# Leading Change in the South African District Health Service

Ken Dovey
University of Technology, Sydney (Australia)
and
The Leadership Development Institute (South Africa)

Amy Strydom
East Cape Department of Health
South Africa

Barbara Penderis
East Cape Department of Health
South Africa

Peter Kemp
The Leadership Development Institute
South Africa

## Abstract

**Purpose**: The paper explores the leadership processes and dynamics of change management in a fragmented, and resource-poor, health service in an impoverished rural region in South Africa.

**Methodology/Approach**: The paper outlines an action research process aimed at assisting the stakeholders of two rural clinics to integrate psychiatric care into the Primary Health Care service that they offer their respective communities. This involved the transformation of existing practices through a form of praxis that involved learning from action and acting on learning.

**Findings**: The findings of the paper relate to the role of leadership in the facilitation of transformational learning in team-based social action. Four areas of leadership responsibility are highlighted: the transformation of inappropriate mental models; the development of strategic resilience; the shifting of the locus of control of stakeholders to a more internal position; and the creation of a social environment in which intangible capital resources are generated and leveraged in the collective interest.

**Limitations**: Our paper is subject to the limitations of potential bias and distortion in action research. Although the 'objective' evidence of the integration of psychiatric services at *Pelsrus* and *Kwanomzamo* clinics exists, our portrayal of the learning processes through which this was achieved could have been influenced unwittingly by our own knowledge and other interests.

**Practical Implications**: The paper endorses the educational importance of work-based projects through which strong tacit leadership knowledge bases can be developed in health sector personnel.

**Originality/Value**: The paper contributes new insight into the emergent nature of strategic action and its successful execution in challenging health operational contexts.



**Key Words**: *Leadership; Teams; Learning; Knowledge Construction; Social Capital; Morale Capital.*

**Classification**: Case Study

## Introduction

In an article in this journal, Dovey (2002) outlined a new initiative, commenced in the East Cape Department of Health (ECDOH) in South Africa in 1998, through which health leadership capacity is being built at a district level. In line with the decentralisation policy of the National Department of Health (see Department of Health, 1997), over the past eight years this initiative has enabled district health teams to manage their challenging operational contexts more effectively, and to offer the comprehensive Primary Health Care (PHC) service advocated by government policy. Furthermore, over the past two years, the initiative has become more institutionalised through the receipt of direct funding from the ECDOH; the formal academic accreditation (jointly by four local universities) of the postgraduate *District Health Management and Leadership Diploma* (DHM&L) through which the learning and knowledge generated by this initiative for district health team members is recognized; and, after eight years of application of its work-based project curriculum, the acculturation within district health teams of the principles of teamwork and management-by-projects as a 'way of working life'.

Over the eight-year duration of the DHM&L, one module in this course - *Transformational Leadership and Team Building* - has been singled out as a key contributor to the development of valuable leadership knowledge and skills in district health personnel (McKenzie, 2004; Kelly & Senekal, 2001; Onyx, 1999). In particular, these reviewers note that, as a consequence of the work-based learning format of this module and the on-the-job coaching provided by the staff of the *Leadership Development Institute* who offer the module, participants are developing the vital procedural and strategic knowledge bases[i] that they require to execute

strategic action effectively in their complex and challenging operational contexts. In 2006, the module was introduced into the State of Ekiti in Nigeria, as part of the transformational health initiatives being conducted there by a consortium of international health organisations, such as the Nigerian Partnership for Transforming Health Systems (PATHS) and Health Partners International (HPI), and funded by the British Department for International Development (DFID).

In order to demonstrate this capacity of the *Transformational Leadership and Team-Building* module, this paper outlines a work-based project, implemented during a recent iteration of the module in South Africa, that addressed the contentious issue of the integration of psychiatric care into the comprehensive Primary Health Care (PHC) service that the ECDOH is attempting to establish at the district clinic level. Completed as an assessment task by two participants from the *Kouga* District Health Management team, the project targeted two clinics in the *Kouga* district with respect to the introduction of psychiatric care as part of the PHC service of these two clinics. In addition to outlining the 'strategic story' of this project, the paper analyses the effectiveness of the leadership of these two District Health Management team members in mobilising the knowledge, social and morale capital resources, available through district team members and other project stakeholders, necessary to achieve the project's objective. Furthermore, it evaluates the strategic knowledge construction processes, embedded in the learning methodology of the module, from the perspective of the conversion of the tacit knowledge developed by this team from the experience of executing the project, into new, contextually relevant, explicit leadership knowledge.

