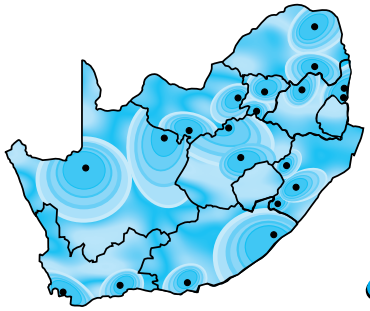
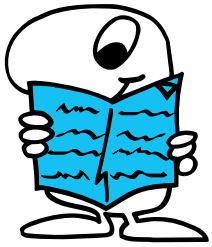


Initiative for Sub-District Support



Kwik-Skwiz #26

The Story of Integration in the Brakpan District

File for quick reference

Introduction

In order for South African health services to be transformed and restructured in line with the district health system, it is necessary to integrate previously fragmented services. This fragmentation has led to confusion for patients and has been wasteful of scarce resources.

In some districts, such as Brakpan, functional integration has occurred. Here staff from fragmented services and different authorities started working together harmoniously long before formal integration commenced.

The story of how the Brakpan health services accomplished this integration of staff serves as an important example for other districts of how to overcome fragmentation and power struggles.

The Brakpan district

The Brakpan district is a well-defined area of the East Rand of Gauteng, with a population of some 250 000. The town, which started as a mine settlement, consists of a core of commercial and industrial areas, with adjacent residential suburbs.

Most people live in Tsakane, situated 15 kilometers across the N17 highway that intersects the district. Tsakane is a high-density urban sprawl made up of small formal houses and rapidly enlarging informal settlements. The environment is thus one of rapid urbanisation, with high rates of unemployment, poverty and crime and the health care challenges these entail.

Currently health services are rendered at seven facilities, one in town, the other six in Tsakane. The local hospital, Pholosong is called a regional hospital as it serves several districts.

How health services were organised in Brakpan before the integration initiatives of the health workers

During the period before restructuring, three different health authorities had responsibility for the delivery of different primary level services. These were the provincially run family planning service, the hospital outpatient curative service and the local authority preventive and promotive services based around clinics.

Three examples illustrate the results of this fragmentation.

- In the town of Brakpan a provincial clinic and a local authority clinic operated 500m apart.
- Two mobile clinics worked in parallel, one for family planning and the other for child health. These sophisticated vehicles, each with two professional and two enrolled nurses visited the same points daily.
- At the main clinic in Tsakane owned by the Brakpan local authority, provincial nurses worked on one side of the building rendering curative services, and local authority nurses had responsibility on the other side for preventive and promotive services, treatment of tuberculosis and sexually transmitted diseases. The fact that the "curative side" was always busy was easily noticable as there was a common waiting room.

This situation in Brakpan was no different from that in many other areas around the country.

Brakpan district services in 2000: (Post Integration)

Brakpan district runs seven health facilities. All are staffed by a mix of Gauteng Provincial Administration and local authority professional and administrative personnel. Some clinics have Gauteng Provincial Administration nurses as heads, others local authority nurses. Where the facility manager is employed by the local authority, the deputy is a provincial staff member and vice versa. Local authority and provincially employed staff constitute 53% and 48% of the total staff complement respectively.

The Integration process in Brakpan

How the Brakpan nurses approached the fragmentation:

- Several of the nurses working for different authorities were aware that the fragmented way services were run was illogical, inconvenient and caused confusion for their patients.
- The local authority community nurses felt under-utilised, even bored, while their "curative" colleagues were very busy. They were concerned that patient care was compromised. For example if they needed to refer a sick child to the provincial side, that would mean a long wait in another queue, as well as their own sense of frustration in being unable to handle certain problems.
- Many of the senior nurses from both authorities were studying together in University courses that highlighted the essence of comprehensive primary care, and the theory of integrated district services. They became friends empathising with each other's work situation. Another factor that precipitated action was the fact that most members of the local authority staff were local residents whose family members and friends were in those long queues. They found it impossible not to help.
- The local authority nurses would go directly to their colleagues on the "other side" for advice on management of sick children, or for a supply of drugs not available to them. They would also consult the visiting (provincial) doctor.
- Although these actions were not strictly according to protocol, the senior local authority nurse turned a blind eye and did not discourage the initiatives. It certainly required commitment and courage to work outside the accepted practices.
- Since they shared one building, the staff had to cooperate around structural issues like power failures, telephone faults, security, as well as common functional plans including disaster management.
- So it was that a team of about 12 staff members of different authorities held regular meetings to discuss the issues and to find solutions themselves, without waiting for national intervention with new policies. This initiative, long before 1994 when integration became a focus, established sound relationships between staff, who agreed to the sharing of responsibilities for health services.

