute minor ailments. The clerk will register these patients first so that they are attended to before those who have come for other services. This motivates them to come regularly to the clinic and it decreases the waiting period they spend at the clinic.

The participants further mentioned that they were also using a numbering system to maintain order and avoid patients jumping the queue.

On arrival at the clinic, each patient is given a number at the gate to control the flow of the queue.

We issue patients with numbers on arrival to be able to know who comes after whom as patients usually make noise if they wait for too long in the queue as only one professional nurse is allocated for the fast queue.

4.5.1.2 Walk through

Participants further indicated that they had walk through services for patients with special needs like workers, particularly the farm workers in rural clinics. The participants reported that the services were made available to suit their working hours. This service was offered as part of extended service or they were attended to first before the rest of the patients. Components of this service included family planning, TB treatment, chronically ill patients and immunizations. All these services were offered in this manner so as to increase accessibility of the services and to decrease the waiting time in the clinic as indicated in these extracts:

> ***Before we start with our routine, we always check for patients that need a walk through service. These are the patients that simply come for hypertensive, diabetic or asthma medication. These clients come every single month for treatment, and they are mostly employed in the area. They will lose their jobs if they are going to sit once a month for the whole day in the clinic. So, we pull these clients and they will be helped very quickly. Not always, but we try the same with family planning patients because they are relatively quick; as long as they are not first visits but they are repeats. One professional nurse will see to those for the first part of the morning. The rest will sit according to numbers on the bench.***

> ***When we do rapid appraisal in the morning before we start with consultations, we also identify those that need a walk through service like scholars and patients for repeat treatment. This service is offered so as not to delay these patients.***

4.5.1.3 Numbering system/ Blocking

Participants reported that they also used the numbering system to control queues. They indicated that patients were given numbers on arrival so as to control the queue since patients at times jumped the queue. When the researcher further asked to probe about this method, the participants reported that this system did cause patients to be turned away once the numbers were finished as was the case in the previous years. The following excerpts indicate the manner in which the numbering system operates in these clinics:

> ***On arrival the security guard gives a number to the patient at the gate. Since we have many queues that the patients join in the waiting area, it is easier for us to identify patients that jump the queue. This numbering system is not used to turn patients away once numbers are finished. The security guard collects numbers from our consulting rooms once they are finished, and then the process starts all over again.***

> ***The security guard gives numbers to all patients at the gate. Although we have one queue for all patients, the numbering system helps to identify patients that jump the queue. If patients complain that there are patients who jump the queue, one of the nurses will always check if patients are seated according to the numbers there were given to them at the gate.***

> ***One of the nursing assistants will now and again check numbers allocated to patients who are in the waiting area to see if they are still seating according to their numbers. If they are not, then patients are re-arranged so that there are no complaints about patients that jump the queue.***

4.5.1.4 Booking system

Participants reported that they also used a booking system for certain services that required more time, specialized skills and the taking of specimens. The transport problem was cited as the main reason that made them to use a booking system as some specimens needed to reach the laboratory within a specified time. Other reasons mentioned for using a booking system were a shortage of staff, lack of space and shortage of equipment to carry out procedures. When using a booking system, some of the services were offered in the morning and some during the later part of the day. Patients were given a booking slip to avoid delays on the appointment date. These were some of the participants' views regarding the booking system:

> ***Pap smears are done on Tuesdays at 14h00. Tuesday is not that heavy. In the morning, we see the asthmatic patients and then in the afternoon we do Pap smears. Only one nurse is allocated for Pap smears due to a shortage of space and equipment. Only one spot lamp is in good condition. At times patients are sent away if there is no capacity to do it and patients are re-booked.***

> ***We only do Pap smear Mondays and Tuesdays because transport collects specimens only on Wednesday. If a patient comes for a Pap smear on a Friday we advise her to come back on Monday.***

> ***We use a booking system for those services that require more time like the taking of Pap smears due to shortage of staff. We also book patients for CD4 count and ante natal care. These services are offered on Thursdays as all our blood specimens have to reach the hospital laboratory on Friday.***

In one of the clinics, the researcher noted that during observation the nurses were using a booking system for TB patients and the nurses reported that it was easier for them to track their attendance if they used this system. During the interview, the professional nurse in charge reported that this facilitated the tracking of defaulters as stated in her own words below:

> ***When we attended a course on TB management, we were told "Do what works for you in your clinic". We wanted to start a soup kitchen, we thought to ourselves, "How are we going to introduce this and have it successful?" Then we suggested that we need to work on an appointment system for the TB patients so that we can look on the book and see who has not come and follow up the defaulters. They have the added benefit of coming in and receiving group counselling. They get their food parcels. They talk to one another and it is almost like a support group for them. They get an opportunity to talk about the common problems and they can share experiences and share what works and what does not work for them. If a repeat patient comes in on any day, for example, on a Tuesday or a Friday, they are attended to but they are given a return date that will be on a Wednesday.***

4.5.2 Special days for certain programmes

In order to overcome the problems of a shortage of staff and overcrowding in both clinics that use supermarket and one stop shop approach, the participants reported that they had special days for certain programmes. They further reported that if the patient came on a day when the service was not offered, that particular service would be offered to the patient and she would then be given a return date that would correspond with the day when the service was offered. In order not to delay patients that came to the clinic for special programmes, the

participants reported that they attended to them first and thereafter to other patients with minor ailments. The participants stated that:

> ***We have special days for certain services due to lack of capacity in terms of staffing and equipment. Patients that come for ante natal care, first visits are done only on Thursdays, thereafter we offer other services.***
>
> ***On Tuesdays, we attend to first and repeat ante natal care visits because it is easier to attend to them on one day because we do group counselling and health education. If some patients come on other days, we do attend to them and then we give them a return date which is on a Tuesday. We do not turn away patients that come for other services on a Tuesday but we give first priority to pregnant women because it is their day. Then later we attend to patients that have come for other services.***
>
> ***Patients who come for chronic treatment are seen on a Friday because they only come to collect their pre-packed medication. Pregnant women that come for first visits are seen on a Thursday because there are investigations that are done and we want to do everything when they are together like group health education and counselling and it is easier for us as we are short staffed. For example, if we have 20 new patients for ante natal care on a daily basis, it will not be possible for us to do individual counseling and take bloods for investigations due to our limited staff. So, we do this for smooth running of the clinic. Women that come for repeat ante natal care are seen between Monday and Friday since there are no bloods that are taken for investigations.***

4.5.3 Dedicated staff members for certain programmes

In order to ensure smooth running of the clinic where the supermarket approach was used, the participants reported that certain programmes were allocated to dedicated staff. The majority of the participants reported that if the patient had multiple problems and was in need of more than one service, the professional nurse would offer all the services except immunization. An enrolled nurse was allocated for immunization. The following excerpts demonstrate the manner in which services were allocated to nurses:

> ***If a patient presents with multiple symptoms, the professional nurse will render all the services and then she would refer the baby to the enrolled nurse for immunization. Immunization is centralized due to shortage of cooler boxesto store the vials.***

> ***We have a dedicated nurse for Integrated Management of Childhood Illnesses (IMCI) because mothers usually develop a bond with the nurse that they see frequently, so we want them to come regularly to the clinic. The patients are quite happy with this.***

From the observations, too, the researcher noted that in these clinics, one nurse provided all the services in her consulting room to the patient that needed more than one service except immunizations. During the interview, the participants cited the following reasons for allocating a dedicated nurse for immunizations: (a) This ensures maintenance of cold chain, (b) It is not feasible to have the necessary equipment for immunization in each cubicle, (c) It is not cost effective to have opened vials in each cubicle should it happen that only a few babies are immunized compared to the number of opened vials, (d) This decreases the workload of the professional nurse as immunizations are usually allocated to an enrolled nurse. The following extracts are a representation of some of the

responses from the participants with regard to allocation of immunization to an enrolled nurse:

> ***Immunizations are done by an enrolled nurse as it is centralized because we prepare one cooler box. We cannot afford to have a cooler box in each room.***
>
> ***One nurse does everything for the patient. Immunization is centralized because of a shortage of cooler boxes. Immunization is done by an enrolled nurse because it is within her scope of practice.***
>
> ***I will render all the services that the patient wants except immunization. That will be prescribed and the child will be taken to another room for immunization because vaccines are kept in one place for reasons relating to the cold chain and for economic reasons like saving those vaccines that once opened should be used for immunizing ten children.***

One of the participants from the clinic where the supermarket approach was used reported that when allocating services to her staff, she considered their qualifications as some of the nurses were not multi-skilled. She stated:

> ***I consider their qualifications and interests when allocating nurses for services since we have nurses that are not trained for certain services but they show an interest in learning how these services are offered. We allocate two professional nurses for sick adults and two for IMCI, one for the fast queue, one professional nurse and one enrolled nurse for repeat ante natal care and family planning, two professional nurses for ante natal care first visits and one professional nurse for TB. Out of 6 professional nurses that we have, only one nurse is PHC trained and the one that is PHC trained***

is on study leave for the whole year and she has not been replaced. We have only three nurses that are IMCI trained.

In order to ensure that nurses did not lose their skills of rendering other services, the participants reported that nurses were rotated between services on a set period basis.

4.5.4 Rotation of staff members

In those clinics where services were allocated to individual nurses, the participants reported that nurses were expected to rotate services on a daily, monthly, quarterly or yearly basis depending on the clinic's preference as stated below:

We rotate the allocation of services to individuals every six months to ensure that the nurses do not lose the skills necessary for the rendering other services.

We allocate certain services to nurses since some of them are not multi-skilled. We use a daily register when allocating the services. We have one nurse that is not midwifery trained….we do not allocate him/her for ante natal care.

When I do the roster, I divide the month into five weeks. To cover each area, each sister has two weeks of doing a duty. They do four weeks in minor ailments so there are always two sisters doing minor ailments because of the heavy workload there. For other programmes the rotation is every second week. We discovered that when we tried to integrate the services, the demand was too much for us. We sat down and discussed in what way we could best deliver the services to cover all the areas. When we employed an

enrolled nurse, then she took over the management of TB patients and she refers all the patients with problems to the professional nurse. We have one professional nurse that is allocated for ante natal care on Monday and Wednesday. She also attends to referred TB patients.

4.5.5 Extension of hours of service

In order to make services more accessible, the participants reported that they worked extended hours. This was done to accommodate patients that could not come during working hours. The following quotes from the data obtained from the participants bear evidence to the observation:

Last year we started providing services on extended hour system make our services more accessible to the community. We are open on Monday-Friday as from 06h00-18h00. We are trying to accommodate patients that are working so that they are able to come to the clinic even after 16h00.

We offer an extended service on Saturday to accommodate patients who are working during the week.

We have just started to offer a 24 hour service in our clinic to make our services more accessible. We usually see emergency cases like gunshots and women who are in labour at night.

4.6 INTERVENING CONDITIONS

Strauss and Corbin (1990: 103) define intervening conditions as “the broader structural context pertaining to a phenomenon. These conditions act to either to facilitate or constrain the action/ interactional strategies taken within a specific context”. Data sources revealed that the implementation of IPHC was influenced by a number of conditions. Facilitative conditions that emerged were: (a) positive attitude of staff, (b) orientation of nurses, (c) involvement of the multi disciplinary team, and (d) community participation. On the other hand, some intervening conditions were categorized as hindering and these included: (a) shortage of staff, (b) inadequate infrastructure, (c) structural and functional fragmentation, (d) lack of career development, (e) lack of capacity building, and (f) service/education disjuncture.

4.6.1 Facilitative intervening conditions

4.6.1.1 Positive attitude of staff

The positive attitude and good working relations among staff emerged as an important factor in the successful implementation of IPHC. Despite the limited resources and poor working conditions in PHC settings, most participants expressed a favourable attitude towards IPHC. During the observation, the researcher also noted that in the clinic where supermarket approach was used, once the nurses had finished seeing patients for the service that they were allocated to, they would always go and help their colleagues with other services that were overcrowded. These were some of the responses by the participants on the positive attitude of staff towards IPHC:

I think the team spirit that we have in our clinic makes it work. That is why we try and do everything for the patient to avoid overworking each other in our respective departments. At about 15h00, the department that usually still has patients is the one that does minor ailments, then people wait for a long time before they are seen. So what we do is that at 15h00, the team leader distributes patients evenly to all the departments because we all have to go at 16h00. We all want to go home. No one wants to stay behind. I always say nobody comes with a patient from home. These are our patients.

A committed and highly motivated workforce and compassionate staff sustains the IPHC. We share responsibilities in our clinic. We have co-ordinators for different programmes e.g. Expanded Programme for Immunization (EPI) co-ordinator. We help each other once we are done with our services. We share the responsibility. If people are given the responsibility to co-ordinate programmes, they own them and make sure that services run smoothly.

This approach does work to a certain extent. We do not have adequate capacity to implement it effectively but I must say that I have a motivated and dedicated staff that is always willing to go an extra mile to ensure that patients get all the services that they want.

4.6.1.2 Orientation of nurses

The participants reported that those nurses who were not trained or qualified to offer some programmes, attended orientation programmes to enable them to render these services in an integrated manner. However, the participants indicated that this orientation was done over a period of few days and they took turns in attending these. The following statement illustrates this:

> ***Nurses who are not trained or skilled to render any of the services that are offered in the clinic, like mental health care have to undergo special training which is offered as a five day orientation course. If a patient with psyche problem comes to the clinic and the person who is trained in mental health is not in, that patient will never leave the clinic having not been attended to.***

> ***District trainers offer short courses on different programmes like IMCI and an HIV counselling course to nurses that have not done these courses to enable them to render these services.***

The participants that were employed by the local authority reported that nurses that were not PHC trained in their clinics, attended a Primary Medical Care (PMC) course that enabled them to do health assessment and managing minor ailments. This PMC course was offered as an orientation course as indicated below:

> ***Nurses who are not trained as PHC nurses attend a PMC course for 20 weeks. They attend two days per week and they do practicals for one day. IMCI is integrated within this orientation course.***

4.6.1.3 Involvement of the multi-disciplinary team

The participants reported that the multi-disciplinary team approach that was used in the clinics further resulted in the successful implementation of IPHC. The multi-disciplinary team in this study refers to any health professionals visiting the PHC clinics to support nurses. These may include doctors, psychologists, dentists and others. The participants indicated that those patients who had complications or needed referral to the hospital for a doctor's consultation or any other specialist were seen at the clinic by the visiting health practitioners. These patients were booked for these specialists and were seen on set days. Therefore, the patients were not referred to the hospital as used to happen before IPHC and this resulted in improved care due to increased accessibility of services although the participants reported that these doctors did not spend the whole day in the clinic. The contribution of the multi-disciplinary team towards the success of IPHC is clearly observed in the following excerpts:

> ***We have an ARV doctor on Mondays, a Medical Officer on Wednesday, a Psychologist and physiotherapist on Thursdays. These specialists come to our clinic to see patients with complicated conditions and patients are booked for these specialists. This multi-disciplinary approach has improved the accessibility of services thus improving care.***

> ***We have a visiting psyche doctor for mental health once every three months for patients that need to be reviewed and assessed. We book these patients for the doctor. We also have a medical doctor every Tuesday for minor ailments who works from 08h00 until 12h00. He sees +-25 clients per day because he also goes to another clinic from here. He does two clinics a day.***

A dentist visits our clinic every Monday for patients who have dental problems. We book these patients and he usually does not see more than 10 patients since he spends only two hours in the clinic.

The participants were of the opinion that health professionals, particularly doctors, played a significant role at the clinics and their visits benefited nurses. They indicated that the presence of doctors in the clinics reduced the workload that they experienced due to the increased number of patients that were seen in the clinic and the shortage of staff. Benefits of the visiting doctors were noted in the following excerpts:

The work is reduced on the days when we have visiting doctors. Some patients are seen by these doctors although they see a limited number of patients due to time constraints.

Visiting doctors reduce the overload and they manage most of the clients locally at the clinic level.

4.6.1.4 Community participation

Data sources revealed that the successful implementation of IPHC was influenced by community participation. Communities contributed to the success of IPHC by participating in the governance of the clinics through clinic committees as well as other structures like support groups. They also provided information to the health care workers regarding their health needs as reported by the participants in the following extracts:

We have a clinic committee. The committee members connect the clinic and the community. They give us feedback from the community regarding our services as well as the areas where we need to improve. For example, if patients are delayed in the clinic,

the community, through the committee, will report this and then we will sit together and discuss the issue.

We have a clinic committee to discuss problems that the clients have and also to mobilize the community when we have polio campaigns and awareness programmes. We do this in collaboration with Community Health Workers. As we have started with a 24 hour service, we utilize the committee to inform the community about the available services and changes regarding clinic opening times.

We also have a suggestion box which is locked and the key is kept by the Chair of the committee and we meet every second Wednesday of the month to discuss the issues that are raised by the community.

4.6.2 Hindering intervening conditions

4.6.2.1 Inadequate resources

Inadequate resources emerged as one of the conditions that the participants regarded as a constraint against the successful implementation of IPHC. Interviewees reported that limited staffing, space, equipment and transport to take specimens to the laboratory were factors that hindered successful implementation of IPHC. These factors meant that the clinics could not offer all the services that were needed by the patients on daily basis. The interviewees stated that:

IPHC resulted in more services that were brought into PHC from the hospital but there was no improvement in staffing, equipment and space. Only one block was built for TB yet all the programmes are now offered in this clinic. This clinic has a big catchment area because the nearby clinic does not offer ante natal care services due

to space problem. Patients with chronic conditions were brought in from the hospital and this resulted in overcrowding.

We also have a problem of space in our clinic. We run so many programmes that need privacy like youth friendly programme, (anti-retroviral treatment) ARV clinic, voluntary counselling and testing for HIV, post natal care, ante natal care, visiting doctors and dental clinic. As a result, you find that one service will wait until there is space which further delays the patients and affects the smooth running of the clinic. We have been promised some park homes but we are still waiting.

We still have a problem with the transportation of specimens to the laboratory. The car that takes specimens to the laboratory only comes twice per week hence we have specific days for certain programmes that require the taking of specimens from the patient. In order for IPHC to work, we would like to have regular transport that will take the specimens to the laboratory.

A shortage of equipment was also highlighted as one of the concerns that occurred as a result of the problems regarding the procurement procedure which led to delays in the acquisition of new equipment. Participants stated that the cumbersome process that they had to go through further contributed to limited resources. As a result, they mentioned that there was a need to change the procurement procedures as stated below in few of the extracts:

Broken equipment is sent to the hospital for repairs but it takes ages for one to get that equipment back. The procurement procedure is too long and complicated and it may take about a year to get the equipment that you have requested.

It is not that clinics do not have equipment. The equipment that we get tends to break down every now and then. It takes forever just to replace a broken piece of equipment. There should be an easier way to acquire equipment to replace any pieces of equipment that break, like BP machines. If we could have a contract for equipment that would make life very easy. For BP machines for example, instead of going through the whole process of advertising the entire procurement process, you just go and get whatever is required.

4.6.2.2 Inadequate infrastructure

Some participants mentioned that although the multi-disciplinary teams visited the clinics occasionally, this had not addressed the problem of poor referral system to the hospital. They reported that they did not have means to communicate with the hospital in case there was a need to urgently refer the patient to the hospital if the doctor was not at the clinic on that particular day. Transport was also highlighted as one of the challenges they experienced since it took time for an ambulance to arrive at the clinic to take the patient to the hospital in the case of emergency. They reported that:

The referral system is still a problem for us. First of all we do not have a telephone to communicate with the referral hospital. We are using our own cell phones to report an emergency. We are given R55.00 airtime per month and it is not adequate since we use this cell phone during the day and night. Secondly, it takes ages for an ambulance to arrive at the clinic in cases of emergency and the patient might end up developing complications.