The key findings of the paper relate to the role of leadership in the facilitation of transformational learning in teams. In particular, the authors identify four critical areas of leadership responsibility: the transformation of inappropriate mental models (assumptions about self, others and 'how the world works') held by project stakeholders; the development of strategic resilience in project stakeholders – specifically their ability to sustain the 'strategic struggle' upon which the successful execution of strategy depends; the shifting of the locus of control of stakeholders to a more internal position where they accept full responsibility for project outcomes; and the creation of a social environment in which collaborative action amongst project stakeholders leads to the generation and leveraging of key intangible capital resources such as those of *social* and *morale* capital.

## The Theoretical Framework and Pedagogical Strategy of the *Transformational Leadership and Teambuilding* Module

The module is framed by a critical enquiry theoretical perspective whereby it is assumed that social reality is humanly constructed and, thus, can be transformed by human action (see Burrell & Morgan, 1979). As a consequence, it utilizes an action research methodology that aims to guide project stakeholders in interpreting and analyzing their social reality, and reflecting critically on their everyday practices and strategic action, in order to transform this social reality in line with their ‘political’ interests and goals (see Carr & Kemmis, 1983). In order to provide perspective and ‘objectivity’ during this research process, the two ‘insider’ action researchers were assisted by their academic supervisors who played the role of an ‘outsider’ or ‘external critic’ - someone who is intimately interested in the project but who provides an outsider's perspective; who is independent enough to challenge the

interpretations and analyses of the insiders; and who is respected enough by the insiders to be taken seriously by them (see Sarason, 1972).

The content of the module addresses the learning and knowledge resources that are required for such analysis, interpretation and strategic transformation. In addition to providing an appropriate conceptual framework for such tasks, the module specifically addresses issues such as 'learning how to learn' and 'knowing what to know' as these issues relate to the knowledge construction (and leveraging) processes that underpin collective transformative action. In particular, the module addresses the structural and cultural dimensions of a learning environment; and advocates a *team* structure through which a *covenantal* culture can be created (whereby district health stakeholders recognise their shared destiny). Thus, in addition to the construction of vital knowledge capital, the pedagogical strategy of the module is focused on creating and leveraging two key intangible capital assets that underpin the successful execution of strategy in organizations. These are *social capital* (resources such as trust and voluntary cooperation between all stakeholders - see Nahapiet & Ghoshal, 1998) and *morale capital* (resources such as the passionate identification with, and commitment to, the shared purpose of the collective; and the capacity for strategic resilience in spite of significant contextual obstacles and constraints - see Dovey & Singhota, 2005). As these resources are collectively owned – they are embedded in stakeholder *relationships* - a team structure, characterized by lateral power relations, frequent opportunity for face-to-face communication, and collaborative learning practices is ideal for their mobilization (see Dovey & White, 2005). Thus, by facilitating the acquisition of new knowledge that is embedded 'in community' (through learning/teaching approaches that include

apprenticeships, coaching, mentoring, and communities-of-practice) teams assist members to transcend self-limiting mental models (especially those impacting an individual's capacity to learn) and to leverage the support of others when engaged in accelerated learning projects that stretch them beyond their 'comfort zones' (see Dovey & Singhota, 2005: 18-19). In this respect, a key aspect of the module is a four-day 'outward-bound' experience in which the participants apply the concepts and principles of teamwork covered in the five-day classroom session, under challenging physical and emotional circumstances. After each activity, their team-based endeavours are rigorously analyzed by the group (through critique and co-coaching) and linked back to the theoretical and conceptual knowledge covered in the classroom-based sessions of the module. In this way, the tacit knowledge gained from experiencing the outward-bound exercises is converted to explicit knowledge forms that, combined with the explicit knowledge gained from the classroom sessions, build new strategic leadership frames of reference for participants.

