

Leadership Development in a South African Health Service

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Abstract

The paper reports the outcomes of one module of a collaborative learning project aimed at the development of leadership capacity in district health management teams in the East Cape province of South Africa.

A work-based learning methodology was selected for the module with the intention of developing strategic and procedural knowledge bases within these teams as a way of addressing the complex problems of policy implementation in South African state organisations.

The paper demonstrates the effectiveness of collaborative work-based projects in developing team members' capacity to solve difficult workplace problems and to implement strategy in a challenging operational environment. It endorses the role of leadership coaching in the development of, and ability to leverage, important strategic knowledge resources that reside within and between team members. The paper concludes with an example that demonstrates the developing ability of team members to initiate successful collaboration around the resolution of complex service delivery problems.

Key Words:

work-based learning; public health team leadership.

This paper reports the outcomes of one module of a collaborative learning project aimed at building leadership capacity in district health management teams in the East Cape Province of South Africa. The collaboration involved the East Cape Department of Health (ECDOH); the Johnson & Johnson Leadership Development Institute (JLDI) of Rhodes University; Management Sciences for Health (MSH), a Boston-based non-profit organisation contracted to the United States Department of Foreign Aid (USAID); and grassroots community organisations. I will argue that the results achieved within the module endorse work-based learning as an educational methodology that can build organisational capacity to implement policy in complex and challenging operational environments.

The Concept of Work-Based Learning

Changes within university curricula and pedagogical conventions recently introduced as a consequence of commercial forces, have opened up possibilities for innovative forms of work-based education in a variety of contexts where the complexity of the 'politics of policy implementation' has rendered ineffective the strategic efforts of more conventionally educated managers. Work-based learning initiatives are centred on the resolution of context-bound problems (see, for example, Lave and Wenger, 1991; Rogoff, 1990; and Resnick, 1989) and facilitate the learning of procedural and strategic knowledge - forms of knowledge that are deeply embedded in the contexts of their acquisition, relevance and application. 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 organisation of people and workplace practices. This form of knowledge is also acquired tacitly through participation in well-organised 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 knowledge and the ‘situatedness’ of their acquisition and use).

Through the implementation of work-based projects, students are empowered to address a key strategic problem/challenge within their work organisation. In collaboration with workplace managers, the academic supervisor guides the experience of students through the strategic action process. While the academic supervisor deals with the issues surrounding the integration of theory and practice, the responsibility of the workplace managers is that of providing ‘cognitive scaffolding’, building alliances, breaking down barriers, and facilitating insights into the task of implementing strategic workplace action. Both of these roles are crucial as they focus the students’ attention upon the culture of practice within their work organisation; they organise students’ knowledge acquisition, and its use, around critical work problems/challenges; and they alert students to the politics of implementation and ensure that these are addressed collaboratively and effectively. As Collins *et al* (1989: 487) put it, all participants in the process develop ‘an awareness of the distributed nature of expertise and insight’ which is ‘the foundation of successful collaboration in all domains’. The role of effective workplace managers thus approximates that of a coach as they mediate power across hierarchical ‘barriers’ and facilitate networks that

traverse work roles and narrow partisan interests, in focusing the collective effort on the attainment of shared interests as articulated in the organisational mission.

Case Study of a Work-Based Learning Partnership in the South African State Health Sector

The Political and Social Context of the Study

South Africa's recent history has had a profound impact upon the complexity of its problems and, in particular, the poor quality of its human resources. The annual *World Competitiveness Report* consistently rates South Africa at the bottom of the list, of countries surveyed, on the 'people' category (see De Jager *et al*, 1998). Through the policy of apartheid, practised in its legislated form over a period of almost forty years, the then-ruling Nationalist Party government systematically denied black South Africans any opportunity to develop themselves, either through formal educational institutions of quality or through informal institutions of learning such as the family, the community, and the workplace. The brutal conditions of life imposed upon black South Africans during this period, resulted in widespread disintegration of the family unit; the development of a 'township culture' of poverty, crime, substance abuse, and despair; and the restriction of job opportunities to those at the bottom of the skills/remuneration hierarchy. Apartheid meant the division of society into sectarian groups based on government-classified racial categories, and thus prevented any effective civic interaction among these groups. The legacy of South Africa's apartheid history is, thus, organisations amongst which there exists very little collaboration, and within which the majority of employees have been unable to develop the relevant knowledge bases, positive workplace values, and proactive attitudes that are a feature of globally competitive organisations. This situation has been exacerbated since 1994