Emergency Medical Rescue Services (EMRS) is problematic in our clinic. For an example, we had a Motor Vehicle Accident (MVA) last week and we called an ambulance to take the patient to the hospital.

I called them at 16h00 and they arrived at 19h00. At times it takes them +- 4 hours to arrive. I understand an MVA is a red code that needs urgent referral to the hospital.

4.6.2.3 Structural and functional fragmentation

Some participants who shared similar views stated that structural and functional fragmentation and duplication of services that were rendered by clinics under local and provincial governments contributed to inadequate resources. They indicated that the integration of provincial and local governments would decrease fragmentation and duplication of services thus enhancing integrated service provision. The limited resources would be better used, increasing efficiency and quality of PHC. Problems related to structural and functional fragmentation were noted in the following excerpts:

PHC services in KZN are still fragmented and not cost effective. Local authorities provide an incomplete PHC package while the provincial clinics provide all the programmes including similar ones that the local authority provides. This duplication of services further depletes the limited resources.

Even if there is a gross shortage of staff, there is no moving or sharing of staff between province and local authority clinics. They run their own schedule of in-service education and we run ours. They have their own management and we have ours. The integration of provincial and local authority clinics will improve staffing and the sharing of resources.

4.6.2.4 Lack of career development

The majority of the participants cited inadequate career advancement opportunities as a constraint that hinders the successful implementation of IPHC. They reported that nurses were not motivated to further their studies as there was no incentive in terms of getting promotion and senior positions in PHC settings. Some participants reported a lack of recognition and they felt that their expertise was not valued and their frustrations were noted in the following excerpts:

> ***We have professional nurses that are not trained in midwifery and psyche. So, they are not allocated for these services. They are given opportunities to improve their skills through post basic courses but they are not interested because there is no career pathing in PHC.***

> ***At times as PHC nurses we feel that our expertise is not valued by our employer. We need more recognition and financial support because of the terrible conditions that we work under where our clinics are overcrowded and there is a gross shortage of staff. One does not see the need to do more post basic courses as there is no financial reward at the end hence IPHC is therefore not successfully implemented due to a lack of expertise.***

4.6.2.5 Lack of capacity building

The results indicated that the majority of the nurses that were employed in the clinics were not adequately trained to offer all the services provided in the clinics in an integrated manner. During the interviews with the persons in charge of the clinic, the researcher noted that there was at least one nurse that was PHC trained in all the clinics except in one rural clinic where none of the nurses were PHC trained. The participants reported that due to increased number of patients in the clinics, there was a need for staff development to ensure the efficient and smooth running of the clinic. These were some of the nurses' views regarding the training needs:

> ***We have only one nurse that is IMCI trained and one nurse that has a qualification in psychiatry in our clinic so we are using a supermarket approach instead of a one stop shop. We feel inadequate to render some of the programmes that we have not been trained to offer.***

> ***Nurses are not multiskilled to offer all the programmes in the clinics. Opportunities to attend training and updates are offered by the training staff but nurses are not able to attend due to the shortage of staff in the clinics and there are no replacements if staff are attending updates or workshops.***

> ***We are now not sure whether the training we undertook at undergraduate level has adequately prepared us for IPHC. We did not do, for example, IMCI whilst we were still on training and we have not been given an opportunity do this programme as part of in-service training due to limited staffing. Then how are we expected to integrate services if we are not adequately trained?***

Newly qualified nurses do not get continuous support in terms of in-service training from the district trainers. When these nurses complete their training, they come out from the college to PHC setting and most of them know the theory part of the programmes offered in the clinics. The practical aspect is usually lacking due to limited exposure to PHC setting whilst on training.

4.6.2.6 Service/Education disjuncture

The lack of partnership between nurse training institutions and service providers emerged as one of the conditions that limited the successful implementation of IPHC. Participants reported that IPHC should be based on a partnership between the service providers and the community because all the stakeholders know their expectations of the approach. This lack of collaborative effort is noted on the following excerpts:

Nursing education does not talk to health systems or health services delivery. You go to the class to learn to be nurses but it is like we are not preparing them to function within the context of South African policies. Something needs to be done. We need to radically challenge the South African Nursing Council (SANC) as far as curriculum development is concerned. I do not understand why a nurse that comes out of college should go through in service training to teach them about EPI or IMCI. Why can't we produce nurses that should be competent and confident to go out and deliver all these services in an integrated manner?

I doubt if nurse educators are invited when there are district updates since they are directly involved in the teaching and training of student nurses that will be future professional nurse that will be placed in PHC setting to deliver the services.

Training institutions must be challenged to meet the needs of the health sector in terms of who is trained and the content of the training. For example, training should include a full course on IMCI, EPI, HIV/AIDS management and others national priorities.

To support the need for collaboration between the service providers and the training institutions, one of the participants raised concerns regarding the calibre of the newly qualified nurses that had undergone a comprehensive four year diploma. They felt that these nurses were not adequately prepared during training to meet the needs of services in relation to a change of the disease profile. They reported that these nurses do not get adequate PHC clinical exposure whilst on training as stated by the participants in the following excerpts:

…What I observed is that these newly qualified nurses need extensive orientation because they are not practically geared for the PHC clinics. They are not ready to assess and manage the kind of clients that we see in our clinics. In other words, their curriculum does not prepare them for the kind of diseases that our patients present with. The moment they set foot in our clinics, they are demoralized and it is traumatizing to them because at times they are left alone due to the shortage of staff. We hardly have time to mentor qualified personnel. We orientate them for few days and then we leave them to cope on their own and you find that they end up having a burnout syndrome. I think these students need more exposure to PHC setting whilst they are still on training.

4.7 CONSEQUENCES

The outcomes, both intended and unintended, of these actions are referred to as consequences (Strauss and Corbin, 1990: 106). The participants reported the following as intended consequences:

4.7.1 Intended consequences

4.7.1.1 Improving accessibility of services

Integrated services were thought to able to increase the access of health care to patients as all their health needs could be met at a single visit. The participants reported that this observation was based on their statistics although no formal comparative studies had been conducted. The following statements were made by the respondents concerning the increased access of services:

> ***Previously we used to see 1000 patients per month but now we are seeing +- 4500 patients per month. We are trying to give them quality care. We go beyond the problem that the patient is presenting with. We ask about family contact and we motivate patients to come for Pap smears.***

> ***We are seeing more patients than before this integration of services started and this indicates that services are more accessible and available.***

> ***We are seeing an increase in the number of patients that come for services in our clinic. Immunization coverage has also improved and we have fewer patients that are defaulting treatment, particularly TB patients. We are also seeing more patients from mobile points coming to our clinics because they do not offer integrated service.***

4.7.1.2 Decreased waiting period in the clinics

Participants who provided a one stop service reported that IPHC resulted in a decreased waiting period spent by patients in the clinic as one nurse provided all the services that were needed by the patient. Patients did not have to join different queues in order to access all the services that they needed. The following extract from the participants' statements illustrate the point:

> ***IPHC has resulted in patients spending less time in the clinic since they are able to access all the services that they want from one professional nurse. Patients are not made to join different queues as used to happen before.***

> ***Less time spent by patients in the clinics has resulted in treatment compliance and this has improved the rate of defaulters. Quick queue and walk in services motivate patients to come to the clinic since they do not have to spend time waiting in queues.***

Furthermore, the participants even mentioned that the set up of the clinic supported this as illustrated below:

> ***Based on IPHC approach, I do everything for the mother and the baby except immunization. As far as the immunization goes, we have inter-leading doors to the immunization section. I will just pick up the intercom and will inform the staff nurse that I am bringing a patient for immunization to her. I will not make her to join another queue. Our clinic is well structured.***

> ***The nurse does everything for the patient to avoid any delays. Our rooms are well equipped with necessary equipment and drugs. We serve a very poor community and people are in a hurry to go back to***

the fields, so we do not want to delay them. Most of our patients are unemployed.

4.7.1.3 Holistic management of the needs of the individual patient

IPHC was acknowledged as serving the needs of the community more effectively than vertical programmes since all their needs were met at one service delivery site as stated in the excerpts below:

IPHC is meeting the needs of the patients as they are able to get all the services in one consulting room. We go beyond the problem that the patient is presenting with. We try to manage the patient holistically.

It has improved the follow up of patients as they tend to identify and bond with nurses. Nurses find it easy to detect changes and problems early to refer patients to the hospital before complications set in.

Patients are able to access all the services under one roof. They actually verbalize this although we have not done any formal patient satisfaction survey. Our records indicate that treatment compliance as well as immunization coverage has improved.

As discussed earlier, the participants reported that the multi-disciplinary team approach that was used in the clinics further resulted in improved quality care.

4.7.1.4 Affordable health care

The majority of the participants reported that patients were able to save on the time that they spent at the clinics as well as transport costs, particularly those from rural areas who had to walk or travel more than 5 kilometres in order to access health care services. Participants argued that IPHC resulted in a limited number of trips that patients had to make in order to access different services. With regard to the cost effectiveness of IPHC, the participants reported:

> ***We are serving a community that comes from a deep rural area and the number of patients that we see has increased dramatically due to the fact that they are able to access all the services that they want under one roof.***

> ***IPHC has shortened patients' waiting time in the clinic as they walk long distance from home to the clinic. We serve a community that is located in deep, deep, rural area and this community is very poor. There is no transport to take patients to the clinic due to the poor conditions of the roads. So, they walk plus or minus 40kms in order to reach the clinic.***

> ***This approach has resulted in increased accessibility of services because in the past, patients were told to come back on certain days for certain services and they did not return. Our clinic is located in a deep rural area and we serve the poorest of the poor. Some patients pay almost R10.00 for transport for a single trip to take them to the clinic. So with IPHC, patients are able to save money and time.***

4.7.2 Unintended consequences

Although the Department of Health's main aim of introducing the IPHC was to identify and address shortcomings in equipment and training needs (Department of Health, 2001b), the PHC nurses reported that this approach had resulted in a shortage of staff, equipment and space. They argued that the introduction of free health services, the collapse of vertical services and the addition of more services in their clinics resulted in overcrowding as space, equipment and staffing had not been increased to cope with the additional services and patient numbers.

4.7.2.1 Lack of space

The participants reported that there was inadequate space to accommodate all the programmes that were offered in the clinics. As a result, it was difficult to maintain privacy. During observation in one of the clinics, the researcher also noted that there were two nurses consulting in one room due to an inadequate number of consultation rooms. The following excerpts support their views on lack of resources:

> ***We have an inadequate number of consultation rooms in our clinics. We have only one room that is allocated to two voluntary counseling and testing for HIV counsellors. You will find that they share this room when they are doing counselling. ….they have to speak softly as means of ensuring privacy. Otherwise, we only allocate an extra room to one of them if there is a professional nurse that is absent or attending a meeting away for the clinic.***

In this clinic we have a problem with space. You always find patients standing outside, even geriatrics. We do not have a veranda outside which makes the patients' lives difficult especially if it is raining or if the weather is too cold or too hot like today.

We need more consulting rooms with bigger space. As it is we have five lay counsellors but have only one room that is allocated to them. So they just fit themselves in any room that is vacant when they do counselling. They use even the tea room due to lack of space. There is no room that is allocated for Prevention of Mother to Child Transmission (PMTCT). They also sit wherever there is space. As a result, there is no privacy during the counselling session.

Although the majority of the participants considered the multi-disciplinary approach as crucial in successful implementation of IPHC as stated before, they cited limited space as a challenge in terms of providing these specialists with consulting rooms in which to assess referred patients. As a result, nurses reported that they vacated their rooms which further resulted in delays. One of the participants reported:

When we have more than one doctor visiting our clinic, one of them does the consultation outside since there is limited space inside the clinic to accommodate more than one doctor. One professional nurse has to vacate her room in order to accommodate just one doctor. So we try and cheer them up by making sure that we work hand in hand with them so that they will not run away. We have lost quite a number of doctors before due to lack of space.

We also have a problem of space. If there is a doctor, he uses my office as a consulting room while he is here. He is here from 07h30-10h30 which means I am unable do any administration work until he leaves.

4.7.2.2 Increased demand on staffing

Although the nurses worked extended hours in order to make services more accessible, some participants raised their concerns regarding the 24 hour service. They reported that it resulted in further depletion of day staff as the Department of Health did not create posts for night duty but instead, they took staff from day duty. This resulted in day staff being overloaded with more work, thus compromising the quality of care. On the other hand, the participants reported that there was less utilization of this service. The participants' concerns and frustrations were evident in the following quotes:

We have a gross shortage of staff. As a result, we cannot cope with the increased number of programmes that we offer in the clinic.

The shortage of staff has been made worse by the introduction of the 24 hour service. Management failed to attract staff for night duty. They ended up stripping day duty staff that is already short staffed. Last month, quite a number of posts were advertised for night duty, and only two professional nurses applied.

We are seeing very few patients at night. I think most people are not aware that we have the night duty service. At times we see only two patients. This compromises the day staff as night duty staff are taken from the same staff establishment that we have for the clinic. The rotation between day and night duty shifts is done very three months. The staff is complaining that they are not doing anything on

night duty. As a result, they do our orders and add the admin duties. We want to see our statistics improving for night duty so that we can continue with the service. It is de-motivating for staff and nurses who are getting paid for being on night duty.

Nurses are reluctant to work on night duty for security reasons. There is only one security guard and he is not armed. Our clinic is located in an area where there is high rate of crime like burglary. In order to ensure that everybody gets a turn to work on night duty, we have a roster where we allocate each person on night duty at least on alternate months; otherwise we do not have a dedicated staff for night duty.

4.7.2.3 Perceived deteriorating quality of care

The results of the study revealed that the quality of services offered at PHC clinics was compromised due to the increased number of patients that were seen in the clinics. This was attributed to the increased number of services that are offered at PHC clinics without taking into consideration the issues of improving staff and space. These were some of the nurses' views regarding the quality of programmes:

Due to the shortage of staff, the integration of services has resulted in poor quality care. The focus is on quantity rather than quality. We are interested in pushing the bench to make our employer happy. The employer is interested in the number of patients that we see per day rather that the quality of care given to patients. If you see fewer patients than your colleagues, you are seen as a lazy person and your colleagues will confront you and then you will be reported to the employer.

….but I must say that in most cases we do not do health assessment properly because all we are interested in is working through the crowd since we are short staffed and our clinic is overcrowded. Like health education, we hardly find time to do it, especially with the pregnant women.

Quality of care is compromised. If we spend 20 minutes with a patient then that patient is receiving luxury care. We do not have the capacity to spend quality time with the patient due to the shortage of staff and overcrowding.

I am not happy about the quality of services that we offer. Some of the services do suffer because we try to get through the queue quickly as some of the patients have to rush for transport. Patients do not want to wait for a long time in the clinic. So we try to push the queue at the expense of quality care.

I must say that quality is compromised in a way. We do not have enough time to take a detailed and accurate history and to do proper counselling. If you spend more time with a patient, other patients that are waiting will complain. At times we hardly go for tea and lunch.

4.7.2.4 Overcrowding

Overcrowding in the clinics also emerged as another unanticipated consequence of IPHC. This was thought to be related to the increased access of services and the transfer of patients from the hospitals to the clinics. The following quotes from the data obtained from the participants bear evidence to this observation:

> ***Nurses are overwhelmed by the overcrowded and poor conditions at the clinic. There is a gross shortage of staff and all the programmes were dumped on the clinics without any consideration being given to improving staffing and space.***

> ***This integration approach has resulted in overcrowding in our clinic since we are seeing more patients for different programmes and we do not have any additional staff and space. Our clinic is located in town and it is central so we get lots of patients from rural clinics and we do not chase them away. The numbers have increased; we are seeing more than 8000 patients per month.***

> ***We are serving a community that comes from deep rural areas and the number of patients that we see has increased dramatically. We used to see 1000 patients per month but now we are seeing +- 4500 patients per month. We are trying to give them quality care. We go beyond the problem that the patient presents with. We look at the patient in totality.***

Although the fast queue system, as discussed before, was used as a strategy for ensuring less waiting time in the clinic thus reducing overcrowding, a few participants argued that patients were dissatisfied with this approach of fast queue. They reported that those that were not in the fast queue felt that preferential treatment was given to few patients. Participants also highlighted

that even some of the patients that were in the fast queue complained about the delay since only one professional nurse was allocated for this queue. They felt that the queue was moving slowly. The following extracts are typical of the negative effects of fast queue:

> ***I think the Department of Health used the incorrect term when they called it a "fast queue". According to my experience there is nothing like fast queue in our clinic since only one professional nurse is allocated for this queue. You usually find that there are 40 patients that are waiting to be seen in this queue and it usually takes almost half if not two thirds of the day to see these patients. Patients will now and again complain that they wait too long in the queue just to collect their treatment.***

> ***The problem is that we lose many TB and family planning patients if the fast queue is moving slowly. They leave before receiving their treatment because they do not want to wait for a long time before receiving their medication.***

4.7.2.5 Disillusioned staff

The participants reported under-remuneration, under-staffing and heavy workloads as factors that contributed to stressors among nurses working in PHC setting. They expressed their concerns and frustrations by saying:

> ***Nurses are dissatisfied, they are angry; they are disappointed with a lot in life. Even if they get a big increase in salary, I can tell you that it's not going to make them happy because of the lack of recognition by the employer of the good work they do despite the terrible conditions they work under.***

I think staff is overwhelmed by the overcrowded and poor conditions at the clinic. There is a gross shortage of staff and all the programmes were dumped onto us without any consideration being given to improve staffing and space.

We also put pressure on each other by comparing the number of patients that each staff member has seen. I believe in giving myself time with each client and treating the person holistically. Yes, quality is equally important as quantity but in most cases we end up compromising the patients' lives due to poor working conditions that we work under. Even our employer displays the attitude that she is interested in numbers not quality care. So we miss lots of things by not taking a detailed history. We even miss abnormalities like hepatomegaly, cardiomegaly because we do not do a thorough examination.

One of the district programme managers highlighted that the attitude of nurses had resulted in decreased service utilization:

This approach is bringing service to the people. It has improved access of services thus resulting in improved quality of care. But there is slight decline in service utilization and this may be related to nurses' attitude. I am not going to go into details with this because we are still in the process of investigating this.

Furthermore, participants reported that some of the nurses resisted the rotation schedule. They cited the fact that some lacked confidence since they did not have the skills to render those services. Some resisted because they felt comfortable rendering the services that they liked and had bonded with their patients. Most of the resistance to rotation came from the nurses who were

accustomed to providing specialist services, and as a result, associated themselves with specific activities. The participants reported that:

> ***One thing that we do know about mental or psychiatric patients on medication is that they are much more likely to be compliant with their treatment if they are seeing the same person. That is why general practitioners are better at treating patients than we are.***

> ***If you put psyche patients together in a quiet place and in the company of a person that they know well, they seem to get along with each other well and they seem to have a good rapport. It is not that you want to discriminate them. Integrated service is such a general term and since we have started practicing IPHC, you have got to do what is actually practical for your service. What works for me might not work for another clinic. But if you have a small community like us here, we are doing what works for us and if something works well, why then try and re-organize everything and cause a disruption to the manner in which we offer the services.***

4.7.2.6 Extension of the role of the staff

Nurses reported that shortage of personnel did not only affect nurses but also the support staff. As a result, they were made to perform duties that were beyond their scope of practice and vice versa.

> ***We are even short of clerks….At times we even use our security guard who is educated and even enrolled nurse to register patients on arrival. At times they refuse as this is not part of their job description.***

As I said we have a terrible shortage, so we do take chances with the repeats chronics and family planning by making the staff nurse to attend to these patients as they do not need a full physical examination. At times she is even made to do the assessment of well babies that have come for immunization but then she refers the baby to the professional nurse if she suspects any abnormalities.