**Broad Context of the Project**

The East Cape Province is approximately the size of France. The *Kouga* Local Service Area (LSA) is a rural district in the south-west of the province characterised by high unemployment and social problems associated with poverty and marginalization. In an effort to recognize the social bases of many of the health problems experienced in such South African communities, the Department of National Health has advocated the PHC approach as policy in all provinces (Department of Health, 1997). Espousing a preventative health strategy, the PHC approach advocates the provision of a comprehensive health service at the clinic level. Through education and appropriate medical intervention, the role of the clinics

is to address health problems in the lived locations of communities in order to build the social fabric and self-help capacity of such communities and to stem the flow of community members to hospitals for inappropriate reasons.

**Policy Background of the Project**

Historically, psychiatric services have operated as a specialist service managed through psychiatric hospitals. Once discharged from a psychiatric hospital, patients received a monthly visit from a psychiatric nurse who was usually based in a psychiatric hospital in one of the larger cities. More recently, in line with the introduction of the PHC philosophy, a dedicated psychiatric nurse was appointed to the *Kouga* LSA to provide a monthly visit to psychiatric patients referred by clinic staff and medical doctors as well as to those discharged from a local psychiatric hospital. In 2004, however, the newly documented *Norms and Standards for Primary Health Care (PHC) Service*, and the *Batho Pele (People First)* principles, committed provincial health departments to the provision of psychiatric care as part of a clinic-based comprehensive PHC service in every community in the East Cape Province. The goal of the project outlined in this paper was to explore the issues involved in the implementation of this policy by piloting the integration of psychiatric care in two PHC clinics – the *Kwanomzamo* and *Pelsrus* clinics - in the *Kouga* Local Services Area (LSA) of the East Cape Province of South Africa..

**Specific Contextual Analysis**

The *Kouga* LSA has seventeen clinics, plus several rural stops, where mental health services are rendered by one psychiatric nurse who packs and dispenses psychiatric medicine, and counsels all psychiatric patients, during her monthly visits to clinics

and rural stops. There is no local referral system to psychologists or psychiatrists, and a medical doctor counter-signs medication prescriptions on a six-monthly basis as required by the Mental Health Act.

At present within this LSA, three bodies render the PHC services: - local authorities (municipalities), the *Cacadu* district authority, and the East Cape provincial authority (ECDOH). Each of these three service providers is independent of the others and has its own budget and staff. Generally, the introduction of policies aimed at the integration of psychiatric services into clinics has met with resistance from all service providers for various reasons that include a shortage of funding, staff, and experience in managing psychiatric patients.

In order to understand the attitudes and mind-set of clinic staff in the two targeted clinics prior to the introduction of the project, they were asked to complete a questionnaire regarding their fears about the integration of psychiatric care into the PHC service; problems that they anticipated with respect to the provision of such a service at the clinic level; and opportunities that such a service may open up. The results are shown in Figures 1 and 2.

**Project Objective**

The objective of the project was to introduce a psychiatric service, as part of a comprehensive PHC service, at the *Kwanomzamo* and *Pelsrus* clinics in the *Kouga* LSA over a period of four months.

The Project team (led by the two members of the District Health Management team who were enrolled in *Transformational Leadership and Team Building* module of the *District Health Management & Leadership* course, and for whom this project was a assessment task), envisioned that an integrated psychiatric service, as with all other chronic services, would enable stabilised chronic psychiatric clients to access treatment at their clinic on a daily basis. Thus, when doctors saw a new psychiatric patient, the prescribed medication would be issued on the same day at the clinic. Similarly, patients from other areas, who had a letter of referral and a prescription, would have their prescribed medication issued at the PHC clinic. Furthermore, all problem cases and new clients, not managed by a medical doctor, would be managed by the dedicated psychiatric nurse who would continue with monthly visits to the clinics as before and would also provide specialised counselling. Every six months the progress of patients would be reviewed and their prescriptions renewed, if applicable, by a medical doctor. PHC clinic staff would manage all acute cases according to prescribed protocols and guidelines. Medication would be ordered directly from the Port Elizabeth dispensary, as with all other EDL medication

**Core Values of the Project Team**

In order to provide a framework through which the strategic action of the project could be governed according to democratic, team principles, members of the Project team conducted a meeting to develop, and reach consensus on, a set of core values by which the everyday project behaviour of members would be governed. Consensus was reached on the following six core values:

- acceptance of the principle of the integration of psychiatric services into the PHC clinics;

- recognition of teamwork above individualism;
- punctuality on all occasions;
- exercising respect and support for each team member;
- enthusiastic participation in all strategic action;
- unwavering commitment to the achievement of the objective of the project.