as, owing to policies of affirmative action by the current government in its attempt to transform the political and economic power bases of South African society, many black South Africans have been catapulted into senior positions in state and private sector organisations. As a consequence of their poor preparation for such positions, and the absence of effective collaboration within and between these organisations, many of those with important workplace responsibilities are failing to manage and lead these constituencies effectively. This has placed South Africa's capacity to transform the inequities and disadvantages of its past under threat, especially in the state sector of several provinces where bankruptcy and collapse are constant dangers.

A feature of the strategic incapacity of South African organisations, including the national government, is their ability to develop high quality strategic plans that, subsequently, they are unable to implement. This is due to contextual constraints that make the politics of implementation of strategic plans complex and very difficult to manage. The deficit in the procedural and strategic knowledge bases of senior management in the state sector is possibly the most important problem with respect to the inability to implement the progressive White Papers produced by parliament. These knowledge bases are always linked in a fundamental way to the solving of problems *in situ* and their development is strongly dependent upon appropriate experience that has been guided by informed and insightful mentors. Such experience and guidance has not been part of the new leadership's formal, or informal, preparation for management roles.

It is almost eight years since the political transformation of South Africa from an apartheid state to an open democracy. The euphoria of the historic moment in 1994,

when the first democratically elected government of the country took office, led to many promises being made by the new government that it has been unable to honour. One such undertaking was the transformation of health services in line with the principles of:

- equity for all South Africans within a single unified health system;
- a functionally integrated package of essential primary health care (PHC);
- districts as the major locus of implementation.

The intention was that,

The management of services should be decentralised and focus on improving the district health system. District teams will have to be established and trained to enhance their capacity for planning, implementation, supervision, monitoring and evaluation of health activities. (Department of Health, 1997: 14)

The Regional and Organisational Context of the Study

The East Cape province is approximately the size of France and is largely under-developed and impoverished. Its two relatively large urban centres (Port Elizabeth and East London) are home to populations of around two million and one and a half million people respectively, with unemployment levels of around fifty percent. The western half of the province is more developed than the east, with a relatively good transport and telecommunication infrastructure. The eastern half of the province, which historically comprised the tribal reserves (subsequently turned into 'self-governing homelands' by the apartheid government), has very poor infrastructure. District health management teams crowd into buildings that should be condemned

given their structural decay, and are at times without electricity or telecommunications (except for the recently introduced cell phones). Four-wheel drive vehicles are required to traverse much of this area but many of those donated by MSH are out of action because of reckless driving or poor maintenance.

The head office of the ECDOH is in Bisho, a small town that consists almost entirely of government offices. Few officials ever visit the districts, most of which are several hundred kilometres away. Mismanagement, corruption, power struggles and poor strategic and procedural knowledge bases within senior management ranks, contribute to a situation in which the department is in a continual state of operational crisis.

In 1996, the USA and South African governments established a bilateral project, entitled the Equity Project, with the objective of creating a 'workable and sustainable East Cape Department of Health by 2001', as a forerunner to similar projects in the other South African provinces. This objective was not achieved within the stipulated time frame and in 2001 the Equity Project was granted an extension of three years by USAID for the achievement of this objective. MSH is contracted by USAID to oversee its funding of, and management interests in, the Equity Project.