We have not had a clerk in our clinic for the past two years. We have made a submission to the authorities for the post but it has not been advertised. So we use an enrolled nursing assistant to register the patient on arrival. If there are no patients to register during the day, she switches over to nursing duties.

4.8 CONCLUSION

This chapter presented the main categories and the sub-categories that emerged in the study. The schematic representation of the practice of IPHC in KZN is outlined in Figure 7.

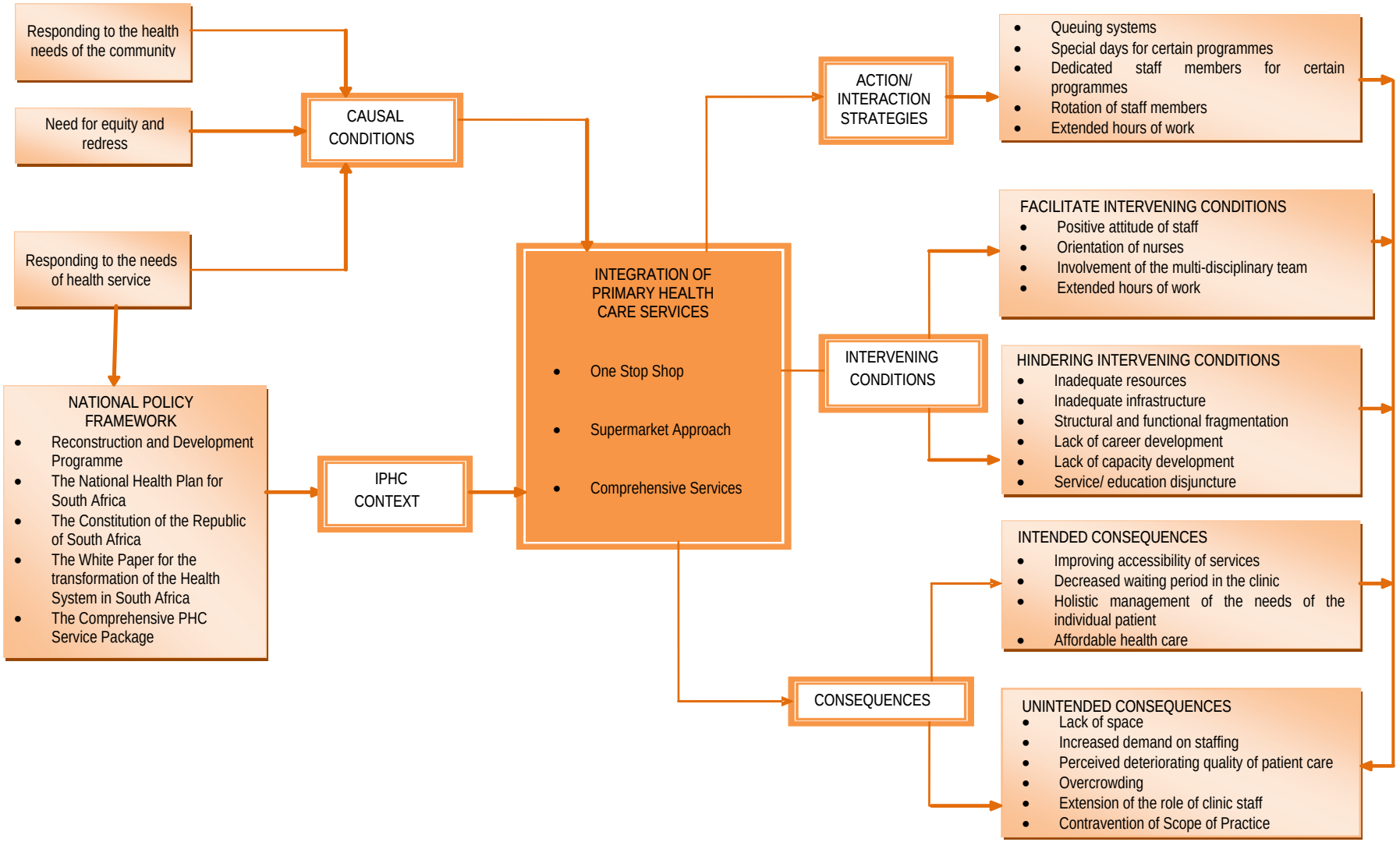


Figure 7: Schematic representation of the practice of IPHC in KZN, South Africa

CHAPTER 5

DISCUSSION OF RESULTS

5.1 INTRODUCTION

In this chapter, the researcher will discuss the results presented in the previous chapter. As discussed in Chapter 3, Strauss and Corbin (1990: 50) state that selective sampling of the second body of literature review should be woven into the emerging theory during the third stage on grounded theory induction, the stage that is termed concept development. Therefore, new literature which was not presented as part of literature review will be used in this chapter to discuss new concepts that emerged during data collection and analysis. This is further supported by Glaser (1998: 67) who states that "when the grounded theory is nearly completed during sorting and writing up, the literature search in the substantive area can be accomplished and woven into the theory as more data for constant comparison".

5.2 THE PRACTICE OF IPHC

How the services are offered in the clinics seemed to be influenced by a number of factors. The results of the study showed that interpreting and/or operationalizing the delivery of IPHC is determined by a number of factors including:

- The size of the clinic
- The number of nurses available
- The level of competency of nurses in terms of skills and training
- The availability of equipment
- The availability of space in relation to the waiting area and consulting rooms

- The structural set up of the clinic.

The researcher noted that the clinics that were observed to be small in size, had few nurses and a lower number of patients was seen compared to the big clinics. One nurse rendered all the services that were required by the patient. The researcher also noted that some of these clinics did not offer all the services, for example, ante natal services as listed on the PHC core package. On the contrary, in clinics where overcrowding was observed, patients that required more than one service were seen by different nurses. Patients joined different queues in order to access these services and in some clinics there were no measures that were put in place to ensure that patients were not delayed. The researcher observed that in those clinics that had consulting rooms with interleading doors, it was easier for the one professional nurse to refer the patient to another nurse without the patient having to join the queue for the second time. In some clinics to avoid any delays, nurses informed the other nurse telephonically or through the intercom about a patient that needed more services. This observation is supported by the findings of the study that was done by Maharaj and Cleland (2005) on the integration of sexual and reproductive services in KZN. These researchers also observed that clients were more likely to form a single queue and see one provider in smaller rather than large health facilities.

Lack of uniform and/or normative practice in the rendering of IPHC is also noted in the findings of the study that was done by French et al (2006: 202-206) on one stop shop versus collaborative integration regarding the delivery of sexual health services in London. These authors state that integrated service, from an organizational perspective, implied integrated management, planning and configuration of services. Their argument was that it was less clear how the integration of sexual health services would work, whether sexual health services would be provided under one roof or whether different specialists should be

housed in the same building. It would seem that at best, the practice of IPHC in South Africa is more of a function of contextual factors and open to situational interpretation than a philosophical or conceptual one.

5.3 CONCEPTUALIZATION OF IPHC

Integrated care has become an international health care buzzword. Integrated care has many meanings. It is often used by different people to mean different things. There are a number of terms that are used synonymously with the term integrated care, yet they contain different connotations. According to Kodner and Spreeuwenberg (2002), integrated care is most frequently equated with managed care in the US, shared care in UK, transmural care in the Netherlands, and other widely recognized formulations such as comprehensive care, disease management and continuity of care. Iglehart as cited by Scutchfield, Lee and Patton (1997) defines managed care as a system that integrates the financing and delivery of appropriate medical care by means of contracts with selected physicians and hospitals that provide a comprehensive set of health care services. Shared care is a term used in health care and social care in Great Britain. A report on shared care cited a definition by Moorehead which explains shared care as an approach to care which uses the skills and knowledge of a range of health professionals who share joint responsibility in relation to an individual's care (Shared Care Network Development Initiative, 2005). The National Council for Public Health care as cited by Bloemen-Vrencken, de Witte, Engels, van den Heuvel and Post (2005) describe transmural care as the health care geared to the needs of the patient, provided on the basis of co-operation and co-ordination between general and specialized care givers, with shared responsibility and specification of delegated responsibilities. It is often directed towards bridging the gap between different levels of care providers, for example between primary care and secondary care. The Disease management Association of America (DMAA) (2009) defines disease management as a "multi-

disciplinary, continuum-based approach to health care delivery that identifies populations with or at risk for established medical conditions". The National Pharmaceutical Council (2008) argues that when properly structured, disease management involves an integrated, comprehensive approach to patient care that extends beyond a focus on the drug line item. Although all these strategies have in common the aim to improve the co-ordination and integration of services, their scope is quite different. Some strategies consider overcoming professional and departmental boundaries and aiming towards the development of multi-professional teams, while others aim to integrate different sectors of care. Grone and Garcia-Barbero (2002) argue that continuity of care emphasizes the patients' experience and journey through the system of health and social services and provides valuable lessons for the integration of systems.

Grone and Garcia-Barbero (2002) view integrated care as a broader term referring not only to the patients' perspective but also to the technological, managerial and economic implications of service integration. These authors suggested the following working definition of integrated care: "bringing together inputs, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency". This definition is supported by the Report of the Study Group on integration of health care delivery that explains the integration of health services as the "process of bringing together common functions within and between organizations to solve common problems, developing a commitment to shared vision and goals using common technologies and resources to achieve these goals" (WHO, 1996: 4).

The Technical Working Group for the care of mother and baby at health care centres identified three dimensions of integrated health services, namely vertical, horizontal and across time (WHO, 1993). The group described vertical integration as the linking together of services at community level, health centre

level and at the first referral hospital. Continuity of care was categorized as integration across time whereas horizontal integration is the linking together different services at the service delivery point. On the other hand, the Technical Report Number 5 for the development of DHS in South Africa identifies two dimensions of integration, namely organizational integration and functional integration (McCoy et al., 1998: 3). Organizational integration was regarded as collapsing of all different health services within the DHS into one administration. On the other hand, functional integration was viewed as the joint rendering of services by different authorities. Functional integration focuses on how the health delivery system functions and thus seeks ways to integrate the services as opposed to integrating the authorities (Toomey, 2000: 13). On the other hand, Tint et al., (2000: 15) refer to integration as the availability of all clinical services to all patients everyday. These services include a broad range of clinical services, social services, rehabilitation services, and others.

Likewise, in analyzing the data gathered from the interviews in this study, the participants had different understandings of the term IPHC. An exploration of the participants' understanding of IPHC revealed a diversity of interpretation and expectations. All participants interviewed understood the IPHC services as the provision of all services in the clinic as stated in the comprehensive PHC core package. Defining IPHC in terms of providing all the services needed by the patients is supported by Schierhout and Fonn (1999: 4). According to these authors, integration implies multi-purpose clinics and multi-purpose staff. However, Magwaza, Cooper and Hoffman (Undated) state that integration implies not only rationalizations of multi-service providers, but also the integration of vertical programmes into comprehensive health care. However, the participants in this study expressed different views regarding the manner in which these comprehensive services were offered. Some participants understood IPHC as the provision of all services within the same premises whereas some thought it related to the provision of services to the patient by one nurse.

In the context of this study, it emerged that there were three core concepts/constructs that were used by the participants as discriminatory dimensions of IPHC in South Africa. These core categories were (a) comprehensive health care, (b) supermarket approach and (c) one stop shop.

5.3.1 Comprehensive health care

Comprehensive health care emerged as the central theme around which the meaning and/or understanding of IPHC revolved. Comprehensive health care as a strategy for ensuring the availability of a range of services was identified as a common theme among provincial and local authority nurses. This is in keeping with the principles of PHC and the PHC package for South Africa, which state that the clinic should render a comprehensive integrated PHC service (Dennill et al., 1999; Department of Health, 2001a). In South Africa, the Integration of Services Policy was enacted in 1996 with the aim of increasing health service utilization by increasing accessibility and availability of all health care services at PHC level. This health care policy was aimed at providing comprehensive integrated services within a district PHC model. As mentioned in Chapter 1, the term ‘comprehensive’ refers to the range of services available (Tint et al., 2000: 15). These authors further state that comprehensive services in a PHC model mean that both preventive and curative services are given equal priority at PHC level.

However, Kodner and Spreeuwenberg (2002) argue that the idea of comprehensiveness overlaps with that of integration. These authors maintain that the word ‘comprehensive’ denotes full understanding of the situation. In other words, what is connoted is a desire to understand the relationship between all the elements that constitute the entirety. Emerging from this context driven approach to comprehensive health care, were two approaches through which

IPHC would be implemented; including the supermarket and one stop shop approaches.

5.3.2 Supermarket approach

According to the findings of this study, IPHC was conceptualized as a supermarket approach where patients that required more than one service, were seen by different nurses allocated in different consulting rooms. These patients had to join different queues in order to access different services. This was observed mostly in larger clinics. World health care today is plagued with increasing costs, long lines for obtaining quality care, inconvenience and inaccessibility, and duplication of efforts. Shah, Bruni and Darling (2002: 106) argue that a similar situation existed in the food and food products retail industry where until the 1930'sone had to go from shop to shop to buy different items. These authors state that consumers did not have knowledge of the quality of each and every product and prices could therefore be unreasonable and bargained. The supermarket revolution in the food and food products sector was the model whereby consumers were guaranteed quality products at a reasonable price and the availability and choice was greater.

According to Halper (2006) 'supermarket' is a difficult term to define. To understand such a complex and important institution, Halper (2006: 253) argues that "one needs to know the origin, the components that make it what it is and how its business model was molded". The supermarket concept started in the very early phases of the Great Depression and was moulded by World War II. Michael Cullen, a Kroger assistant store manager launched America's first supermarket on 4 August 1930. Before the advent of supermarkets, a shopper walked into the store, usually with a shopping list in his/her bag and approached a retail clerk for all the items he/she wanted. The clerk would then bring all the items and would tally the order, take money and pack the items purchased in a

big brown paper bag. More often than not, the shopper would leave the bag at the counter and the store would arrange for a free delivery. This system was found to be inefficient and this was reflected in food prices which were rising in 1930. As a result, in 1930s the supermarket grocery departments began to be operated on a self-service basis. Unlike the grocery departments of contemporary supermarkets, supermarket grocery departments of the 1930s occupied very large parts of the supermarket storeroom. Low-priced groceries were the supermarket's featured attraction back then. Self-service reduced the cost of store operations, and the savings were passed on to the customers in the form of lower prices. Lower prices, in turn boosted sales volume and profits. Large stores made it possible to carry many more product categories without sacrificing the depth of inventory that makes it possible to avoid turning away customers looking for the numerous well-advertised products available. Later free parking, shopping carts, automatic doors and air conditioners were considered essential components of the supermarket business model (Halper, 2006).

Like any other sector, supermarkets were faced with challenges. Labour shortage was one of the challenges that threatened the supermarket industry's existence. A very large percentage of the predominantly male supermarket labour force joined or was drafted into the armed services. Resistance to the conversion was also a challenge. Produce department managers were reluctant to try self-service because they were concerned about shoppers squeezing tomatoes, bananas and other fragile fruits and vegetables. Meat managers were worried about consumer acceptance as meat was cut to order (Halper, 2006). Nevertheless, for the retail industry, the supermarket remained the most preferred solution to increased revenue and client satisfaction, at least with respect to the availability of a large range of products under one roof. This mode of delivery continues to be based on the principles of convenience and time saving, affordability and quality products.

In the health care sector, the supermarket approach was initiated in Tanzania and has been successfully adopted in several East African countries. The emphasis of this approach is client-oriented and aims for the provision of all services at the time of visit to the clinic (WHO, 1996). However, the process that is followed in Tanzania for the implementation of this approach, is not described. The South African handbook for Clinic/CHC Managers describes the supermarket approach as the daily provision of all services to the community but does not specify how these services will be offered (Pillay and Asia, 1999). The question that arises is, "Is the supermarket an ideal concept to use to describe an approach used in PHC service delivery?"

The emphasis on consumerism is very new to managers in the health service sector (Winkler, 1987: 1). Winkler argues that many people reject the commercial concept of 'consumerism' as not being relevant for organizations concerned with patients' rights. He argues that the supermarket vision of customer relations extends to reducing the waits at the check-out counter and exchanging faulty goods with the minimum of questions asked. It does not extend to consulting them about investment or even about what should be on the shelves, let alone in their products. The supermarket concept certainly does not mean that retailers help customers sue manufacturers of products that have caused harm. A number of studies reveal that the supermarket approach is preferred by patients for the delivery of services (Shah et al., 2002; Thomas, Murray and Rogstad, 2006; Botsford, 1997). The findings of the study that was done by Thomas et al. (2006) revealed that half of the patients would prefer a separate clinic for under 20 year olds and only 35% wanted a one stop shop for the delivery of sexual health services.

5.3.3 One stop shop

IPHC was also conceptualized as the provision of services to the patient by one nurse. Functional integration as explained before, meets both patient and organizational needs since the patient receives the comprehensive package of primary health services in one location, in one visit. Toomey (2000:14) refers to this approach as a 'one stop shop'. Tint et al. (2000: 15) state that IPHC implies that services will be rendered by the same provider(s) in the same consultation in one visit. The comprehensive primary health care service package for South Africa states that through a one-stop approach, the facility provides comprehensive integrated PHC service for a minimum of eight hours per day, five days a week (Department of Health 2001b:12). However, during data collection, the researcher noted that the majority of the clinics were opened for extended hours in order to make services more accessible to the community.

Retail markets have increasingly provided consumers with the ability to do one stop shopping. In grocery retailing, for example, supermarkets have come to offer many categories. These include fresh baked goods, deli products, fast food, liquor, clothes, banking service and flowers that were once sold in smaller more specialized stores (Messinger and Narasimhan, 1997: 2). Given the magnitude of these changes, these two authors explored the reason why the one stop shop had grown in popularity. Their results revealed that greater prevalence of one-stop shopping was firstly in response to growing consumer demand for time-saving convenience and secondly, technological improvements had made the establishment and running of large supermarkets more cost-effective.

In the health care service delivery, French et al. (2006: 202) alluded to this explanation by referring to one stop shop as "provision of services on a single site". These authors argue that one stop shop services have evolved in different ways, dependent on setting, provider interest and resources. Their study has

identified the following strengths and weaknesses associated with a one stop shop approach in delivering sexual health services (See Table 7).

Table 7: Summary of strengths and weaknesses associated with a one stop shop approach in delivering sexual health services

	Strengths	Weaknesses
Logistics	• Provides sexual health care under one roof	• Lack of clarity about who should provide care and what levels of care should be provided. • Different ways of collecting data and monitoring
Public health	• Evidence of reduction in defaulting after referral to second service • Opportunity to screen for other health problems • Health issues are commonly related and some users may be unaware of the need for the alternative service	• If target population for each service is different then utilization is not increased • Contraceptive clients are not at disproportionate risk of HIV/STIs • Centralization of services can reduce access and increase delays
User	• Many consumers appreciate advantages of one stop shop • Move towards a holistic philosophy of care • Provides continuity of care • Referral to a second service reduced	• Reduced service in both areas • Evidence of reduced information given to clients • Some users prefer separate specialist services which offer more choice
Staff	• Potential to increase staff job satisfaction due to extended role • Improve career opportunities • More team approach • Greater management flexibility	• Staff lose specialist skills • Results in overloading of staff • Contradictory service cultures makes working together challenging • Staff may prefer different employment conditions
Cost	• Avoid duplication of services • Reduced client/provider contacts • Opportunity for cost sharing • Both client groups have similar needs	• Cost increase if service offered is comprehensive • Reduction in specialized funding for services

Source: (French et al., 2006)

The above table clearly indicates that one stop shop approach has its own advantages and its flaws. Although the above table focuses on the delivery of sexual health services, which is a component of IPHC, the same principles apply to the delivery of IPHC. For example, the findings of the study by French et al. (2006) as indicated on the above table indicates that through the one stop shop approach, patient convenience, clinic efficiency and effectiveness are achieved. As an approach for a broader phenomenon of IPHC, the one stop shop is a move towards a holistic philosophy of care and this would ensure that gaps in service provision are addressed and operational systems such as integrated patient records are streamlined. One of the weaknesses of the one stop shop that was identified by French et al. (2006) was that staff may lose their specialist skills. One of the questions that was raised by Botsford (1997) in her study on specialists or expert generalists is whether health services need clinical experts with particular bodies of knowledge or whether they would operate better with multi-skilled workers.