**Strategy Formulation and Execution**

The project team reached consensus on the following strategies through which they intended to achieve the project objective:

1. *Disseminate Information Regarding the Integration of Mental Health into the PHC Clinic Services* (to be executed within three weeks of the commencement of the project). The following stakeholders were identified and informed: the District Health team, PHC service managers, targeted clinic staff and health committees; nearest hospitals to the targeted clinics (including the nearest psychiatric hospital), local general medical practitioners; the local ambulance and police service; and the local magistrate's office.
2. *Form an Integration Task Team* (to be formed within two weeks of the commencement of the project). All key stakeholders in the project were invited to a meeting at which the proposed integration plan was explained and discussed. Select members of this group of key stakeholders committed to participation in the integration task team. The primary function of this team was to assist the Project team in addressing emergent problems as the project was implemented.

3. *Train and Educate Stakeholders on Mental Health Where Necessary* (initial training/education to be executed within eight weeks of the commencement of the project, followed by on-going training/education as needed). The focus of this strategy was on preparing clinic staff for the new demands on them that the integration of psychiatric care into the PHC offering of the targeted clinics would initiate. These new aspects of their role included psychiatric patient management, drug management, community management, and the management of effective communication with the Project team, the Integration Task team, and the District Health Management team. Another focal point of this strategy was the education of the three 'governing' teams with respect to the need for rapid, empathic, responses by them to issues raised by the clinic staff.
4. *Commence Integrated Psychiatric Services in the Two Targeted Clinics* (to be executed within fourteen weeks of the commencement of the project). The execution of this strategy involved the development of an appropriate integration model for each of the two clinics; the implementation of the model; close monitoring of events over the implantation period; and ensuring rapid empathic responses to all issues that emerge from the process. Furthermore, regular visits to each clinic were conducted by the Project team to boost staff morale and to gain valuable first-hand information on the effectiveness of the project team's strategies.

*Evaluation of the Strategic Execution Process*

All the objectives linked to strategy one were achieved but the process over-ran the time limit set for its implementation by several weeks. All stakeholders (clinic staff,

patients, hospitals, doctors, the ambulance service, police service, and magistrate's offices) were informed and, in return, promised their full support for the initiative. With respect to strategy two, difficulties were experienced with respect to stakeholder attendance at Integration Task team meetings due to the demands of other projects/programs on their time. To address this problem, the Project team developed alternative communication strategies - these included individual meetings with stakeholder representatives at times that suited them; telephone communication; and the effective distribution of minutes of meetings to all stakeholders. A decision was taken to have all subsequent meetings of the Integration Task team coincide with the dates of the District Health Management team monthly meeting in order to facilitate attendance and save travelling costs. Overall, Integration Task team members participated enthusiastically in on-going monitoring and remedial action at the two clinics (some more actively than others). In this respect, the sharing of the Project team's core values with the members of the Integration Task team proved to be a very important factor in the successful execution of this strategy.

Strategy three was the most difficult strategy to execute because of resource constraints. In particular, the training of clinic staff was difficult to organize because, as all clinics were operating on skeleton staffing schedules, managers were reluctant to release staff for the one-week of intensive training. In order to accommodate this situation, the Project team decided to conduct the necessary training on Fridays over a five-week period (as opposed to a full week of training). However, after the completion of the training, participants still did not feel competent to manage psychiatric patients. As a result, an additional two Fridays were allocated for training, and on-the-job support was provided to assist them in becoming comfortable with

their new responsibility. Other forms of training (patients, community members and clerical staff) were conducted without any problem arising.

Furthermore, the team experienced difficulty in getting a budget to develop training manuals, and documented guidelines for each clinic. This problem was overcome by demonstrating the relevance of the training to other health issues (such as HIV-AIDS and gender violence) and, as a consequence, accessing funds from related health initiatives that have a higher political profile and, thus, better funding. As a result of the resource constraints experienced by the team, the original time frame for the execution of this strategy was unrealistic.