The essential factors in the integration process:

- The staff is convinced that the key to integrating services and working well together was **goodwill.** This came together with a **willingness to focus on patients.** There was also **support** for colleagues who were under pressure. There was no magic wand and integration did not just happen. It was **hard work to negotiate constructively** around the use of limited resources and increasing workloads. This required a **common vision of using opportunities** without focusing on the threats.
- Factors that helped this were the existence of a **shared building** and facilities, **relationships with colleagues** through studying together, the **gaining of knowledge** in the practice of comprehensive care, and **managers who did not obstruct** the suggestions of their staff.
- A number of **joint processes** were put in place. The local authority nurses taught the provincially employed professionals how to immunise infants and in turn were taught family planning protocols. Courses on patient counselling were shared across health authorities. The duplication of mobile services was tackled by agreeing to **divide the mobile points** between the two sets of staff in order to share the workload. Thus each point was visited by a single mobile clinic, which delivered a more comprehensive service. In the Tsakane local authority clinic building, **workspace was provided for provincial staff** so that curatives services could be made available under the same roof. **Staff worked where the needs were greatest**, helping one another and reducing patient waiting times.

- The process of working together was achieved through a series of **carefully planned phases** for each health programme. This enabled nurses to handle anxieties and fears about unfamiliar work. The clinic nurses were also **supported and encouraged by their managers**. The phases were ordered as follows:
  - Firstly the family planning services were integrated.
  - This was followed by the curative services then school health, mental health, and health promotion.
  - Later on the clerical and general workers were included in this process.
- Later developments which were vital to the success of the process were the presentation of the issues to the local authority in the district. Credit must go to the Brakpan town council who showed political will and who took a formal resolution in September 1995 to integrate health services. Further evidence of their positive approach was another resolution early in 1996 that provincial staff would be welcome to work in local authority clinics without paying rent.
- In April 1996, the process of consultation and sharing was further strengthened when the new policy of free primary health care for under-five year olds and pregnant women was announced by the Ministry of Health. The increased numbers of patients encouraged the further development of strategies to improve services and conditions for staff, and to manage increased workloads. **A more formal system of cooperation was introduced** whereby provincial staff provided drugs so that local authority staff could manage sick babies, while they saw the sick adults.
- The Gauteng regional office assisted with **a workshop on integration**, the objective of which was to **provide information on the emerging district health system** as well as to allay anxieties of staff concerning changes. This was followed by a session on personnel attitudes. These meetings helped to endorse the support and joint work being done on a daily basis.
- Another area of integration was to build a **common identity.** Staff made the decision to wear the same uniforms. Although local authority employees received an allowance the provincial staff paid for their own so that they could be part of the same team as their colleagues.
- A feature of this process was the development of **an enlightened joint transport and travel policy.** Vehicles of the two authorities are now shared for a variety of purposes including service delivery, staff training and meetings. A newly appointed provincially paid transport officer controls all district vehicles. Provincial staff may now drive local authority vehicles. A decision allowing local authority staff to drive provincial cars and mobile clinic vans is expected.

Some of the Advantages of integrating health services:

For patient care:

- Patient care is comprehensive with preventive, promotive, curative and some rehabilitative care available for the community at district clinics. (e.g. A mother can attend a clinic to immunise her infant and at the same time she can attend the antenatal clinic and also obtain advice and counselling about HIV.)
- Patient confidence is enhanced because they see professional staff willing and able to perform the same work, wearing the same uniforms.

The pooling of resources has meant that:

- All clinics are able to share the consultative services of a doctor for at least a few hours each day cutting down on the need for large numbers of referrals.
- Service infrastructure is better because resources are shared between health authorities. The service delivery is more cost-effective.
- Transport systems are in the process of being combined; drug ordering is a fully integrated process.
- There is joint planning of services at every facility and joint management and problem solving by the integrated district management team.

For health service staff:

- Staff have the opportunity to learn new skills and to rotate through different service areas available in clinics. Nurses have gained confidence because they know they are practising within the principles of good primary care.
- A uniform policy on leave and hours of service has been regarded as much fairer by the staff.

For community involvement:

- Integrated services that are community-based can be directed and monitored by the community being served, through community committees and forums. The community is not bewildered by the overlap and disorder of fragmented services.

Remaining Challenges:

- It would be unrealistic to ignore the existence of different conditions of service between Gauteng Provincial Administration and local authority staff in this and all other districts. Salaries still differ slightly; working conditions including uniform allowances are not yet identical. However staff accept that further changes will iron out these discrepancies.
- For professional nurses to be competent in primary care delivery, they need **training and updating**. With limited numbers of staff in each facility, this has to be done over time. In a clinic with a professional staff of two or three, not more than one can be involved in outside training at any one time. Not all staff have yet undergone training in diagnosis and treatment of common health problems, but they are expected to manage these problems as best they can, or (preferably) refer them to colleagues with more training and experience.
- Staff training budgets are still separate.
- The referral system for problems that cannot be managed at primary care level must be efficient and effective. An understanding of the responsibilities and capabilities of community-based and hospital staff needs to be achieved through the same goodwill process as initiated in Brakpan's functional integration of clinics. Meetings to discuss these and other district resource issues would help to generate solutions.

Conclusion

Integration in this district was achieved through good personal relationships with phased-in changes. Handling specific programmes one by one lessened stress. There is further work to be done to complete the integration process, but this district is an example to others of what can be accomplished by local health workers. They did not wait for impetus from outside. They used their collective initiative to deal with a key constraint in improving health care.

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