Sharrock and Happell (2006: 9) in their study on competence in providing mental health care, argue that nurses working in general health care settings have difficulty in meeting the needs of mentally ill patients due to a lack of knowledge, skills and confidence in the assessment and management of mental health problems. In its health report, WHO (2006b) argues that skill mix and distribution imbalances compound today's problems as a result, the skills of limited, yet expensive professionals, are not well matched to the local profile of health needs. According to Bodenheimer (2006: 861), the great majority of patients prefer to seek initial care from a primary care physician rather than a specialist. He further argues that at the same time, primary care physicians are expressing frustration that the knowledge and skills they are expected to master exceed the limits of human capability, making it impossible to provide quality care to every patient. The same could be applicable to PHC nurses who are expected to provide a

range of services to a variety of patients; with or without the requisite competencies to render such a service.

Tint et al. (2000: 15) argues that the integration of services is understood differently by different people, depending where they are positioned within the health system structure. This has implications in terms of how IPHC is implemented. However, the participants' understanding of IPHC is somehow similar to the definition of PHC offered by the Institute of Medicine that defines it as "the provision of integrated, accessible health care services, by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients and practicing in the context of family and community" (Donaldson, Yordy and Vanselow, 1994: 16).

5.4 CAUSAL CONDITIONS

From the data sources, it emerged that IPHC in South Africa arose in response to both community needs and service needs. According to Health Sector Strategic Framework 1999-2004, prior to 1994 the South African health system was built on apartheid ideology and characterized by racial and geographic disparities, fragmentation and duplication and hospi-centreicism with lip service paid to the PHC approach. Access to health care for rural communities and those classified as 'blacks' was difficult (Department of Health, 1999: 5). Because equity and access to health care have since 1994 been considered the key principles to steer the transformation of health services in South Africa, a mechanism was required to define parameters for service delivery. This mechanism was realized in the form of comprehensive PHC service package which provides guidance on which services should be made available at different levels of care (Department of Health, 2001a).

5.4.1 Improving access to health care

All the participants interviewed reported that the drive behind the introduction of IPHC was to improve accessibility of services to the community. Accessibility is defined as “the continuing and organized supply of an equitable level of health care that is within easy reach of all citizens geographically, functionally, financially and culturally (Hattingh, Dreyer and Roos, 2006: 121). Asserting to this, Tint et al. (2000: 15) as discussed in the previous chapters, states that the integration of services policy was put in place to increase health service utilization by increasing the accessibility and availability of all health care services at PHC level. Much of the rationale for IPHC was to reach low income communities with health care services, therefore the primary concerns are physical access and distance to care. The White Paper on health identifies the need to focus on vulnerable groups and to achieve universal access to an essential package of PHC interventions (Republic of South Africa, 1997). Similarly, the constitutional right to health combines the consideration of prioritizing the most disadvantaged people in the population and establishing core minimum obligations or standards.

The Department of Health states in its Strategic Plan 2006/7-2008/09 that the provision of the wider basket of comprehensive PHC services improved in most health districts during 2004/05 and the use of services improved from 96 million to just over 100 million visits per year (Department of Health, 2006b: IV). The National Minister of Health in South Africa alluded to this in her budget speech by stating that access to PHC services had doubled over the last decade to 101 million visits in 2007/08, compared to 67 million in 1998 (Tshabalala-Msimang, 2008). According to the Annual Report 2007/08, a national PHC utilization rate of 2.2 visits per person was achieved in 2007/08, which was slightly higher than the 2.1 visits per person between 2006/07 and 2007/08 (Department of Health, 2008: 4). The findings of the study that was conducted by Maharaj and Cleland

revealed that the providers of PHC services were of the opinion that the integrated services served the needs of clients more efficiently and effectively than vertical programmes, and as a result, are more likely to contribute to greater client satisfaction (2005: 313).

5.4.2 Shortage of staff and limited infrastructure

IPHC was put in place in South Africa to address the problem of a shortage of staff and limited resources in PHC settings. The PHC package identifies shortcomings in both equipment and training availability hence it advocated IPHC (Department of Health, 2001a). Brown and McCool as cited by Kodner and Spreeuwenberg (2002) suggested that the integration of services results in less duplication and wastage of human and material resources. African countries have a very low density health workforce, compounded by a poor skills mix and inadequate investment (Chen, Evans, Anand, Boufford, Brown, Chowdhury, Cueto, Dare, Dussault, Elzinga, Fee, Habte, Hanvorangchai, Jacobs, Kurowski, Michael, Pablos-Mendez, Sewankomba, Solimano, Stilwell, de Waal, and Wibulpolprasert, (2004). Over the years the production of health professionals in this country has either declined, remained static or increased only marginally (Department of Health, 2006a). As the South African population continues to grow, there is the need to maintain the production of health professionals to care for it. It is now being argued that one of the constraints in reaching many of the key health MDGs, particularly the three-health related goals namely, reduction in child mortality, improving maternal health and combating HIV/AIDS and other diseases, such as tuberculosis and malaria, is the poorly functioning health systems in much of the developing world, with one of the main problems being the shortage of health care workers (Travis et al., 2004; WHO, 2006b; Rhode, Cousens, Chopra, Tangcharoensathien, Black, Bhutta, and Lawn, 2008).

Since the first group of nurses was trained in clinical health assessment, treatment and care in 1982, South Africa has come a long way. There has been a major shift in health care from a mainly hospital based to a PHC focused health care service and these changes have made health care more accessible to the community. These changes place a tremendous burden on PHC nurses. The Department of Health acknowledges that the free health care policy and clinic upgrading and building programme led to an increase in PHC services utilization (Department of Health, 2000). This is supported by the opinion of a professional nurse at such a clinic who has worked her entire life for the State: "*There are so many people in the public sector who need us. We are very short staffed and there are so many patients, the need is great"* (Thom, 2005: 116). However, the Department of Health (2006a: 14) argues that public spending on human resources is in excess of 65% of the health sector's annual budget. As will become apparent in the discussion under the section on unintended consequences, the result was in fact more overcrowding and a severe shortage of staff. Perhaps as noted by French et al. (2006), contrary to expectations, IPHC is overloading the available staff rather than dealing effectively with the challenge of staff shortage.

In her budget speech for 2008, the National Minister of Health of South Africa reported that among the successes of the Department of Health, there has been an increase in the number of health professionals employed in the public health sector, including training of midlevel workers in a range of health disciplines. She further reported that community service for professional nurses commenced in 2008, further increasing the number of nurses available to serve the community. She also reported that in order to address the challenge of the shortage of health professionals, a clinical associate programme commenced in January 2008 and the first cohort of 23 students started training in Walter Sisulu University (Tshabalala-Msimang, 2008).

5.4.3 Need for equity and redress

Historically, it is important to note that the legacy of apartheid policies in South Africa had created a fragmented health system with racially based services. Before 1994, as discussed in preceding chapters, South Africa's public health services were racially segregated, highly unequally distributed between the rural and urban areas and rich and poor communities, overwhelmingly hospital-based and curative in their emphasis. Health policy in the apartheid era, like all government action, served the dominant objective of maintaining economic and political power for the white population group. As a result, the health system inherited by the new government in 1994 was highly fragmented in structure, with 14 separate departments to look after the health of different racial groups, and six self-governing territories. In comparison with the rest of South Africa, the homelands displayed massive inequities, disparities and backlogs in respect of health care (van Rensburg et al., 1992). The Pick report published in 2001 described "complex distortions of supply, production, distribution and development of health personnel". In terms of nursing it found "no uniformly applied staffing ratios in health facilities and striking inequalities between urban and rural facilities" (Pick et al., 2001: 1).

The participants in this study reported that IPHC was put in place to address issues related to equity and redress. Equity is traditionally understood as being rooted in the notion of distributional justice that is purely a function of distribution of health care access (McIntyre and Gilson, 2002: 1639). These authors further identify the following as the key equity challenges that the ANC-led government was faced with:

- Redistributing public sector health care resources between and within provinces;
- Initiatives to increase PHC utilization levels for the disadvantaged groups; and

- Addressing the public/private mix to facilitate making resources currently located in the private sector accessible to a broader section of the population, and/or redistributing resources from the private to the public sector.

Considerable progress was made in re-allocating health budgets between provinces during the first two years after the 1994 elections when provincial budgets were determined by the Health Function Committee. Since the adoption of the Constitution of the Republic of South Africa (1996) and the move to a fiscal federal system, provinces were allocated global budgets. Provinces have the authority to decide to a large extent, how much of the global funds transferred to them are allocated to the various sectors such as health. The decentralization of the decision making authority for resource allocation to the provincial level appears to be the major factor that is slowing down the move towards a more equitable distribution of PHC resources across provinces (Okorafor, 2005).

The participants of this study reported that the National Department of Health had implemented a range of actions to try to address these imbalances by introducing scarce skills and rural allowances in 2003, importing doctors from other developing countries, the introduction of community service for doctors and other health professionals including nurses as from 2008. However, despite these actions, there have been criticisms that there has been a skewed distribution of health personnel between provinces and between public and private sectors. As a result, the National Department of Health put in place a National Human Resources Plan for Health in 2006. The purpose of the plan was to provide a national guideline for human resource policy and planning to ensure that the right human resource mix was applied in the health sector to fulfill the health care delivery objectives in South Africa (Department of Health, 2006a: 2).

5.4.4 Fragmented PHC services

The participants reported that the main aim of integrating PHC services was to transform the fragmented services into comprehensive and integrated services. Pre 1994, South Africa had a highly fragmented and bureaucratic health care system. The term 'fragmented' not only describes the existence of racial segregation but also the existence of a confusing multiplicity of authorities and structures responsible for the management and delivery of health care (De Beer, 1988: 1). Further fragmentation occurred as a result of vertical services delivery, with the curative and preventative services being delivered by different authorities: the former falling under the provincial government and the latter under local government structures. Schierhout and Fonn (1999: 29) define vertical programmes as those programmes that are free-standing at all levels. There has been a pressing need to co-ordinate local authority and provincial services in South Africa, particularly in KZN.

5.5 THE CONTEXT OF IPHC

According to findings of the study, the current national health policies emerged as part of the context within which IPHC was introduced. A review of documents explicating the policy environment since 1994 corroborates these observations. The National Policy Framework that guided the National Department of Health in introducing IPHC includes a National Health Plan for South Africa (ANC 1994a), the RDP (ANC 1994b), the Constitution of the Republic of South Africa (1996), the White Paper for the Transformation of Health System (Republic of South Africa, 1997), and the Comprehensive PHC Service Package for South Africa (Department of Health, 2001a). When the ANC came to power in the first democratic elections in 1994, it committed itself to implementing measures to reduce poverty and to redress the disparities of the past.

The RDP was used by ANC as a tool to deal with the apartheid legacy of the past. The RDP described a package of social and economic policies that were aimed at redressing the massive inequities within all spheres of South African life. One of the six tenets that underpinned the political and economic philosophy of RDP was the intention to introduce an integrated and sustainable programme for development that harnessed all the available resources in a coherent and purposeful effort (ANC, 1994a: 4). Furthermore, the RDP laid the foundation for the introduction of IPHC by setting programmes that had both a direct and indirect bearing on health care and these programmes encompassed: meeting of basic needs, upgrading of human resources, strengthening the economy, democratizing the state and society and the public sector more efficient. It is not surprising therefore, that the participants in this study cited a facilitative policy environment and a change of government as the context that ensured a realization of the variables that were favourable for the adoption of IPHC in South Africa.

In its attempt to re-organize health care service delivery, the ANC as a leading political party, with the help and the technical support of the WHO and the United Nations Children's Fund (UNICEF), prepared a National Health Plan in May 1994. The National Health Plan for South Africa (ANC, 1994a) was an extension of the RDP. The Plan reiterated the basic tenets of the RDP, but then proceeded to elaborate in detail the post apartheid health strategy. The policy proposed the provision of free health services for certain categories of consumers and treatments at the clinics. These include:

- children under six years of age;
- pregnant women;
- the elderly;
- the disabled and certain categories of chronically ill;
- promotive and preventive activities;
- school health services; and

- provision of contraceptives (ANC, 1994a: 19).

Prior to the 1994 democratic elections in South Africa, health care services were deemed a privilege rather than a right and the main beneficiaries were the privileged classes, in the main whites (van Rensburg, 2004: 116). In the Bill of Rights Chapter 2 of the Constitution of the Republic of South Africa (1996) pays special attention to, among others, the right to access to health care services as previously discussed. The Bill of Rights, supported by the Constitution of South Africa, declares health care as a basic human right. It is therefore, the responsibility of government to ensure that all citizens enjoy access to health services. The Batho Pele (People First) programme across the public sector and the Patient's Rights Charter across the health sector showed government's commitment to humane service delivery and the creation of accountability of civil servants to local communities and consumers of government services (Department of Health, 2001b: 10-11).

The main health policy document after 1994 was the White Paper for the Transformation of the Health System in South Africa. The White paper, published in the Government Gazette Number 17910 Volume 382 on 16th April 1997 by the Ministry of Health, laid the framework for restructuring the health sector. The aim of the White Paper was to present policy objectives and principles upon which the unified health system of South Africa would be based to reduce disparities and increase access to improved services. The strategic approach guiding the White Paper is that of a comprehensive PHC, which accords with and builds on the health objectives spelled out in the RDP and the National Health Plan for South Africa. The paper identifies the DHS as the "major locus of implementation" for the health system, enabling the development of a single, unified health system emphasizing the PHC approach and facilitating community involvement in the "planning, provision, control and monitoring of services" (Republic of South Africa, 1997: 12). Chapter 4 of the White Paper sets

out the intentions for the future development of human resources. One of the main principles listed was the training and development of health personnel, albeit with special emphasis on the PHC approach. It consists of 21 chapters dealing with different health aspects under the control of the Department of Health. The aims of restructuring the health system were to:

- Unify the fragmented health services at all levels into a comprehensive and integrated national health system
- Reduce disparities and inequities in health service delivery and increase access to improve integrated services based on PHC principles
- Give priority to maternal, children and women's health and
- Mobilize all partners including the private sector, non-government organizations (NGOs) and communities in support of an integrated national health system.

In 2001, the National Department of Health introduced a comprehensive PHC core package. The PHC core package represents the services that should be rendered for PHC services to be regarded as fully comprehensive (Department of Health, 2001a: 7). The package further attempts to define services in terms of both level of care and approach. Services at the clinics were defined, not by size of the facility, but by the level of skills of the staff. As such they include, as part of the common package, services which can be delivered by a professional nurse. Additional services could be delivered if regular visits by doctors or other specialists are organized. For the organization of clinics, the comprehensive PHC core package suggests three service points, namely children, adults and fast queue/ repeat, although local clinics may choose different types of organization (Department of Health, 2001a: 9).

5.6 ACTION/ INTERACTION STRATEGIES

Clinic organization emerged as an important factor to ensure smooth running of the clinic. Harrison (1997: 28) alluded to this by identifying re-organization of services as a pre-requisite for successful implementation of IPHC. The following strategies were identified as systems that were put in place to ensure clinic organization: (a) queuing systems, (b) special days for certain programmes, (c) dedicated staff members for certain programmes, (d) rotation of staff members, and (e) extended hours.

5.6.1 Queuing systems

PHC clinics have processes in place that they provide as queuing systems in which patients arrive, wait for service, and then depart. Customer satisfaction is improved by predicting and reducing waiting times. Ajayi (2002: 121) states that waiting times at outpatient clinics, especially in developing countries have been demonstrated to be long. Pillay and Asia (1999) suggest tracking of patients from arrival until discharge to identify blockages that may necessitate re-organization of services to ensure better throughput.

According to Fomundam and Herrmann (2007) in a queuing system, minimizing the time that customers wait and maximizing the utilization of the nurses are conflicting goals. When a patient is waiting in a queue, he/she may decide to forgo the service because he/she does not wish to wait any longer and these two authors refer to this as reneging. The clinics where their study took place had queuing systems in place to reduce reneging where patients were separated by the type of service required. They had a fast queue for those patients that did not need a full physical examination. Roche et al. as cited by Fomundam and Herrmann (2007) found in their study that the number of patients who leave the health care service without being served is reduced by separating non-acute

patients and treating them in dedicated fast-track areas. Participants further indicated that they had walk through services for patients with special needs like workers, particularly the farm workers in rural clinics. The participants reported that the services were made available to suit their working hours. This service was offered as part of extended service or they were attended to before the rest of the patients.

The results of the current study also revealed that a numbering system was also used to control queues where patients were given numbers on arrival since patients at times jumped the queue. A numbering system and blocking are terms that are sometimes used interchangeably yet they have different meanings. Fomundam and Herrmann (2007) describe blocking as a queuing system which places a limit on queue length. These authors further explain that patients are turned away once the numbers are finished or when the waiting room is full and this implies denying access to health care services. However, the participants in this current study reported that the numbering system was not implemented to limit the queue but as a control measure.

Green (2006) argues that on arrival, patients are placed in different queues, each of which has a different service priority, the queue discipline may be preemptive or non-preemptive. In the latter, low priority patients receive service only when no high priority patients are waiting, but the low priority patient who is receiving service is not interrupted if a high priority patient arrives and all nurses are busy. In the preemptive queue discipline, however, the service to a low priority patient is interrupted in this event. In the current study, the researcher observed that in those clinics where the supermarket approach was used, patients who came on the day when a particular service was not offered, were seen last when all priority patients had been attended to unless there was an emergency.

Clinics were also using a booking system or an appointment system for certain services to reduce arrival variability and waiting times at the facility. The participants reported that when using a booking system, some of the services were offered in the morning and some during the latter part of the day. This practice is supported by the handbook for clinics/CHC managers which state that patient flow should be arranged to ensure that work is spread throughout the day by using block times or appointment schedules for return visits (Pillay and Asia, 1999). Ajayi (2002: 121) indicates that a long wait is common in the health care setting where patients are not given time-specific appointments. Kurata et al. as cited by Ajayi (2002) identify several factors responsible for non-utilization of time-specific appointments in some settings. Some of these include a cultural perception of time, low literacy level of patients, poor transportation systems in the community and lack of understanding about the appointment system. DeLaurentis et al. as cited by Fomundam and Herrmann (2007) point out that if patients do not keep their appointments, this could lead to a waste of resources. These authors propose implementing a short notice appointment system based on a queuing network analysis tailored to the realities of any particular clinic.

5.6.2 Special days for certain programmes

The participants further mentioned that they had special days for certain programmes that required more time and expertise due to the number of activities involved in those programmes. For example, group and individual counselling of patients, taking of specimens and extensive assessments are time-consuming. They further reported that if the patient came on a day when the service was not offered, that particular service would be offered to the patient and she would then be given a return date that would correspond with the day when the service was offered. The practice of rendering part of the PHC programmes on certain days is in contrast with what is outlined by the norms and standards of the PHC package of South Africa which stipulates that the clinic

should render comprehensive IPHC services for at least eight hours a day, five days a week (Department of Health, 2001b: 12). This is further supported by Chabikuli, Blaau, Gilson and Schneider (2005: 111) who state that all services must be available everyday and all PHC nurses must have the competency to render all services in the comprehensive PHC package.