With respect to strategy four, in spite of a lot of unforeseen problems, both clinics are fully integrated. Fourteen weeks after the initiation of this project, the integration process at *Kwanomzamo* was operating well although unresolved issues still remained at *Pelsrus* where resentment over the integration strategy was still being expressed by some staff (note that the integration process at the *Pelsrus* clinic was commenced a month later than that at *Kwanomzamo*). Subsequently, the situation has improved as a consequence of the Project team continuing to monitor and guide the situation at both clinics, and address the residual problems at *Pelsrus* clinic. From a functional viewpoint, the clerks are playing a positive role in monitoring the behaviour of patients in the waiting rooms; the transfer, admission and transport of patients is running smoothly; all protocol and guidelines have been introduced; and the dedicated psychiatric nurse is able to focus on problem cases and new patients. However, waiting-room space and daily patient load remain a concern and these two issues require further strategic action.

**Evaluation of the Project**

Staff at the two clinics completed the same questionnaire (as completed prior to the commencement of the strategic action of the project) at the end of the integration process. The results are shown in Figures 1 and 2.

**[Take in Figure 1 and Figure 2 here]**

**Key Leadership Principles Derived from the Integration Project**

Participants in the *Transformational Leadership and Team-Building* module of the course are assessed on their ability to make the tacit knowledge, gained from the work-based project experience, explicit through the sloganization of key leadership principles (with annotations of the new knowledge constructed, providing links back to a learning journal where the experience that sparked the insight is noted). The leadership principles are sloganized in order to make them more easily memorable, and thus the knowledge they convey more accessible for strategic use in subsequent situations.

The following key leadership principles were articulated by the participants who managed this project:

*1. In order to transform ourselves, we need to transform our assumptions*

Through this project, all stakeholders were forced to confront their mental models (assumptions about self, others and 'how the world works' – see Senge, 1995, and Kim, 1993) about psychiatric patients and psychiatric disorders. Through exposure to such patients on a regular basis, all came to question their tacit fears and prejudices with respect to this phenomenon and, through collective engagement with it,

overcome inappropriate assumptions about the management of such disorders and caring for these patients. In some cases, this process required considerable patience – for example, the mental models of staff at the *Pelsrus* clinic were far more rigid than those of staff at the *Kwanomzamo* clinic – and required clear evidence of success before staff became more accepting of the change in service. In this respect, the visibility of the successful integration of psychiatric services at the *Kwanomzamo* clinic was an important factor in the gradual transformation of staff mental models about psychiatric phenomena at the *Pelsrus* clinic. It became evident that it required sustained new experiences that contradicted old assumptions, for people's mental models to transform. This process was facilitated by the project team's non-judgemental attitudes towards, and empathic acceptance of, staff's fears, and their encouragement of staff to construct their own approach to the integration process. Furthermore, the Project team took seriously staff concerns about lack of space in the clinic for the increased patient load, and lack of shelf space for psychiatric medication, and assisted them in strategising around such problems. An immediate observation that the Project team made was the importance of social capital (especially resources such as trust) and morale capital (especially commitment to the task) in transforming negative mental models. In this respect the poor team spirit and low levels of trust that the Project team initially encountered at the *Pelsrus* clinic, made the transformational leadership task there far more difficult.

*2. New situations require new knowledge*

The requisite knowledge for the successful integration of services in the two targeted clinics had to be constructed *in situ* through intense collaboration by all stakeholders. The success of this process depended strongly on the intangible capital assets held by

the relevant teams – especially morale and social capital. By building and leveraging the resources embedded in these forms of capital, the Project team was able to draw on the tacit and explicit knowledge bases of all stakeholders. Stakeholder collaboration took the form of discussion and debate through which knowledge was shared (and, in the case of tacit knowledge, made explicit) and 'workshopped' with the view to the construction of appropriate strategic and procedural knowledge bases that would inform project strategy and focus stakeholder learning. In this respect, the explicit *core* (objective and values) of the project helped greatly to keep discussion and debate focused upon 'what really mattered'. Also crucially important to the success of the project was the tacit-to-tacit knowledge sharing that occurred as Project team members, experienced in psychiatric care, coached inexperienced clinic staff by working actively with them, debriefing the events daily, during the first few weeks of the integration process at each clinic (see Brown & Duguid, 1991, for an analysis of such situated learning). Through such practices the Project team built the confidence of clinic staff and assisted them in overcoming their fear of the process. Interesting cases of unexpected tacit knowledge bases among project stakeholders emerged – for example, the clerk at the *Pelsrus* clinic had previously worked in a psychiatric service and, with the sound knowledge of psychiatric medication that she had built over the years, was able to assist greatly in the dispensing of medicine under the supervision of the clinic nurse.

The Project team members also learnt from clinic staff what they (the Project team members) 'didn't know' about psychiatric service provision in its community. For example, they learnt about issues such as the need to get the police to remove dangerous and/or intoxicated patients (and the protocol surrounding such a service);

long waiting periods for ambulance services (and the protocol to which ambulance drivers had to adhere when transporting psychiatric patients); and the skeleton staff situations that prevail in clinics. Not only was such knowledge useful in helping the Project team to understand better staff resistance to the integration of a psychiatric service into the clinics, but it also proved to be crucial to the successful planning and execution of the project.

The Project team also learnt that in order to build social and morale capital, problems must be addressed promptly. In this respect keeping open lines of communication (especially through face-to-face meetings where all could participate openly) was fundamental to building the requisite trust among all stakeholders (minutes of problem solving meetings and the active use of the core values proved useful tools in addressing this issue)

When the concept of integration was first introduced to the *Cacadu* District Health Management team, heated debate occurred before the idea was accepted. As a consequence of the constructive management of these 'creatively abrasive' meetings, team members learnt that positive conflict is necessary in order to gain a better understanding of each other's perspective, build stronger relationships with each other, and achieve challenging team goals. This learning transferred effectively to conflict management practices in the Project team and the Integrated Task team.

*3. If you take responsibility for it, you will learn how to do it*

Each step of the integration process needed to be planned in collaboration with all Project team members and clinic staff in order for all to 'own' the project. These

collaborative planning sessions provided all with a clear understanding of the entire process and the project objective. Through these sessions, the initial idea of wanting the clinics to start with the entire package of psychiatric services was questioned - in terms of the consequences of failure on staff fears and morale - and, as a result, a more realistic and achievable process was implemented. Thus, only the chronic cases were introduced initially, with the full service offering introduced only after all staff felt secure enough to manage the entire suite of services.

A key learning for the Project team was that clinic staff had to see the value of more meaningful work and purpose before they would accept the extra workload demands that the principle of integration placed on them. To achieve this, the ECDOH vision, mission and *Batho Pele* principles were used as a framework for the clinic staff to create their own vision – one in which they believed – to guide their everyday work. Through such processes of vision/mission 'customization', greater morale capital was built in the clinics and through it, greater commitment, energy and resilience amongst clinic staff.

Similarly, resistance to training was overcome by the Project team's empathy for the situation of staff regarding staff shortages and single-nurse clinics. By listening to staff concerns but remaining positive, and demonstrating good strategic thinking skills, the Project team assisted staff in overcoming the constraints to training. Similarly the team learnt not to criticise or accuse staff when they did not perform as expected but, rather, to spend time listening to them in order to understand the work and personal circumstances that undermined their performance. For example, the clerk at *Pelsrus* clinic seemed irritable in initial meetings and at times did not

take part in discussions. The Project team member selected to speak to her discovered that the clerk has a disabled husband, and an alcoholic son who was causing a lot of problems. Although her personal circumstances did not change throughout the implementation of the project, the empathic gesture from the Project team resulted in greater commitment, and better performance, from the clerk.

When the project was tabled, the whole team was eager and everything seemed manageable but as the implementation process was rolled out, problems became apparent. For example, the time limit set for strategy execution was too short; some staff did not manage their responsibilities well; and not all staff shared the Project team's commitment to make the project a success. In order to manage such issues, the team had to re-strategize frequently and learnt to take small, achievable steps forward in order to ensure success and, thereby, sustain the morale of the team and the clinic staff. Similarly, the team learnt that more evaluation visits than initially planned, were necessary. For example, the ordering of medication and the correct use of statistics remained a concern throughout the implementation of the project. The team learnt that daily evaluations by any individual Project team, or clinic staff, member could prevent the project being undermined before the entire process had become integrated into the everyday routine of each clinic.