5.6.3 Dedicated staff members for certain programmes

In order to ensure the smooth running of the clinic where the supermarket approach was used, the participants reported that certain programmes were allocated to dedicated staff. According to the National PHC survey, the comprehensive 'supermarket' approach to health care is more efficient as users can attend one facility to obtain several services (Health Systems Trust, 2004: 18). The allocation of programmes to certain individuals then reflects the emphasis on nurturing of skilled generalists rather than specialists, hence the rotation of staff.

5.6.4 Rotation of staff members

In order to ensure that nurses did not lose their skills of rendering other services in the clinics where supermarket approach was used, nurses reported that they rotated in all programmes for a set period. They reported that they rotated the services on three or six monthly basis so as to develop skills and confidence in rendering all the services. However, the nurses interviewed reported that some of the nurses resisted rotation schedule. This could be attributed to the fact that some lacked confidence since they did not have the skills to render all of the services. The participants also reported that some nurses resisted rotating because they felt comfortable with particular programme and had bonded with their patients that attended it. Tembani, van Rooyen and Strumpher, (2003: 69) recommend a long term clinic rotation plan which is sufficiently flexible to take

special requests into account. These authors argue that stress caused by a need to continually orientate and arrange training for new staff, is minimized. On the contrary, research studies on rotational programmes that have been conducted by Charnley and Kelly as cited by Varden (2006: 32) revealed that nurses welcome the opportunity to gain a variety of clinical experiences. The vision for the rotational model as explained by Bellot (2005: 38) is to fast-track the development programme that would address the future needs of the system by preparing nurses for a specialist qualification in a specialization of their choice. The individual would then be expected to demonstrate academic ability while delivering expert care in a variety of clinical environments. High quality nursing care can only be a reality in an environment where nurses are kept up to date with modern developments (WHO, 1996).

5.6.5 Extension of hours of service

The participants reported that the clinic was opened for extended hours in order to make services more accessible. This was done to accommodate patients who could not attend during working hours. The utilization of clinics in eThekwini district was found to be lower than expected and the district had embarked on strategies to ensure improved utilization by extending hours of service in selected clinics, especially in areas where there were no CHCs which render 24 hour service (KZN Department of Health, 2006a). This is supported by the findings of the study that was done by Souliotis and Lionis (2004: 648) on IPHC in Greece which recommended extended working hours of facilities in order to have functional primary care. However, extension of hours of service requires an internal shift rotation system so that there is adequate staff to provide services. According to Scott (2004: 180), internal shift rotation was developed in response to the need for high quality continuity of care for patients for 24 hours a day. Although extension of hours is aimed at improving accessibility of services, nurses in Britain are dissatisfied with the internal shift rotation. According to the

Royal College of Nursing (RCN), more than 39% of nurses want to leave nursing where internal rotation is the main system in place. The RCN further argues that this system denies nurses the basic right of being able to balance their professional and personal lives. It is therefore, advocating for the abolition of compulsory shift system (Scott, 2004: 180).

The clinic staff would need to feel safe and secure in order for them to be able to render 24 hour services especially at night in the PHC setting. The reported incidents of assaults on staff were recorded for the first time in the National PHC facilities 2003 survey. Robberies or assaults were reported in 18% of facilities nationally. In KZN more than six out of ten facilities (66%) and more than four out of ten nationally (42%) were judged to have adequate security (Health Systems Trust, 2004: 37). The findings of the study that was done by Tint et al. on IPHC revealed that the common concerns raised by health providers pertained to lack of security for night duty staff as being one of the factors hindering the implementation process (2000: 15).

5.7 INTERVENING CONDITIONS

Data sources revealed that the implementation of IPHC was influenced by a number of conditions. Facilitative conditions that emerged were: (a) positive attitude of staff, (b) orientation of nurses, (c) involvement of the multi disciplinary team, and (d) community participation. On the other hand, some intervening conditions were categorized as hindering and these included: (a) shortage of staff, (b) limited resources, (c) inadequate infrastructure, (d) structural and functional fragmentation, (e) lack of career development, (f) lack of capacity building, and (g) service/education disjuncture.

5.7.1 Facilitative intervening conditions

5.7.1.1 Positive attitude of staff

Staff morale and attitudes are factors that impact significantly on policy implementation and the overall quality of health service provision. The Study Group on Integrated Care alluded to this by stating that the success or failure of integration depends on the attitude of service providers who need to work together (WHO, 1996: 4). There is evidence that working within an integrated service maximizes staff motivation. The positive attitude and good working relations among staff emerged as important factors in the successful implementation of IPHC. This is supported by the findings of the study that was done by Mashego and Peltzer (2005: 15) on community perception of quality of PHC services where the results revealed the staff showed different attitudes. The participants reported that some staff members were polite whilst some were perceived to be insensitive to patients. Sibbald (2008) support these authors by stating that nurse led PHC care is superior in that nurses give more information to patients regarding their ailments. While staff commitment is no doubt an essential precondition for successful integration, IPHC is unlikely to be fully realized unless staff are trained in all services that are offered in the clinics. Linked to training are the issues of supervision. Without supervision staff easily feel unappreciated and insecure, particularly in the implementation of new policies and treatment regimes (Lehmann, 2008). Orientation of nurses was therefore cited as one of the facilitative intervening conditions. However, Tarimo (1991: 86) argues that at times training and redefinition of tasks may not be enough by themselves to motivate health workers adequately. The author suggests that it may be necessary to improve both the status and financial rewards of all staff to expect good performances.

5.7.1.2 Orientation of nurses

The participants reported that those nurses who were not trained or qualified to offer some programmes, attended orientation programmes to enable them to render these services in an integrated manner. Of special concern is that although nurses form the backbone of the PHC system in South Africa, their training has not oriented them towards the provision of a comprehensive discourse of care. However, the World Health Report (2006) asserts that in recognition of the rapid growth and rate of change of knowledge, and dynamics of the workplace, there is increasing acceptance that training programmes cannot teach everything nurses will need to know. Educational processes have therefore been moving away from didactic teaching towards student-centred, practice-based teaching and problem-based learning, with greater emphasis on 'know how' rather than 'know all' (WHO, 2006b). Reorientation and in-service education programmes for nurses are therefore important in facilitating a comprehensive discourse of care (Tarimo, 1991; Peterson, 2000; Toomey, 2000; Walley et al., 2008).

According to the National PHC Facilities Survey of 2003, very few nurses in KZN had received training updates during the 12 months preceding the survey (Health Systems Trust, 2004: 31). For example, only 10% of professional nurses had received training updates on IMCI and 24 % of professional nurses had attended updates on TB diagnosis and management. Continuing education is an enormous challenge in South Africa. Lehmann and Makhanya (2005: 143) argue that training courses are often of short duration, so they do not impart the required knowledge and skills adequately. These authors advocate for a comprehensive capacity development programme that will allow for a guided acquisition of theory and practice.

Often training workshops or courses for district-level workers are held at a central venue or at an academic institution outside the province, to which various districts are asked to send one or two people. This may be a challenge, particularly for health workers from rural areas who may find it difficult to access these workshops, reinforcing patterns of inequity (McCoy et al. 1998: 38). Programmes often train health workers by taking them away from their jobs for several days or weeks, leaving their posts vacant. Travis et al. (2004) argues that this training tends to be uncoordinated across programmes, and may result in the same worker receiving the same training courses in a year, with a substantial loss of services being delivered. On the other hand, training workshops provide an opportunity for interaction between health workers from different health centres.

5.7.1.3 Involvement of the multi-disciplinary team

One of the strategies employed in providing a comprehensive, integrated service is the incorporation of visits to clinics by doctors and other health professionals in support of the other members of the PHC team, particularly nurses. Because of the shortage of health workers in an integrated PHC approach, health workers must work as a team. An effective IPHC can only be achieved through teamwork. Teamwork means that everyone involved needs to understand the system, their own role in it, and have an appreciation of and acknowledge the importance of everyone else. The final outcome of this involvement is better health for the community (Tumbo, Hugo and Couper, 2006: 16d). While Sibbald (2008) states that nurses should be acknowledged as the true frontline providers of PHC, Knight (2008) argues that moving to a purely nurse led service would be a backward step in a climate of increasing multi-professional working. Knight (2008) acknowledges that the roles of doctors and nurses while dynamic are different. He states that each needs appropriate, role focused training.

PHC service provision, although supported by visiting doctors and other health professionals is nurse driven in the South African public health sector. For innovation in the public sector to be successful, sustainable and replicable, it must have support of all role players to provide quality care. Professional nurses, who often have varying degrees of training in PHC, run these clinics. Usually visiting doctors, employed by the district hospital or by the district itself, support them. These doctors visit the clinics on a schedule that varies from monthly to daily, depending on the situation and the need. In selected communities, medical students, supervised by medical practitioners, provide health services at clinics (South Africa Yearbook, 2007/08: 332). The Department of Health estimates that 30% of PHC clinics benefit from a doctors' visit at least once a week (Republic of South Africa, 1997). However, there is unequal distribution of doctors in rural and urban areas in South Africa. For example, the doctor: population ratio in the Western Cape is 10 times higher than in some of the poorer rural provinces (Aitken and Kemp as cited by Van Damme et al., 2008: 2111). Evaluation of community service programme suggests that new graduates continue to feel ill-prepared for service in rural areas and PHC settings. Lack of skills is aggravated by insufficient supervision, particularly in rural areas where community service doctors find themselves the only doctors in certain facilities (Lehmann, 2008). Increased recruitment of medical students from rural areas would also be an effective strategy to improve rural retention of nurses and doctors upon completion of community service (De Vries and Reid, 2003).

Besides the problem of a shortage of doctors, the findings of the study that was done by Couper, Malete, Hugo and Tumbo (undated) on the role of the visiting doctor in PHC clinics (unpublished paper) identify transport as a critical aspect in making a success of the visit. These authors state that if there is a problem with the transport, it makes it impossible for the doctor to reach the clinic on time and this breaks the continuity and the trust that patients and staff have in the doctor. These authors further recommend that the doctors should be allocated to a

specific clinic at least for a specified period, for example six months, to maintain continuity and the building of relationships.

5.7.1.4 Community participation

The findings of this study revealed that the successful implementation of IPHC was influenced by community participation. The concept of community participation in health first appeared over three decades ago in the developing world as part of movement for social justice (McCauley as cited by Bandesha and Litva, 2005: 241). One of the PHC principles that were identified at the Alma Ata conference was the principle of community participation. The 1978 Declaration of Alma-Ata defines community participation as “the process by which individuals and families assume responsibility for their own health and welfare and for those of the community, and develop the capacity to contribute to their community’s development” (WHO, 1978: 20). Alma-Ata declaration further states that “the people have the right and duty to participate individually and collectively in the planning and implementation of their health care” (WHO, 1978: 3). This suggests that a meaningful approach to enabling community participation must be integrated through all stages of the planning process, at both strategic and operational levels. It also suggests that community participation is closely linked to the process of empowerment, whereby people gain confidence, self-esteem, understanding and power to take increased control over their lives. The community can be involved in the assessment of the situation, the definition of problems and the setting of priorities, and can then help to plan PHC activities and co-operate when these activities are carried out (Dennill et al., 1999: 9). For the clinics included in the study, community participation was found to be in the form of clinic committees and health forums where health related issues were discussed by the clinic staff and the communities.

The concept of community participation has been used in a wide variety of ways to mean many different things. Rifkin (1996) argues that the framers of the Alma Ata Declaration purposely left the concept of community participation vague and flexible in recognition of the fact that countries presented diverse contexts. Rifkin concludes that the concept has become many different things to different people making it difficult to reach a generally agreed definition. Although many people agree that community participation is critical in development programmes, very few agree on its definition. As the debate on the meaning and practice of community participation continues, it would appear that it has become an umbrella term for a people-centred approach to development. It is generally acknowledged by national and international health planners that community participation is the key to successful organization of PHC.

In order to ensure active participation of communities in health programmes, the National Department of Health in South Africa states clearly that all PHC facilities must run community outreach programmes aimed at galvanizing the energies of communities (1999: 17). Community empowerment is considered central to the process of participation, enabling people to have a greater say and more control over their own lives and local health decisions. Active involvement and participation of communities in those matters that affect their health and well being lie at the very core of a well-functioning district-based PHC system. The Health for All policy frameworks for the WHO European region states that countries should have health services that ensure individual's participation and recognizes and supports people as producers of health care (WHO, 2002).

5.7.2 Hindering intervening conditions

5.7.2.1 Shortage of staff

Shortage of staff emerged as one of the conditions that the participants regarded as a constraint of the successful implementation of IPHC. Both the Constitution of the Republic of South Africa and the National Health Act 61 of 2003 mandate the National Department of Health to ensure delivery of health services to the South African society (Republic of South Africa, 1996; Republic of South Africa, 2004 respectively). This signifies ensuring the provision of adequate human resources to enable the health system to deliver on that mandate. Currently the number of posts in the PHC system may be too few given that the public health sector is now serving more people than pre-1994. The Department of Health acknowledges for example, that the free health care policy and clinic upgrading and building programme have led to an increase in PHC services utilization (Department of Health, 2000). This is further supported by the findings of the study that was conducted by Walker and Gilson (2004) on the experience of PHC nurses of the free health policy. The study described the nurses' commitment and agreement with the policy. It also found that the frustration over resource limitation, poor communication and limited consultation was central to nurses' practical experience of the policy. According to Cleary, Chitha, Jikwana, Okorafor and Boulle (2005: 69) PHC utilization is approximately 2, 5 visits per capita, based on 2002/03 District Health Information System (DHIS). However, these authors further state that the target PHC headcount is 3, 85 visits per capita and this has implications on staffing.

According to the Department of Health (2000: 13) nurses constitute the largest professional group in South Africa's health care services and form the backbone of PHC in South Africa. Nurses provide the bulk of service provision in the public health sector. This emphasis is most striking at the primary care level. Given

this situation, the need for well-trained primary level staff is imperative. The South African yearbook (2004/05: 345) states that patients visiting PHC clinics are treated mainly by PHC-trained nurses, or at some clinics, by doctors. However, according to the Department of Health (2004: 8) only about 40% of facilities have PHC qualified nurses. This means that the pace of training has been slower than planned. However, migration of nurses has also impacted on these figures.

A number of research studies have attempted to explore the 'push and pull' factors that result in South African nurses working in other countries. Emigration is a commonly cited the main cause of the PHC attrition rate in South Africa. Migration of health personnel, also dubbed the brain drain, partly from rural to urban areas, but more particularly out of the country, has become a debated issue in human resource circles, not only in South Africa, but also on the continent of Africa itself. According to the Department of Health (2006a: 27) for many years before 1994, South Africa constituted a preferred destination for many health professionals, the majority being doctors from the African continent. This situation has, however changed since the late 1990's when a policy of not recruiting from fellow developing African countries was adopted at the Southern African Development Community (SADC) Health Minister's level. The findings of the study that was done by Oosthuizen and Ehlers (2007: 23) indicated that nurses' inadequate remuneration, poor working conditions, excessive workloads, lack of personal growth and career advancement possibilities were major factors that influenced nurses' decision to emigrate. Lucas (2005: 1037) argues that although African countries have a shortage of health workers, they continue to migrate from Africa to more developed countries. Tarimo (1991: 86) argues that it is unrealistic to expect good performances under the difficult conditions from workers who are poorly rewarded.

In addition, the World Health Report cites death from HIV/AIDS as the largest cause of worker exits from the workforce in several Southern African countries (WHO 2006b). Van Damme et al. (2008: 2108) state that high AIDS-related mortality among young adults is ravaging societies in Southern Africa. Up to 15,7% of South African nurses in the young age group were estimated to be infected with HIV in 2002 (Shisana, Hall, Maluleke, Chauveau and Schwabe, 2004: 849). Furthermore, WHO estimates that 2, 5% of HIV cases in health workers around the world are as a result of needle-stick injuries. Such high HIV prevalence among health workers has serious implications for the health system. Those who remain often work in under-staffed health facilities that are overburdened with patients who are often infected with HIV. High prevalence rate of HIV would lead to high staff absenteeism, low morale, overloading of non-infected workers and increased occupational exposure to HIV in health care settings (Shisana et al., 2004; WHO, 2006a; Van Damme et al., 2008). From the results of this study, it would seem that IPHC exacerbated rather than abated the challenge of staff shortage in PHC settings, presumably due to increased utilization and the extended hours of service.

5.7.2.2 Limited space

Limited space was another constraint that was reported by the participants. The participants reported that lack of space resulted in a lack of privacy for patients. The findings of the National PHC Facilities Survey of 2003 revealed that only four out of ten PHC facilities in KZN compared to only six out of ten nationally had adequate consulting rooms. Only 37% had adequate waiting areas. This clearly indicates that the issue of space in PHC settings is a problem that requires urgent attention. On the contrary, Kleczkowski et al. (1984: 77) argue that many PHC tasks can be performed without special buildings. These authors argue that some tasks are much more adequately performed in a building designed and built with those tasks in mind. For example, health assessment and treatment

usually require private rooms for their execution. Chen et al. (2004) suggest that countries must improve poor work environments by scaling up good practices to strengthen management of existing resources. However, Aitken and Curtis (2004) in their study on integrated health care, state that integrated care is most effective when services are provided via co-location, that is, when different health professionals work in the same consulting rooms. These authors argue that health professionals consult regularly about the patients needs and being in the same rooms will improve the quality of care. This type of integrated arrangement obviously improves collaboration between health care providers and more importantly, the patient. To address the problem of the lack of space, the National Minister of Health of South Africa in her budget speech for 2008 reported that among the successes of the Department of Health, there had been a massive expansion of health infrastructure for the delivery of PHC through the building and upgrading of more than 1600 clinics (Tshabalala-Msimang, 2008). However, the question that remains is whether these clinics are adequate for the +- 57 million population in South Africa.

5.7.2.3 Inadequate infrastructure

No matter how motivated and skilled health workers are, they cannot do their jobs properly in facilities that lack adequate infrastructure. The challenge facing developing countries is to develop a sustainable health infrastructure which will provide health care in an integrated way (WHO, 1996: 1). The traditional concept of an infrastructure is that it is something that is just there, ready to use, completely transparent and not open to question. Wentzer and Bygholm (2007: 2) argue that there is a tendency to perceive infrastructure as ‘hardware’ such as water, electricity supply or telecommunication, whereas Edwards points out that it also includes ‘software’, such as socially-communicated background knowledge, general acceptance and reliance. Lack of means for communicating with the

hospital in case of emergency was identified as one of the hindering factors towards successful implementation of IPHC.

Transport was also highlighted by the participants as one of the challenges they experienced since it took some time for an ambulance to arrive at the clinic to take the patient to the hospital in cases of emergency. Research on the adequacy of emergency services in KZN is inconclusive. Most complications and emergencies cannot be anticipated in advance. Delays reduce the chances of survival, so transport becomes necessary as and when complications arise. For instance, the Health Systems Trust (2004: 26) argues that the actual time taken for an ambulance to arrive at facilities during office hours in KZN was much longer than the expected time. The difference between the expected time and the actual time taken for ambulances to arrive at facilities was 99 minutes, which was 40 minutes more than that of the national average.