*4. The more inclusive the team, the more effective the strategy*

The Project team learnt that integration cannot function in the clinics without intersectoral collaboration. When the team first invited the police, the ambulance service, and social welfare to a meeting, the representatives of these services were defensive and reluctant to accept more responsibilities. However, once informed on

the objective of the project, and invited to participate in decision-making, a shared purpose was created. This built greater social capital between these various services, whereby 'identity resources' were leveraged, resulting in stronger trust in each other and joint commitment to the social services rendered by each to the community. As a result of this increase in social capital, three months into this project, good working relations existed between the different sectors and, through working together to know the rules, regulations, and communication protocols, effective guidelines that have saved time, money and energy, have been developed for the transfer, and transport, of psychiatric patients.

*5. No meaningful purpose: no morale, no focus, no resilience.*

Prior to the two Project team leaders' experience in the *Transformational Leadership & Teambuilding* module, their understanding of the concepts of 'vision', 'mission' and 'core values' did not go beyond the political value of having such statements, in frames on walls, during inspections. Through the implementation of this project the practical, strategic, value of these concepts was realized by all members of the Project team and clinic staff.

In particular, these leadership tools facilitated morale capital in providing a motivational mission and clear focus on 'what mattered', and in generating the resilience, and learning, necessary during difficult times in the project when failures demoralized some of the team members. Through collective discussion and debate – in which members learnt to listen and reflect rather than advocate and dictate - the effectiveness of the team's strategies was evaluated constantly and modified as necessary. The procedural knowledge gained from such exercises included the

recognition that the social context of each clinic is different and, thus, the constraints and strategic solutions to problems faced by clinic staff vary according to contextual factors. The learning for the Project team members, therefore, was that their role was to inspire commitment to the project mission; guide clinic staff through problem-solving processes; and facilitate access to the significant tacit knowledge and understanding these staff have with respect to workable solutions in the context of their clinic.

The Project team also learnt the value of *intrepreneurship* in organizations that are structured as functional hierarchies (bureaucracies) [see Foster & Kaplan, 2001; Pinchot, 1985.] in that at times it was necessary to break the rules in order to achieve project goals and, thus, the organization's mission. Inevitably, in organizations structured in this way, legacy policy and procedures become embedded constraints in terms of the staff's ability to execute new and creative solutions to intractable problems. In this respect, the project team members learnt that putting mission accomplishment above such constraints requires the courage to violate inappropriate and contradictory organizational rules. Without passionate purpose, they learnt, such courage is unlikely to be exercised

**Conclusion**

Through the example of a project executed as an assessment task for the *Transformational Leadership and Teambuilding* module of the DHM&L, we have attempted to share the effectiveness of work- and project-based learning in building leadership capacity in district health teams in South Africa. In particular, we have outlined how the learning strategy of the module leverages the team structure of the

district health management units in order to create and exploit the social and morale capital resources that are potential available through such a structure and the covenantal culture that it spawns. Furthermore, we have attempted to show how these resources are leveraged in the generation of mission-pertinent tacit knowledge that is then converted by project stakeholders into explicit knowledge forms that can be used more effectively in framing subsequent strategic action. In this way, team strategy becomes emergent (a continuous 'work-in-progress') and is constantly renewed and/or refreshed by action-informed theory that is current and contextually relevant.

As with all forms of action research, - especially insider action research (see Coghlan, 2003), our paper is subject to the limitations of potential bias and distortion. Although the 'objective' evidence of the integration of psychiatric services at *Pelsrus* and *Kwanomzamo* clinics exists, our portrayal of the learning processes through which this was achieved could have been influenced unwittingly by our own knowledge and other interests. In this respect, in order to provide a broader range of perspectives and methodological approaches to the evaluation of the *Transformational Leadership and Teambuilding* module, more research into the effectiveness of this module, and the other modules of the DHM&L, is required.