Harrison (1997: 14) identifies the shortage of vehicles in the clinics as an issue of concern. He states that vehicles are crucial to district health care, hence there is a need for clear transport policies and a transport management system. The findings of the study that was done by Hall and McCoy (2000: 8) revealed that the transport in that particular district was used more often for meetings, workshops and administrative functions relative than for health service delivery. A number of studies revealed that supervisors often missed the planned supervision visits due to lack of transport (Tembani et al., 2003; Davids and Loveday, 2005; Rowe, de Savigny, Lanata and Victora, 2005). This is further supported by the extract from the field that illustrates the importance of transport officers in rural districts, *"in many districts the unavailability of transport prevents clinic supervisors and programme managers from doing regular supervisory visits. Clinic visits which are planned a month in advance are often cancelled at short notice due to there being no transport available. However, transport is always made available to attend meeting at the provincial capital. In fact, the*

vehicles originally allocated to supervision are usually those reallocated at the last minute to transport participants to meetings or workshops called at last notice by the provincial office". However, the findings of the National PHC Facilities Survey of 2003 revealed that KZN was doing well in terms of availability of emergency transport services. The survey indicated that during office hours an ambulance service was available 96% of the time in KZN and 80% of the time after hours (Health Systems Trust, 2004). This is further supported by the Annual National Health Plan 2007/08 which reports that in KZN, the Department of Health purchased a total of 200 ambulances (50 replacements and 150 for expansion) in 2005/06. The report further states that the purchase of these vehicles had a positive effect on reducing downtime for service and repairs. Since the public health sector budget had increased to R53.2 billion in 2007/08 compared to R29.3 billion in 2001/02, one can anticipate that there might be an improvement in the provision of infrastructure, including transport (Tshabalala-Msimang, 2008). Hence the perceived need to allocate specific days for particular services, such as those that require transportation of laboratory specimens.

5.7.2.4 Structural and functional fragmentation

The participants reported that despite the introduction of the phenomenon of IPHC in 1996, structural and functional fragmentation still exists within PHC settings. They reported that structural and functional fragmentation resulted in the duplication of services rendered by local government and provincial department of health resulting in further depletion of resources. Pillay (2002) states that structural integration goes hand in hand with functional integration. However, functional integration is a transitional measure or a first step that needs to take place before structural integration can be accomplished. Pillay et al. (2003) define functional integration as the integration of provincial and local government health services for the purpose of decreasing fragmentation and

duplication. Structural or organizational integration entails that the different health service rendering authorities within a district be collapsed and integrated into one unified authority and administrative structure (McCoy et al. 1998).

According to the report on the progress in DHS implementation in South Africa, there is slow progress in integrating health systems at district level to eliminate fragmentation and duplication between the health services rendered by local government and provincial department of health. The integration of health workers at district level proved to be the single most important challenge for the achievement of service integration and a major barrier is the disparity in salaries and service conditions between health workers employed by provinces and municipalities, and between municipalities of different grades (Pillay et al., 2001).

5.7.2.5 Lack of career development

The majority of the participants cited inadequate career advancement opportunities as a constraint that hinders successful implementation of IPHC. The study results showed that nurses were not motivated to further their studies as there was no incentive in terms of getting promotion and senior positions in PHC settings. Some participants reported a lack of recognition and they felt that their expertise was not valued. On the contrary, the findings of the study that was done by French et al. (2006: 204) revealed that most interviewees thought that integration of services would increase career opportunities.

The matter of the skills mix remains a challenge for the South African health system. According to Department of Health (2006a: 18) a number of nurses have been trained in PHC. However, while a review of the records of the SANC reveals that 1033 nurses have been trained in Clinical Nursing Science and Health Assessment, it could not be established whether they are practicing as frontline providers within the DHS. The likelihood is that they may have moved to

other areas of service delivery and therefore possess skills that are not necessarily applied where they should be. The Department of Health (2006a: 18) further argues that the system currently does not provide for any material or even professional recognition of clinical nurse practitioners. They do not receive any additional remuneration, for example, in spite of carrying a much greater burden of clinical responsibility than other professional nurses. There is thus no real incentive for these nurses to continue to provide clinical care. This is supported by the eThekwini District Health Plan which states that the shortage of nurses will remain a challenge as long as there is no career pathing for PHC (2006a: 9-10). Furthermore, according to the study that was done by Oosthuizen and Ehlers (2007: 22) on factors that may influence South African nurses' decision to emigrate, the results indicated that 70,1% of the respondents considered leaving South Africa because of inadequate career advancement opportunities in nursing, while 66,3% considered leaving because of lack of recognition in the institutions where they worked.

In 2007/08 the Department of Health achieved numerous key milestones in its efforts to ensure a reliable supply of adequately trained, appropriately remunerated and motivated human resources for health. The Department of Health introduced Occupation-Specific Dispensation (OSD) in 2007. OSD is a career-pathing model for all occupational categories which was aimed at improving the government's ability to attract and retain skilled employees through improved remuneration. However, Fouche (2007) questions if there are any quality assurance measures in place to ensure that these skilled nurses remain skilled and competent to qualify for further increments within the OSD structures. Other achievements included the implementation of Community Service for nurses and the recruitment and deployment of 36 Tunisian doctors in 2007 in five provinces, Eastern Cape, Free State, KZN, North West and Northern Cape (Department of Health, 2008: 69). The first cohort of nurses undertaking Community Service was observed in 2008.

5.7.2.6 Lack of capacity building

The results indicated that the majority of the nurses that were employed in the clinics were not adequately trained to offer all the services provided in the clinics in an integrated manner. Alluding to this, Parent, Fromageot, Coppieters, Lejeune, Lemenu, Garant, Piette, Leveque, and De Ketele (2005) state that human resources in the health care system in sub-Saharan Africa generally show an inadequate balance between expected skills as a professional and the health care needs expressed by the populations. Quality nursing care is a constitutional right of patients, and this right must be upheld by skilled nurses.

Human resources are an important factor in all health care services. They account for more than half of the health care system's expenditure. The lack of training of staff in providing integrated service was also highlighted as a negative outcome in the study that was done by Maharaj and Cleland (2005: 316); Petersen (2000); Petersen and Swartz (2002). These authors indicated a need for adequate training of staff that would enable them to provide comprehensive, integrated services. According to Edelstein as cited by Petersen (2000) training in tertiary academic centres teaches nurses to take instructions from doctors. This author argues that it does not, therefore, engender in nurses the necessary skills to work autonomously, which is necessary in PHC settings.

In individual vertical programmes, capacity building has been carried out according to the needs of the programme rather than those of the workers, leading to duplication of effort and wasted time and resources. This demonstrates a need for integrated training (WHO, 1996: 32). The WHO study group introduced the concept of 'learning district' which offers an integrated continuing education based on an assessment of local needs and resources and using the existing separate training programmes to facilitate integrated training (WHO, 1996: 32). (Grone and Garca-Baebero (2002) resolve that the education

of health care professionals should not end with the granting of the university degree or through the period of residency training, but should be extended throughout the professionals' careers. Woodward (2000: 25) maintains that accreditation of health education facilities also helps to ensure that educational programmes are relevant to the needs of the health care system. He argues further that skills upgrading for PHC nurses should be experienced as job enrichment, and not as is often the case, resented as the imposition of additional burden and expectation on an already stressed health worker.

5.7.2.7 Service/Education disjuncture

In this study, the lack of partnership between nurse training institutions and service providers emerged as one of the conditions that limited the successful implementation of IPHC. The participants reported that the curriculum that student nurses followed whilst on training did not equip them to deal with diverse health care needs of the community. New graduates experience a disjuncture between the academic training expectations and the actual conditions in the public service (Lehmann and Makhanya, 2005: 139). The findings of the study that was done by Sharrock and Happell (2006: 11) revealed that the participants considered that their comprehensive undergraduate education gave them general and psychiatric nursing qualifications, yet they perceived themselves primarily as general nurses. McCoy et al. (1998: 38) argue that personnel may find it difficult to translate their new knowledge and skills into action when they return to workplace. These authors further argue that the gap between theoretical-based understanding of certain DHS activities could be attributed to lack of experience of trainers and lectures regarding the constraints and day-to-day problems of working in health services. To bridge this gap, Norushe, van Rooyen and Strumpher (2004: 69) in their study on in-service education and training recommend that the training needs of both the registered nurses and providers of in-service training programmes should be addressed in the short

term and long term so that maximum efficiency and value for money can be obtained. Loquist (2002: 35) states that in the United States, partnerships between nursing education and practice are beginning to flourish in an attempt to meet the faculty requirements through preceptor programmes.

According to Grone and Garca-Baebero (2002), professional training has been oriented towards specialization and fragmentation and this has not been compensated for by a managerial culture engaging professionals to deliver services across institutional boundaries. In order to change the culture of professionals these authors suggest the development of a more relevant and practice-oriented curriculum that integrates between disciplines horizontally and vertically to stimulate integration. New trends in education aim to improve the health of the community by implementing this idea in training methods. This involves integrating three approaches, namely practice-based teaching, problem-based learning and patient-focused practice. Coomarasamy and Khan (2004) assert that the integration of the three approaches yields greater improvement in skills, attitudes and behaviours of health professionals. These authors argue that while standalone teaching and integrated teaching are both effective in improving the knowledge base, it is clinically integrated teaching of evidence based medicine that is likely to bring about changes in skills, attitudes and behaviour. Changes in attitudes are likely to be the vehicles that will bring about sustained changes in behaviour, which may ultimately benefit the care of patients.

The South Africa's government's commitment to improve the quality of education and training finds expression in a range of policy and legislative frameworks developed since 1994. These include the South African Qualifications Authority (SAQA) Act, 1995; the Skills Development Act, 1998; the Skills Development Levies Act, 1999. The main objective of these policies/ legislation is to facilitate the training and provision of a health care workforce that possesses the requisite

skills and competencies that will be able to meet the health needs of the country (Department of Health, 2006a: 11).

5.8 CONSEQUENCES

The result of the study revealed that there were intended and unintended consequences of IPHC.

5.8.1 Intended consequences

5.8.1.1 Improving accessibility of services

The findings of the study indicated that integrated services were thought to increase access of health care to patients as all presenting health problems could be addressed at a single visit. According to the Strategic Plan 2006/07-2008/09 the DHS was strengthened during 2005/06 (Department of Health (2006b: 8). Key to this was the need to clearly define the roles of provinces and municipalities with respect to service delivery and to ensure that where needed, functional integration was achieved so that patients experienced seamless access to PHC services regardless of which authority provided the service. The Strategic Plan further states that the District Health Planning (DHP) guidelines and their implementation were also revised to strengthen PHC services through a more systematic planning process and by improving the implementation of plans and the monitoring of service delivery. The Department of Health further reports that most health districts provide the full basket of PHC services but the challenge is to ensure that this also is a feature in all health sub-districts. Furthermore, the use of PHC services has increased from 67 021 961 visits per year in 1998 to 98 633 210 in 2005 according to data from the District Health Information System (DHIS) (Department of Health (2006b: 8). The Department of Health further reports that since 1994, more than 700 clinics have been built or

upgraded, 2 298 clinics have been upgraded and provided with new equipment, and 125 new mobile clinics have been introduced. There are now more than 3 500 clinics in the public sector (South Africa Info, 2007b). This clearly indicates that there is improved accessibility of PHC services to the community. It is not known however, how many of these offer IPHC.

5.8.1.2 Decreased waiting period in the clinic

Participants who provided a one stop service reported that IPHC had resulted in a decreased waiting period spent by patients in the clinic as one nurse provided all the services that were needed by the patient. The supermarket approach was also identified as an excellent approach if used appropriately. This is supported by the findings of the study that was done by Netshandama, Nemathaga and Shai-Mahoko (2005: 64) on the experiences of nurses regarding the provision of free health services which revealed that the supermarket approach was an excellent approach that resulted in decreased waiting period where there were no staffing problems. The results of the study that was done by Mashego and Peltzer (2005: 18-19) revealed that in clinics where that were limited resources and overcrowding, patients reported that they waited for a long time before they were seen by nurses and at times they were sent back home without seeing a nurse. Tint et al. (2000: 15) argue that women in particular like the approach of integrated care because of the reduced times spent in the clinic as it gives them more time to do other money-generating activities. Shah et al. (2002: 106) argue that the patient is able to enter the system and receive the complete treatment in a convenient and timely manner. The end results of this system were increases in productivity, availability and convenience to the patient.

5.8.1.3 Holistic management of the needs of the individual patient

IPHC was acknowledged as serving the needs of the individual patient more effectively than vertical programmes since all their needs were met at one service delivery point. All the nurses interviewed alluded to the importance of using a holistic framework to intervene in health problems of individual patients. This is in keeping with the principles of PHC and nursing ideology, which is underpinned by holism, understood to encompass physical, psychological, social and spiritual aspects of a person (WHO, 1978).

The holistic management of patients' needs was also mentioned as a positive outcome of integration in the study that was done by Maharaj and Cleland (2005: 314). Their results revealed that integrated services were acknowledged as serving the needs of clients more efficiently and more effectively as clients had all their needs met at one service delivery site to ensure greater continuity in services. The report of a WHO study group on integrated care confirms that integration could improve the overall effectiveness of the health system thus benefiting the health of the population by addressing the health problems in a holistic manner (WHO, 1996).

5.8.1.4 Affordable health care

In recent years there has been an acceptance of the role of IPHC in providing cost effective health care (Netshandama et al., 2005; Coetzee et al., 2004; WHO, 1996). Improving health service through IPHC can benefit both the consumers of care and the services. The results of this study also revealed that IPHC was cost effective in the sense that it resulted in a limited number of trips that clients had to make in order to access different services, saving time for both the client and provider. It has been argued that IPHC improves cost effectiveness by avoiding a duplication of service delivery functions and by delivering more services per

client contact. The study conducted by Netshandama et al. (2005:64) revealed that the supermarket approach was effective for the clients because they do not have to wait for special days in order to access different services. Integration normally reduces differences in the access and utilization of services between geographical and socio-economic groups, leading to greater equity in health care (WHO, 1996).

As mentioned before, IPHC seems not only to benefit the patients, but also the health system at large. According to the study that was done by Coetzee et al. (2004) on integration of TB and HIV management, the available human and financial resources can be optimally used.

5.8.2 Unintended consequences

Despite the above-mentioned intended consequences of IPHC, the participants also reported a number of unintended consequences. These include a lack of space, increased demand on staffing, deteriorating quality of care, overcrowding, disgruntled staff and contravention of the scope of practice. These will be discussed in detail below.

5.8.2.1 Increased demand on space and staff

Although the main aim of introducing the IPHC was to identify and address shortcomings in both equipment and training needs, the participants reported that this approach had resulted in a shortage of staff, equipment and space. They argued that the collapse of vertical services and addition of more services in the clinics resulted in overcrowding as the space, equipment and staffing had not been increased accordingly. On the contrary, the comprehensive PHC core package states that it serves as a planning and prioritization tool with equity, efficiency and cost-effectiveness. One of the barriers identified by Schierhout

and Fonn (1999: 22) to multi-purpose workers delivering integrated services were that the drugs essential to the integrated programme were delivered reliably, particularly in public sector which could be related to overcrowding in the clinics. This is supported by the findings of the study that was done by Mashego and Peltzer (2005: 18) where the participants reported that most of the time clinics did not have adequate supplies of medication and the shortage of drugs was found to be related to overcrowded clinics.

Limited space was also identified as an unintended outcome of IPHC. However, several studies on IPHC argue that integration is not just about new buildings and more staff. The authors of these studies maintain that there is a need to be innovative and utilize the existing infrastructure efficiently (French et al., 2006); (Souliotis and Lionis, 2004). Overcrowding in the clinics also emerged as another unanticipated consequence of IPHC due to limited space. This was thought to be related to increased access of services and transfer of patients from the hospitals to the clinics. Netshandama et al. (2005: 64) revealed in their study that the introduction of the free health service and the supermarket approach implied that the PHC nurses had to deal with large numbers of patients that were coming to the clinics, thereby increasing their workload, as has been found in other studies conducted in South Africa (Netshandama et al., 2005; Maharaj and Cleland 2005; Coetzee et al., 2004; Mashego and Peltzer 2005). Under the pressure of overcrowding, it is hardly surprising that the nurses dealt as efficiently and quickly as possible with patients' needs before moving to the next patient.

5.8.2.2 Deteriorating quality of care

The results of the study revealed that the quality of services offered at PHC clinics was compromised due to the increased number of patients who were seen in the clinics. This was attributed to the increased number of services that were offered at PHC clinics without taking into consideration the issue of increasing staff and space. This is further supported by the strategic priorities for the national health system 2004-2009 where it is stated that since the introduction of free PHC services, clinics are seeing more patients, while there are many instances where the movement of patients away from hospital outpatient departments to clinics has not been accompanied by a corresponding transfer of staff (Department of Health 2004: 18). Combined with the incomplete integration of curative and preventive health services in clinics, the increase in patient loads in clinics has led to some forms of compromise in the quality of care at that level (Department of Health, 1999: 18). The findings of the study that was done by Mashego and Peltzer (2005: 16) indicated that the respondents reported that they were not examined at the clinic and consultation was reported to be brief with no thorough examination except history taking and medications given on the basis of history given by the patient. This is further supported by the findings of the study that was done by Netshandama et al. (2005:65) which revealed that due to limited resources, patients were not examined thoroughly before medication was prescribed, or if it was done, it was done haphazardly. Missed opportunities to address other related concerns thus stem to a large extent from the pragmatic but powerful factor of limited resources. Until this constraint is reduced, it will continue to thwart the full potential of IPHC.

There are many different definitions of quality in health care. The word ‘quality’ itself has several different meanings. With respect to health care, it concerns the degree to which the resources for the health care or the services included in health care correspond to specified standards (Roemer and Montoya-Aguilar

(1988: 3). Drug availability and number of staff were used as proxies for service quality in studies of PHC in Kenya, Ghana and Nigeria (Lewis, Eskeland and Traa-Valerezo, 2004: 305). In most developing countries, there are difficulties in making measurements and in the quantification of the phenomenon where information systems are typically weak. Collection of data depends on having systems of recording and reporting. Much of the difficulty in understanding and doing quality assessments arises from the semantics. Thus if quality refers to the merit of a thing, can it be considered as the opposite of quantity? These authors argue that quality in PHC should not be seen in opposition to quantity. It is not something separate from the coverage or accessibility or utilization of a clinic.

The National Department of Health in South Africa (2007: 14) identifies three key areas that need to be considered at the organizational development goals to improve quality in the National Health System and these are:

- *Quality improvement requires leadership* – only strong leadership can build an organizational culture that supports change, establishes aims for improvement and mobilizes resources to meet those aims
- *Quality improvement requires learning* – a health care organization dedicated to continuous improvement must become a learning organization
- *Quality improvement requires organizational change* – not all change is improvement, but all improvement is change.

The Director-General for the Department of Health stated in the Strategic Plan 2006/07-2008/09 that among the major challenges facing the public health sector, was a need for service transformation plans in each province which highlights the quantum of services to be provided and the resources needed to provide and manage these services; the human resource for health needs in the country, improving the quality of health services and improvement in quality of care (Department of Health, 2006b).