[i] Strategic knowledge refers to the usually tacit knowledge base that underlies a competent person's ability to make use of other forms of knowledge, as well as heuristic, control and learning strategies, in order to solve problems and carry out difficult tasks. The capacity to apply strategic knowledge successfully depends upon a sophisticated understanding of how such problem solving strategies are embedded in the context of the problem. Similarly, procedural knowledge refers to knowledge relating to the sequencing of events, monitoring of learning and other processes, and the general organization of people and workplace practices. This form of knowledge is also acquired tacitly through participation in well-organized endeavours led by experienced individuals or teams of people (see Collins *et al*, 1989; Rogoff, 1990; and Lave & Wenger, 1991, for greater detail on procedural and strategic forms of knowledge and the 'situatedness' of their acquisition and use).

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| Pre-Integration Views on Problems | Post-Integration Views on Problems |
|---|---|
| Extra workload. | Workload remains a concern but staff are coping. |
| Shortage of space in clinics for medication and files as well as a room for counselling. | Inadequate physical facilities remain a concern but are being addressed. |
| Fear of aggressive and psychotic patients when staff are alone in a rural clinic. | Staff are more confident in dealing with psychiatric patients since they have got to know the patients better. |
| Lack of transport in order to do home visits. | Lack of transport for home visits remains a major problem. |
| Lack of time to engage in preventative counselling visits to schools and other facilities | The health promoter and the non-communicable diseases officer are assisting with these duties. The LSA has motivated for a school health nurse post. |
| Waiting rooms are already too small for the patient load. | Over-crowding of waiting space remains a problem but the previous overload of patients on the day of the monthly psychiatric clinic has ended now that patients can attend daily. |
| Fear of medicine being out of stock with aggressive patients demanding treatment. | Clinic staff order drugs on time with neither clinic being out of stock yet. |
| Fear of handling dangerous psychiatric drugs and their side affects. | Although still uncertain at times about handling psychiatric drugs, staff are following guidelines and asking for help when uncertain. |
| Reluctant to have to do more administration with statistics and referrals, etc. | Administration has improved in general. Statistics are kept as for all other chronic treatment rendered daily. |
| Not sure that they could handle all the different languages in counselling sessions. | Most patients are trilingual – when necessary, translators are used as is the case with other chronic patients. |
| Fear of not being able to get an ambulance or police to transport aggressive patients. | After combined meetings with police and ambulance staff the transport of aggressive patients is no longer a problem |
| Not educated regarding the Mental Health Acts and handling of court cases with rapes and gender violence. | Daily exposure to psychiatric patients has made staff less fearful of them. The dedicated psychiatric sister still manages the difficult cases |

**Figure 1: Problems Associated with the Integration of Psychiatric Services in PHC Clinics**

| Pre-Integration Views on Opportunities | Post-Integration Views on Opportunities |
|---|---|
| Would be rendering a comprehensive service to the community, as promised by the ECDOH. | Staff expressed pride in being one of the fully integrated clinics. |
| Treatment available on a daily basis for patients who work shifts or in 'deep rural' areas. | The provision of a daily service has proved to be of great benefit to rural workers. |
| The fact that patients can get treatment on any open day and not only on one day a month will improve default statistics. | It is too soon to compare default statistics. |
| Staff will gain experience from working with psychiatric patients and be able to identify side affects earlier. | Staff value the experience they have gained in the area of psychiatric services in such a short period of time. |
| Break down discrimination towards, and stigma attached to, psychiatric patients. | All chronic patients (psychiatric and other patients) are now together in the same waiting rooms without incident thus far. |
| Clinics will be able to handle acute cases locally and thus eliminate transport problems to hospitals. | The patients, emergency and PHC staff, and the families have benefited from the local management of acute cases. |
| Nursing staff will be able to get to know all patients better. | Relationships between clinic staff and patients have improved since getting to know each other better. |
| | Clinic staff are proud that they accepted the challenge and surprised the Integrated Task team by the effective way that they have implemented the project. |
| | Workload remains a concern but good cooperation between staff has enabled project implementation. |

**Figure 2: Opportunities Provided by the Integration of Psychiatric Services in PHC Clinics**