5.8.2.3 Disillusioned staff

The findings of the study revealed under-remuneration, under-staffing and heavy workloads as factors that contributed to dissatisfaction among nurses working in the PHC settings. The study by McIntyre and Klugman (2003) also yielded similar results. According to McIntyre and Klugman (2003), staff morale was identified as the greatest barrier to the delivery of high quality health services whilst the shortage of financial resources, particularly as reflected on shortage of staff, was found to be the biggest constraint. This is further supported by the findings of the study that was done by Oosthuizen and Ehlers (2007: 21) on nurses' emigration which revealed that 94, 2% of the respondents considered leaving South Africa due to stress resulting from inadequate staffing. Furthermore, 88, 2% of the respondents indicated that a shortage of nurses put both patients and nurses at risk. Netshandama et al. (2005: 65) alluded to this in their study where they reported that most nurses said that the increased workload also resulted in burnout, leading to stress and strain. If these problems are not addressed, this may eventually result in a strained relationship between nurses and patients. The results of the study by Mashego and Peltzer (2005) support this. The findings of the study that was done by Mashego and Peltzer revealed that the patients responded negatively to items related to health personnel conduct which included poor reception, poor communication, discrimination and lack of compassion (2005: 19). According to the World Health Report (2006) disgruntled workers can paralyze a health system, stall health sector performance, and occasionally even bring down a government (WHO, 2006b).

However, the National Department of Health in its Strategic Plan 2006/07-2008/09 reported that it was faced with many challenges including accelerating production, recruitment and retention of the workforce needed to provide a quality health service (Department of Health, 2006b: 10). Magwaza et al., (undated: 95)

recommend in their study that clinic staff fears, concerns and complaints should be taken seriously and addressed promptly for successful IPHC. Ways should be found to sustain and build upon positive factors that create job satisfaction amongst nurses. In 2003, the Department of Health introduced two measures to address inequities in the distribution of health personnel: the rural and scarce skills allowance. One of the problems identified, however, was that the allowances were not uniformly available to nurses working in rural and under-serviced areas (Padarath, Ntuli and Berthiaume, 2004). In 2007 as discussed in the previous section, OSD in the Public service was introduced. OSD means "revised salary structures that are unique to each identified occupation in the public service" (Republic of South Africa, 2007). The intention was to improve the government's ability to attract and retain skilled employees through improved remuneration.

5.8.2.4 Extended role of the clinic staff

The availability of sufficient and competent health professionals with appropriate skills is central to the success of the transformation process of the health care system in South Africa. Management and nursing staff are not the only personnel involved in IPHC. The auxiliary staff within the district must be brought into closer alliance with the integration efforts of the district office (Toomey, 2000: 46). According to the World Health Report (2006b), people who help the health system to function but do not provide health services directly to the population, are often forgotten in the discussions about the health workforce, yet they provide an invisible backbone for the health systems (WHO, 2006b: 4). The report further argues that if these support workers are not present in sufficient numbers and with appropriate skills, the system cannot function as they are critical to scaling up service delivery. The findings of the current study supported this by revealing that shortage of staff not only affected nursing personnel, but also the supportive staff. As a result, lower categories of nurses and non-nursing

personnel were made to do duties that were beyond their scope of practice. The SANC defines the scope of practice as “the knowledge, practices and attitudes required to fulfill a professional role” (SANC, 2001: 2). SANC states that the scope of practice should not be too restrictive, since that could artificially limit practitioners from assisting where they are able to do so. It also argues that it should not be so vague as to allow for numerous interpretations of what is meant. Task shifting is the “name given to a process whereby specific tasks are moved, where appropriate, to health workers with shorter training and fewer qualifications” (WHO, 2008: 7). WHO further reaffirms that by reorganizing the workforce in this way, task shifting can make efficient use of existing human resources and ease bottlenecks in service delivery. Task shifting can make better use of the human resources that are currently available by moving appropriate tasks to less specialized workers. The most important task shift is to the patients themselves (WHO, 2006b).

Maharaj and Cleland (2005: 317) suggested two partial solutions in their study of integration of sexual and reproductive health services. They proposed that systematic screening of the needs of all clients should be done by aides or booking clerks. The alternative was to make use of lay counsellors to take history in recognition that many sexual health concerns only come to light after sensitive probing. The principles of PHC emphasize the central importance of collaboration. This stems from the recognition that improvements in wellbeing can only be achieved by a broad-based approach to development that involves different levels of health workers. One of the most significant hurdles is to expand human resources through task shifting without compromising the quality of service. WHO (2006a) asserts that a standardized programme for training and certification will therefore be necessary to guarantee essential standard of care. WHO further argues that an enabling regulatory framework to effect changes in the scope of practice will be necessary.

Gwele in her inaugural speech (2003) argued that producing a nurse practitioner with the requisite skills mix, knowledge and competence for effective deployment and utilization in the country's health services, requires entrants with potential to succeed in such an educational programme. For example, the enrolled nurse, after two years of nurse training cannot be fully utilized in health services, as neither her educational preparation nor scope of practice allows her/him to work independently. The Nursing Act, 2005 (Act 33 of 2005) creates a legislative framework for the review of the scope of practice for the different categories of nurses to ensure that the practice of nurses in South Africa is aligned to the needs of the health care system (Republic of South Africa, 2005). However, the current scope of practice for nurses has placed constraints on the capacity of nurses to deliver care in the South African health care system. According to Subedar (2005: 98) some of these constraints included a lack of a clear distinction area of practice for the different categories of nurses; a lack of clearly stated broad parameters and a lack of definition of the minimum competencies required for the scope of practice for each category of nurses. As a result, in 2003 the SANC drafted a revised scope of practice for each category of nurses. The factors that influenced the review of the scope of practice was a changing health care system identified in the White Paper for the Transformation of Health System in South Africa and the changes in education system brought about by the National Qualifications Framework (NQF) and the South African Qualifications Act (SAQA). The new scope of practice, however, is yet to become a policy. Approval processes and enactment within government policy formulation structures are often long and protracted.

5.9 CONCLUSION

This chapter discusses how IPHC is practiced in South Africa. What was clear during the discussion of the results is that there is no clear understanding of what IPHC means within the South African context. The three concepts that emerged in this chapter, namely comprehensive services, one stop shop and supermarket approach and will be further analyzed in Chapter 6.

CHAPTER 6

A MIDDLE-RANGE THEORY OF INTEGRATED PRIMARY HEALTH CARE SERVICES

6.1 INTRODUCTION

The purpose of this study was to analyze IPHC in South Africa with the aim of discovering the shared meaning of this phenomenon and to develop a middle-range theory grounded on what is practiced as IPHC. Theories differ in their level of generality. A grand theory or macro-theory purports to describe and explain large segments of the human experience whereas a middle-range theory is made up of limited concepts and propositions and is more specific to the phenomena under study (Polit and Beck, 2004: 115). A middle-range theory is clearly stated and operationally defined and hypotheses are formulated so that they can be tested through research (Stanhope and Lancaster, 2000: 203). This chapter presents a middle-range theory of IPHC based on the South African context. The theory presented in this chapter builds on the theoretical schema provided in the previous two chapters. Strauss and Corbin (1998: 22) define theory as a set of well developed categories, for example themes and concepts that are systematically interrelated through statements of relationship to form a theoretical framework that explains a phenomenon.

Chinn and Kramer (2004: 92) identify six components for developing a theory and these include:

a) purpose of a theory which specifies the context and situation in which the theory applies
b) concepts which are described as group of words that are used as the building blocks of a theory
c) definition of concepts to clarify the meaning for concepts within the theory

d) nature of relationships which describe how concepts are linked together to give structure to the theory
e) structure of the theory which gives the overall form to the conceptual relationships within it
f) assumptions which are basic givens or accepted truths that are fundamental to theoretic reasoning.

The six components of theory namely, goals, concepts, definitions, relationships, structure and assumptions form categories that can be used to describe theory and are also useful in the analysis of the existing theory as they are embedded within a theory when it is being developed (Chinn and Jacobs, 1983: 108).

6.2 THE PURPOSE OF THE IPHC MODEL

The model for the integration of PHC services is aimed at increasing the accessibility of PHC services to the community. The ultimate aim of the model is to provide a framework to guide the policy formulation and implementation of IPHC as the country continues to achieve a comprehensive and seamless PHC delivery system. This model will guide the programmatic, structural and functional integration of PHC services and the benefits could impact on financial resource allocation. The model should reveal a shared meaning of the phenomenon IPHC in South Africa and could be used for integrated PHC policy review by the Provincial and National Department of Health.

6.3 CONCEPTS USED IN THE MODEL

As discussed before, concepts are the building blocks of a theory. As the phenomenon of interest in this study is IPHC, it is treated as the main concept in this model. The model identifies three approaches that are used to deliver the services in PHC setting. Each approach describes the functional organization of

PHC services. The model describes the three types of levers that can be employed to promote an enabling work environment when using any of the three approaches to deliver the services, namely human resources, organization support services and collaboration.

6.4 DEFINITION OF CONCEPTS IN THE MODEL

According to Chenitz and Swanson (1986: 153), any grounded theory should lend new insight into the phenomenon under study and should suggest new directions for future inquiry. The description of concepts is crucial because their quantity and character form the understanding of the purpose of the theory, the structure and nature of the theoretic relationships, the definitions and assumptions (Chinn and Kramer, 2004: 97). Regarding the definition of concepts, Chinn and Kramer further state that concept definitions can be implied by how the theorist uses the conceptual terms in the context (relatively associative definition) or by how he/she defines terms specifically by what they mean (relatively specific definition). The researcher in this theory defined the substantive concepts of IPHC in a relatively associative manner in order to bring an understanding of how IPHC is conceptualized in this particular IPHC theory. Chinn and Kramer (2004: 116) suggest that concepts should be given a structural form to clarify their relationship by means of a symbolic representation. To make it possible to follow the reasoning of the development of this model, the nature of its structure and the process description of the model will be presented simultaneously because of the nature of their relatedness. Based on the definitions provided in the preceding section, the following relationships are proposed as depicted in Figure 8:

6.4.1 IPHC as comprehensive health care

IPHC is an approach to the provision of comprehensive health care within a DHS. The term 'comprehensive' refers to the range of services available in the PHC settings. The Alma Ata Declaration promoted a comprehensive approach to improve health with a strong emphasis on PHC (WHO, 1978). The comprehensive approach is seen as a strategy for ensuring the availability of a range of services as the drive behind the introduction of IPHC was to respond to the needs of the community and to improve accessibility of services to the community. Of particular relevance to the development of a comprehensive health system is the clause in the Alma Ata declaration stating that PHC "addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly" (WHO, 1978). Comprehensive services include, therefore, curative and rehabilitative components to address the effects of health problems, a preventive component to address the immediate and underlying causative factors which operate at the level of the individual, and a promotive component which addresses the more basic causes which operate usually at the level of the society (Sanders and Chopra, 2001). Basic programmes provided at PHC level include immunization, sexual and reproductive health, communicable diseases, health promotion and/or health education, pharmaceutical services, clinic disease management, medical services, mental health, nutrition, minor ailments, diagnostic services, school health, maternal, women's and child health, referral services, and emergency medical services (van Rensburg, 2004: 423).

In South Africa, vehicles and/or approaches to the delivery of comprehensive services include the supermarket approach and the one stop shop. The selection of the appropriate approach for the clinic is guided by a number of factors, including:

- The size of the clinic
- The number of nurses available
- The level of competency of nurses in terms of skills and training
- The availability of equipment
- The availability of space in relation to the waiting area and consulting rooms
- The structural set up of the clinic.

6.4.2 IPHC as a supermarket approach

A supermarket approach is used for the delivery of PHC services where patients that require more than one service are seen by different nurses allocated in different consulting rooms. Patients are channeled to different consulting rooms based on the required services. Since these patients join different queues to access different services, in those clinics that have consulting rooms with interleading doors, movement between consulting rooms occurs more seamlessly and faster. The nurse also informs the other nurse telephonically or through the intercom about the patient that needs more services to avoid any delays. A supermarket approach requires a team effort to ensure that patients' needs are met promptly and comprehensively. This approach is characterized by close collaboration between nurses and other health professionals who consult regularly with each other throughout the day, often informally about different patients' problems and interventions. In order to ensure that nurses do not lose their skills of rendering other services in the clinics where supermarket approach is used, nurses rotate over a set period. Nurses are allocated according to their qualifications, specialties and interests.

Ajayi (2002) argues that patient satisfaction is directly linked to the waiting time and not to the care received. The shorter the time patients wait, the more satisfied they are with the service. The supermarket approach is client-oriented

and it entails the provision of all services at the time of visit to the clinic (WHO, 1996). Therefore, in order to avoid any delays in PHC settings, systems are put in place, for example, the use of different queuing systems such as fast queue, walk through, numbering system and appointment systems for those patients that do not require a full physical examination.

6.4.2.1 Fast queue

Fast queue is a system that is used for those patients that do not need a full physical examination. Patients, for example, who have come for repeat family planning, TB treatment etc., are attended to first to avoid delaying these patients. One or two nurses are allocated for the fast queue.

6.4.2.2 Walk through

Walk through is for patients with special needs for example, farm workers in rural clinics to suit their working hours. This service is offered as part of the extended service. These patients are attended to first before the rest of the patients to increase accessibility of PHC services as outlined before as the main purpose of IPHC.

6.4.2.3 Numbering system

A numbering system is implemented to control queues where patients are given numbers on arrival either at the gate by the security guard or in the waiting room. This system is used as a control measure to avoid patients jumping the queue.

6.4.2.4 Appointment system

In order to ensure that work is spread throughout the day, block times or appointment schedule are used for return visits. In order to ensure that patient flow is spread throughout the day, some of the services are offered in the morning and some during the latter part of the day. For example, patients with chronic conditions may be seen early in the morning and Pap smears may be done in the afternoon.

6.4.3 IPHC as a one stop shop

The one stop shop approach is conceptualized as the provision of services to the patient by one nurse. In other words, a nurse is responsible for providing all the services that are needed by the patient and this requires nurses who are multi-skilled. The one stop shop approach ensures that gaps in service provision are addressed and operational systems such as integrated patient record are streamlined. In support of this, Harrison (1997: 29) argues that the one stop shop approach will ensure that people are treated as a whole not in 'bits and pieces' like body parts. According to Kegg, Jackson, Pakianathan, Oakley and Fox (2003), the one stop is more effective in addressing the holistic sexual health needs of patients especially the young ones by offering a comprehensive range of services in one visit. Therefore, this approach requires a nurse who is multi-skilled to offer all the services required by the patient. Reorientation and in-service education programmes for nurses are therefore important in facilitating a comprehensive discourse of care (Tarimo, 1991; Peterson, 2000; Toomey, 2000; Walley et al., 2008).

6.5 RELATIONSHIP STATEMENTS OF THE MODEL

Theories are basically sets of relational rules and they contain many concepts and specify how concepts relate to one another (Strauss and Corbin, 1998; Chinn and Kramer, 2004). Chinn and Jacobs (1983: 73) describe relational statements, which are sometimes referred to as propositional statements that suggest a specific relationship between two or more concepts or constructs. The relational statements of the IPHC model are inherent within the definitions of the key and their related concepts.

6.6 THE NATURE OF THE STRUCTURE AND THE PROCESS DESCRIPTION OF THE MODEL

Chinn and Kramer (2004: 100) suggest that concepts should be given a structural form so as to clarify their relationship by means of a symbolic representation. See Figure 8. To make it possible to follow the reasoning of this model, the nature of its structure and the process description of the model will be described simultaneously because of the nature of their interrelatedness. The model is depicted by Figure 8. All the six central and related conceptual relationships are included within a single structure.

The central circle depicts the three approaches for the delivery of PHC services. As mentioned before, each approach describes the functional organization of PHC services. The model identifies the following three factors necessary for the smooth functioning of the clinic:

- human resources
- organizational support, and
- collaboration.

The presence of these three pre-requisites results in an enabling work environment which may result in successful integration of PHC services. Neither of these approaches to IPHC is likely to be effective without an enabling environment.

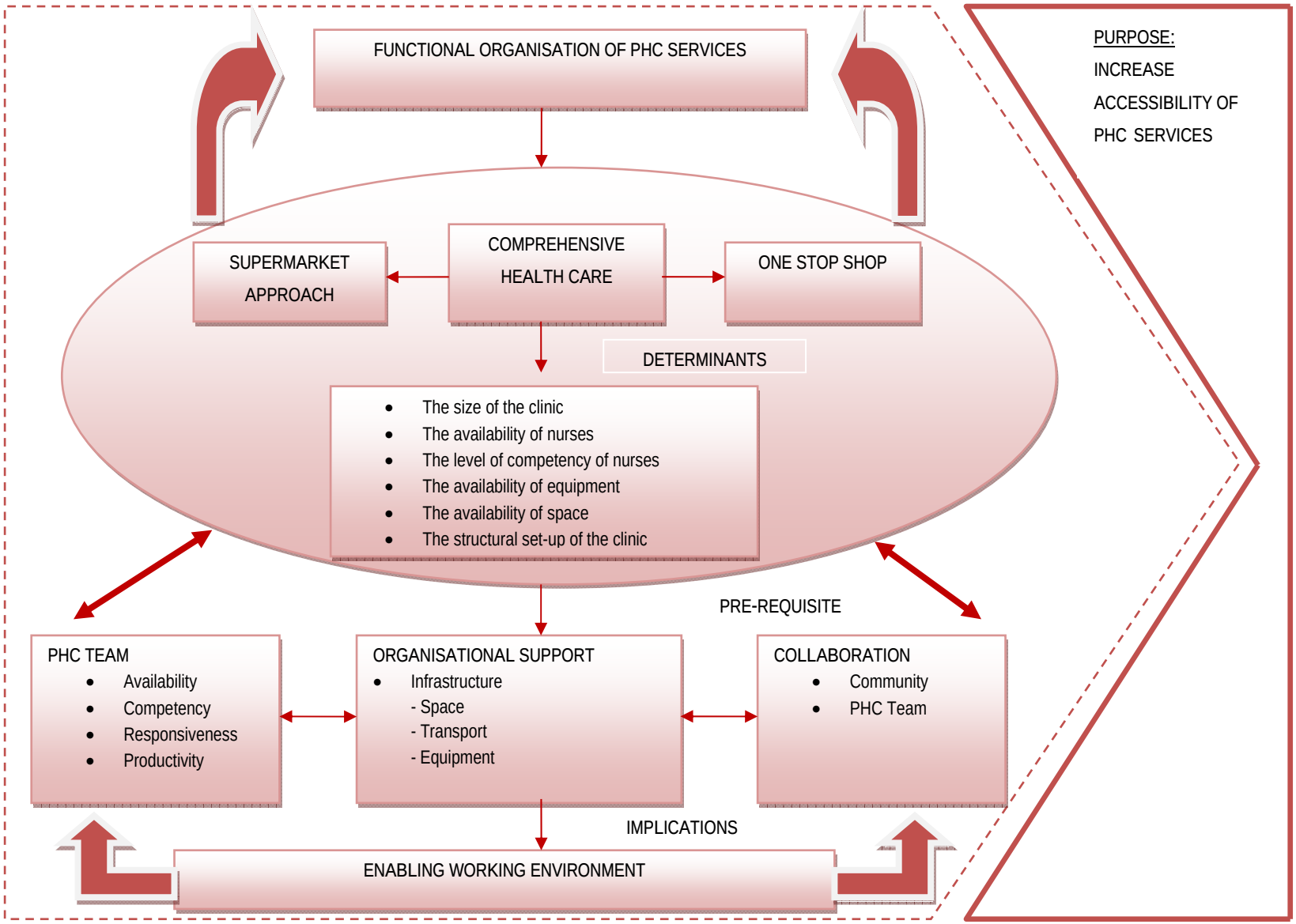


FIGURE 8: A MODEL FOR THE INTEGRATION OF PRIMARY HEALTH CARE SERVICES (PHC)

6.7 ENABLING ENVIRONMENT

6.7.1 Human resources

The model lists four desired dimensions of human resources: availability, appropriate competencies, responsiveness and productivity.

6.7.1.1 Availability

The availability of sufficient and skilled health professionals is central to the success of IPHC in South Africa. Therefore, new and innovative ways of recruiting and retaining PHC nurses are put in place in the present employment climate in order to meet the changing needs of clients and the required levels of service provision. Financial incentives are the most obvious ways of inducing people not to move. These include direct or indirect payments such as improving their conditions of service, for example, salary improvements and the provision of incentives for the nurses that are placed in PHC clinics. This will ensure that more staff is attracted to PHC. However, non-monetary incentives like encouraging better career development, providing opportunities for training and raising the status of health workers through enhanced career progression opportunities, will improve staffing in PHC setting.

Task shifting is one of the strategies that is used to scale up workforce in PHC settings. Task shifting makes better use of the human resources that are currently available by moving appropriate tasks to less specialized workers. For example, immunization, management of patients with TB can safely be delegated to an enrolled nurse (WHO, 2006a). However, regulations of scope of practice designed to establish minimum standards and protect patients, become impediments to the pursuit of change. An enabling regulatory framework to effect changes in the scope of practice will, therefore, be necessary so as not to

compromise the quality of service. According to the World Health Report (2006), greater efficiencies in health personnel performance can be achieved by applying two of the cardinal rules for scaling up interventions effectively, namely simplification and delegation (WHO, 2006b: 23). According to the WHO, simplification often improves staff productivity by allowing more to be done with greater consistency and more often by less skilled personnel. The simplification of basic tasks requires strategic decisions, technological innovations and locally appropriate adaptation. For example, during polio campaigns, all available human resources, from community health workers to professional health workers, could administer vaccines (WHO, 2006b). Task delegation is also important in a resource-constrained setting. The report further argues that plans to simplify and to delegate tasks require careful assessment of the intended impact. Although evidence for task shifting from doctors to nurses and from health professionals to lay health workers does exist, the evidence base needs to be strengthened (Lewin et al. as cited by Walley et al., 2008). This is in line with international thinking on rational allocation of tasks for HIV/AIDS as well as maternal-child health interventions (Bhutta, Ali, Cousens, Ali, Haider, Rizvi, Okong, Bhutta and Black (2008). If well-trained, supervised and supported, international evidence suggests that CHWs can take responsibility for a number of tasks within PHC. These encompass behavioural interventions to promote healthy behavoiur, preventive and therapeutic interventions (Haines, Sanders, Lehmann, Rowe, Lawn, Jan, Walker and Bhutta, 2007). However, these authors argue that tasks delegated to CHWs need to be focused since they cannot provide comprehensive care for all community health needs.

6.7.1.2 Appropriate competencies

Quality nursing care is a constitutional right of patients which must be upheld. Health care in all its manifestations is an extremely competence demanding service. IPHC demands competent nurse practitioners to improve performance. An essential first step towards improving performance is understanding factors that influence it. Rowe et al., (2008) identify among other factors, health worker factors such as knowledge, skills, experience, professional values and comprehension of work experiences. Competencies encompass the combination of knowledge, understanding, skills and attitudes that an individual develops or acquires through education, training and work experience, which can be used to describe particular occupational roles or functions against which individual performance may be assessed (WHO, 2008: 79). In order for IPHC to work, nurses need to possess appropriate knowledge, skills and behaviours. In other words they have to be multi-skilled to be able to provide comprehensive services, especially nurses who are using a one stop shop approach. In the presence of IPHC, all nurses need to be adequately educated and equipped with expertise to be able to offer all the PHC services needed by the community

It is important to support the learning needs of nurses, especially the newly qualified to ensure that their skills, knowledge and experience are developed rapidly for a demanding clinical environment. Reorientation programmes for nurses are therefore important in facilitating a comprehensive discourse of care. This requires supportive supervision coupled with audit, feedback and lifelong learning. There is a need for ongoing supervision and mentorship of staff following initial training to ensure competent and skilled nurses.

Management of health workers for improved performance brings together the health and educational sectors to achieve three core objectives, namely coverage, motivation and competence (Chen et al., 2004). Coverage strategies

focus on adequate remuneration, positive work and career environments and a supportive health system. Competence is advanced through educating for appropriate attitudes and skills. Therefore, in their philosophy, training institutions should embrace issues of their social responsibilities, and show commitment to quality, equity and relevance with an emphasis on public or community health. Training of health professionals is therefore done in as close an approximation to the work situation as possible (WHO Regional Office for Africa, 2007: 8).

6.7.1.3 Responsiveness

Responsiveness was identified as one of the key goals of health systems in the World Health Report 2000 (WHO, 2000: 22). The concept of responsiveness was developed as part of WHO's broader conceptual framework of health systems developed in 2000, which identified three focuses for health system goals: health, responsiveness and financing fairness. The World Health Report 2000 defines responsiveness as an indicator used to measure how well a health system performs relative to non-health aspects (WHO, 2000). IPHC as a social system, like other social systems, for example, education is expected by its populations to meet a core goal plus common social goals expected of all social systems. Responsiveness therefore, implies that people should be treated decently, regardless of whether or not their health improves, and irrespective of who they are. WHO argues that responsiveness is not a measure of how the system responds to health needs, which shows up in health outcomes, but of how the system performs relative to non-health aspects, meeting or not meeting a population's expectations of how it should be treated by providers of prevention, care or non-personal services (WHO, 2000: 31). Bacal (2008) identifies the following characteristics of responsiveness: An individual (or organization can be considered responsive if he/she:

- Identifies both the explicit (clearly stated), and implicit (unstated or below the surface) needs of another person or people he/she interacts with
- Uses the understanding of those needs to fulfil those needs when possible
- Acknowledges and works in partnership with other parties to find some means of fulfilling needs that is possible, even if only partial fulfillment results
- Uses a family-like communication techniques and skills (co-operative communication techniques) that indicate interest and concern for others, indicates willingness to work together and acceptance of responsibility for communication and follow-up behavior.

As with the other dimensions of performance, no single lever alone is sufficient but the following appear to have the most significant effect: norms and codes of conduct; supervision; and basic amenities, such as privacy during consultations. Team-based interventions that make health workers feel valued and permitted to innovate can also boost responsiveness. However, according to the World Health Report (2000), responsiveness promotes utilization but this is not always the case (WHO, 2000). A positive attitude and good working relations among staff are important factors in the successful implementation of IPHC. While staff commitment is no doubt an essential precondition for successful integration, IPHC is unlikely to be fully realized unless staff is trained in all services that are offered in the clinics. Flexibility and willingness to collaborate with people from multiple disciplines while maintaining an attitude of openness and understanding, is essential (Aitken and Curtis, 2004: 327).

6.7.1.4 Productivity

The health workforce is a major input in the production of health care within the health system. According to the World Health Report “at the heart of each and every health system, the workforce is central in advancing health” (WHO, 2006b). The South African population continues to grow; hence the need to maintain the production of health professionals to care for it. Furthermore, needs are not only changing but also increasing, owing particularly to changing disease profiles. According to the National Health Resources Plan for Health in South Africa, the short term trend shows a slight decline in the numbers of key public sector health personnel in the country as a whole. Kreitz and Kleiner (1995: 36) define productivity as “simply comparing input with output, the input being labour hours and the output being services provided for patients”. Productivity involves producing the maximum effective health services and health outcomes possible given the existing stock of health workers and reducing waste of staff time or skills. Strategies to redress skill mismatches could reap huge productivity gains. Adjusting the way that health workers are paid, improved teamwork, and responsibility with accountability also offer potentially large benefits. To address the problem of unequal distribution of health care personnel in urban and rural areas, strategies to attract and retain professionals in rural areas must be put in place. The recruitment of students from rural areas and increased exposure of students to rural practice during training also improve staffing in these areas. In order to scale up human resources, task shifting is undoubtedly needed but this will require extensive changes in legal framework. Task shifting requires that training institutions also to modify their curricula and approaches.

6.7.2 Organizational support

No matter how motivated and skilled health workers are, they cannot do their jobs properly in facilities that lack the necessary infrastructure like space, transport and other supplies. For workers to be effective, there must be adequate infrastructure, and for them to use these inputs efficiently they must be motivated, skilled and supported. Adequate consulting rooms to accommodate all the comprehensive services that are offered in PHC clinics are a necessity in order for IPHC to work. The implementation of effective and comprehensive health programmes in a district is dependent on the availability of adequate transport. Being able to provide transport to a referral centre for emergencies that occur during the usual working hours as well as after hours is vital for a well functioning health service. WHO (2005) argues that in the short term, health systems can use resources that already exist. But in the medium and long term, wise investment in human resources, physical resources and knowledge will improve health service performance.

6.7.3 Collaboration

For IPHC to be successful, sustainable and replicable it must have the support of all role-players at all levels of the service. All levels including individual, family, community, facility, district, provincial, national and global have a role and responsibility if IPHC is to be achieved. The incorporation of visits to clinics by doctors and other health professionals in support of the other members of the PHC team, particularly nurses improves collaboration between health professionals. An effective IPHC can only be achieved through teamwork (Tumbo et al., 2006). Teamwork means that everyone involved needs to understand the system, their own role in it, and appreciate and acknowledge the importance of everyone else. Aitken and Curtis (2004: 322) argue that integrated care is the increased collaboration of different health care professionals. The multi-

disciplinary team consults regularly throughout the day about the patient's needs and will, in some situations, see a patient together to help determine the most appropriate treatment plan. The final outcome of this involvement is better health for the community. Inherent in IPHC is a strong emphasis on collaboration and teamwork between health workers and the community. The principles of PHC emphasize the central importance of collaboration (Dennil et al., 1999).

The success of PHC depends on the interactions of families and communities with PHC workers. Human resources are key, not just in terms of skill and distribution but in their relationships with communities (Lawn et al., 2008). Nurses depend heavily on the community members to provide care to patients and to be involved in care planning and decision-making. Kim's (1983) dyadic theory of collaborative decision-making in nursing practice describes and explains the collaborative interaction between patients and nurses in making health care decisions and how collaboration affects patient outcomes. Kim's theory encompasses concepts that are organized in four categories. The first category, context of participant, includes patient-related factors of the patient's role expectations and attitudes, knowledge, personal traits and definition of the situation. The second category, context of situation, includes organization of decision-making and nursing care decision type that incorporates programme decisions, operational control decisions and agenda decisions. The third category, primary outcomes, includes level of collaboration and nature of decision. The fourth category, secondary outcomes includes the patient outcomes of goal attainment, autonomy and satisfaction. However, Dalton (2003) identified a gap that in Kim's theory, the family caregiver or community was not included; hence she developed a theory for collaborative decision-making in nursing practice for triads which was an extension of Kim's theory.

The theory of collaborative decision-making in nursing practice for a triad was developed to enhance the understanding of collaborative decision-making in triadic interactions in nursing practice (Dalton, 2003: 29). Community and family empowerment, involving the community both in health promotion and demand for care with community cadres and extension workers for provision of curative care when appropriate. The base of the worker system consists of family members, relatives and friends and they are backed by diverse informal and traditional healers and by formal community workers (Chen et al., 2004).

In IPHC, tasks are shifted from health care personnel to the community itself. The active involvement and participation of the community in those matters that affect their health and well being lie at the very core of a well-functioning district-based PHC system. The community is involved in the assessment of the situation, the definition of problems and the setting of priorities, and can then help to plan PHC activities and co-operate when these activities are carried out. Therefore, to successfully integrate PHC services, partnerships, links and an enabling environment are needed.

6.8 ASSUMPTIONS

A model is based on a number of assumptions, some of which have been taken from the paradigm guiding the research and some of which have been derived from the identified concepts. Political will is given. The workforce presents a set of interrelated problems which require all stakeholders to be engaged together, both in diagnosing and solving them. The key is to mobilize political commitment, including sustained government involvement and support to tackle workforce challenges. Successful strategies have been demonstrated that can energize the workforce and win public support. The political challenge is to apply known solutions to craft new approaches to monitor progress. Commitment to produce appropriately trained health personnel to meet the health needs of the country is

necessary. The success of IPHC does not only depend on the political will but also on community participation. Dr Jeene used the term 'political commitment' to describe what was needed to move health policies forward and stated that major shifts in thinking about health will only work if communities and politicians start working together in the PHC setting to promote health (10th Annual briefing of the NGO Advisory Group on Health Promotion).

Although the focus of PHC service delivery is on the integration of services, structural integration is more an ideal than a reality. Functional integration is visible and happening on the ground. As discussed in Chapter 3, health district A is in the process of devolving PHC services to local government in order to integrate provincial PHC services within the context of the overall city plan. PHC services are considerably better resourced in metropolitan areas, that is 28% higher because of stronger local government revenue capacity (Blecher et al, 2008). Therefore, provincialisation of PHC services risks losing access to local government revenue streams.

6.9 USEABILITY OF THE MODEL

According to Chenitz and Swanson (1986: 153) any grounded theory should lend new insight into the phenomenon under study and should suggest new directions for future inquiry. As mentioned before, this model could be used to guide policy formulation and implementation of IPHC at provincial and national levels. The model for IPHC can be used to guide further research and clinical practice.

6.10 EVALUATION OF THE MODEL

Evaluating the theory itself is the most important step in the evaluation and critique of grounded theory research (Chenitz and Swanson, 1986: 153). The current study was supervised by an expert in model development and qualitative research. Furthermore, phase one of the model (schematic representation of the practice of IPHC) was evaluated internationally by a panel of experts at an international conference held in 2008. Locally, the model has been discussed with the Provincial and National Deputy Directors for PHC. Another point to consider in evaluating grounded theory research pertains to the data collection techniques used in the study. According to Chenitz and Swanson (1986: 152) the 'reliability and validity' checks in this process depend on the use of more than one type of data and the careful selection of subjects. During data collection in this study, observation and extensive interviews were conducted to do cross checking, filling of gaps and verification of categories and concepts that emerged from the data. When developing a model, Glaser and Strauss's four central criteria for judging the applicability of the theory to a phenomenon as discussed in Chapter 3 was also considered (1967: 237-249). The model was also evaluated on the basis of theory generation as described by Chinn and Kramer (2004: 117).

6.11 CONCLUSION

IPHC is context-driven. The phenomenon, IPHC means different things in different contexts. According to Owen (1998: 67), a contingency approach to an organization takes a different view. According to a contingency approach, which is sometimes referred to as a situational approach, an organization should use the style that best fits the work situation. There is no one best way to describe IPHC. In a country such as South Africa with such huge inequities in the distribution of health services and related enabling factors such as staff

adequacy, infrastructure etc. in which a supermarket or one stop shop view of IPHC underpins practice, is always going to be a function of the context in which the PHC practitioners have to operate. Of essence, is that the patient, the practitioner and the service should find meaning in what works for all concerned. However, it is clear that PHC continues to be a fundamental component of health policy and of health systems in South Africa.

6.12 LIMITATIONS

A limitation, and one that should be resolved in future studies in order to be even more comprehensive about IPHC, is that the study did not include patients as consumers of PHC services because the focus was on the meaning of IPHC rather than outcomes and/or patient experiences. Nevertheless, based on the premise that IPHC was put in place to increase access of PHC services, it would be of great interest to see how patients perceive and understand IPHC. Participants decried the disjuncture between service and education. Unfortunately, the nurse educators' understanding of IPHC and the educators' role in the provision of relevant nursing education programmes was not part of the study. Hence, this is a limitation. This important sector's voice is silent in this study. Given these limitations, the results presented here should be the first step towards developing a comprehensive, relevant IPHC approach. This model still needs to be implemented, tested and refined if there is a need.

6.13 RECOMMENDATIONS

The following recommendations, with special reference to policy development and implementation, institutional management and practice, nursing education and further research, are based on the findings of this study.

6.13.1 Policy development and implementation

Although there is a policy commitment to look at how IPHC can better be developed, more evidence is required on the impact and appropriateness of this approach. Despite the many benefits of integrated care, several challenges exist. The gross shortage of health care workers is one of the challenges that seem to cripple health care delivery in PHC settings. Although efforts have been made to retain valuable skills in the country through the introduction of Community Service in most health professions and financial incentives like rural and scarce skills allowances and OSD, staffing still remains a problem. Therefore, South Africa needs a clear policy on human resources, based on objective analysis of needs and opportunities aimed at strengthening the health care system in a sustainable manner. The persistence of personnel shortages and maldistribution are due to long-standing policy gaps. To overcome this problem, there must be a clear policy on human resources that will include strategies for dealing with the migration of health staff to developed countries as well as the retention strategies. Because blocking the movement of people violates human rights and is generally impossible to enforce, the global management of health worker migration should seek to protect both health and human rights. However, the South Africa Yearbook (2007/08: 332) re-iterates that South Africa has played a significant role in ensuring that the issue of the migration of health personnel remains high on the global health agenda. South Africa assisted in developing a code of ethical recruitment for members of the

Commonwealth although this does not guarantee that health personnel will not leave South Africa.

Based on the findings of the current study, there is some evidence that task shifting due to gross shortage of human resources, is currently taking place in South Africa especially in rural PHC settings. This is happening without proper authority and regulation. Therefore, proper regulation of task shifting must be put in place. However, task shifting should not be a substitute for long-standing plans on investment that are aimed at strengthening human resources in the national health system (WHO, 2008).

6.13.2 Institutional management and practice

Tint et al. (2000: 16) argue that providing integrated services is a complicated process that requires multi-skilled providers who cross-reference between different sets of knowledge and protocols that are seldom presented in an integrated manner. There is the real danger of overloading health workers with too many tasks, hence careful and systematic tailoring of tasks to local health needs and available resources will be necessary. Adequate supervision is a key factor in improving the quality of PHC services. Among the 22 recommendations issued in its Task Shifting Guidelines, the WHO proposes in recommendation 11 that supportive supervision and clinical mentoring should be regularly provided to all health workers within the structure and functions of health teams (WHO, 2008). Although a national PHC supervision rate of 70% was attained in 2007/08, it reflected significant improvement from performances in 2005/06 (Department of Health, 2008). However, the quality of supervision and its impact needs further review. This could be better achieved in South Africa with special reference to KZN if there is integrated supervision of local and provincial government facilities to overcome the problem of the resources. Availability of the resources such as transport, staff, and equipment will improve the

supervisor's ability to function in his/her role. Also of importance within the South African context has been the lack of consideration of how vertical programme managers engage with decentralized integrated service provision and this could result in confusion about roles and responsibilities. However, the main problem as identified by Davids and Loveday (2005) in their document on a 9 step guide to implementing clinic supervision is that the lines of communication between the district and provincial programme managers and PHC supervisors are not clearly defined. Hence, these authors recommend that provincial and district managers should address any confusion regarding the supervisory role of district programme managers.

6.13.3 Nursing education

PHC in South Africa is overwhelmingly nurse-based. In response to increased burden of the disease and a growing population, the training of sufficient numbers of nurses with appropriate skills must be a human resource priority. Therefore, the current study recommends an expanded role of schools, colleges and university programmes of nursing education in developing continuing professional education in IPHC. Although curriculum transformation is taking place in most nursing training institutions, there is still a need for a comprehensive audit of their curricula in light of changing needs and service expectations (Lehmann, 2008). Hence, there is a need to develop basic educational experiences in IPHC so that new graduates understand IPHC and their roles and how to function in these settings.

The results of the current study revealed that there was a need for ongoing supervision and mentorship of staff following initial training to ensure competent and skilled nurses. A supportive supervisor or senior colleague could reduce the stress experienced by nurses confronted by heavy workloads and poor working conditions (Oosthuizen and Ehlers, 2007: 22; Walley et al., 2008; Rowe et al.,

2008). Supervisors themselves require periodic training and updates to remain abreast of many changes in health care.

6.13.4 Further research

The researcher recommends that further research be conducted on the impact and appropriateness of IPHC. This study has revealed that IPHC was put in place to improve accessibility of services to the community. So, further research is needed to assess the impact of such approach to the community or client satisfaction.

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