The District Health Leadership Development Course

In 1998, the JLDI, of Rhodes University, formed a learning partnership with the ECDOH and MSH with a view to the provision of effective leadership education for appointed, and prospective, district health managers as a step towards the implementation of the decentralisation policy of the White Paper.

A steering committee, representing all the stakeholders, was established with the purpose of designing, implementing and managing a new two-year course, entitled the District Health Management Certificate (DHMC). Comprising four six-month modules, the DHMC enrolls a new cohort of ECDOH staff, drawn from the district health management teams, each year. The first module of the course is entitled *Transformational Leadership* and is designed according to work-based learning principles, with a work-based project as its core task. This paper covers the delivery of this module over the period 1998 - 2001, and offers an analysis of the work-based projects conducted by the four cohorts of students enrolled in this module during this period.

The Methodology of the Transformational Leadership Module of the DHMC

The district health management teams vary in composition from district to district. In most cases the team is comprised of between twelve and twenty people and includes professional staff from regional hospitals, co-ordinators of local health clinics, environmental health officers, local government representatives, transport and information officers, pharmacists, and co-ordinators of various health programmes.

The challenge for each team is to improve its district health profile by transforming its service to a team-based, primary health care model. The module begins with an initial week of lectures covering topics such as the nature of *transformational leadership* and the ways in which it differs from conventional management (especially in its visionary dimension and its capacity for strategic thought); *organisational structure/culture* (specifically the concept of a team structure/culture and contrasting it with a hierarchical structure and its concomitant bureaucratic culture); *coaching and*

team-building (specifically the management of power, conflict, and interpersonal perception); and the basic principles of *strategic action research*.

Thereafter, in collaboration with their district health management team members, participants decide upon a problem/challenge to be addressed by the work-based project (the coordination of each project rotates to that member of the district health management team who is enrolled in the module in any particular year). Each project is perceived as one of successive cycles of sustained strategic action aimed at the resolution of key workplace problems/challenges. Strategic action plans are drawn up by each team and presented in a workshop session wherein the plan of each district is critiqued.

The responsibility for the coaching of teams as they commence the strategic implementation of their projects is taken on by the JLDI. Each district has a nominated coach to whom access, whenever necessary, is guaranteed. In addition, each district receives at least one visit from its coach during the implementation of the project.

At the end of the project cycle (and academic semester) each team presents its project to senior managers of all stakeholder organisations. These presentations serve the strategic purpose of strengthening the power bases of the district teams by alerting all senior members of the ECDOH, especially, to the academic and professional status accorded to this initiative by the government. They also enable the sharing of the learning gained from the projects, amongst all the district health management teams.

The methodology of the module thus follows an action-research format. Each district health management team undertakes a collaborative study of their collective practice by following a strategic action process that is characterised by reflection, discussion, and shared responsibility for the team's learning about their key strategic problems and challenges-in-practice. The pacing (time frame) of the implementation of each project is limited to eight weeks due to the semester-long duration of each module in the DHMC. Apart from the initial series of lectures and the eventual academic assessment of the participants, the primary responsibility of the JLDI staff is to assist in the process of making explicit the tacit learning related to the development of strategic and procedural knowledge through the action-research processes within each team. In line with the principles of work-based learning, the assessment process focuses upon the nature of the learning gained (as documented in the project report) rather than the success/failure of the project to achieve its objective for that cycle of strategic action.

Process and Related Outcomes of the District Health Management Team Projects

Each step in the strategic action process produces its own outcomes.

1. The Establishment of the Mission of each District Health Management Team

Each team has accepted the mission of the ECDOH as its mission. The ECDOH mission statement reads as follows:

The provision of an accessible, comprehensive and integrated health service, based upon the principles of Primary Health Care, for all in the East Cape Province

The key words of the mission statement are *accessible, comprehensive, integrated* and *Primary Health Care*. These allow the district health management teams to focus their project objectives on ‘what really matters’ with respect to the mission of the ECDOH.

2. Establishing Core Values That Constitute a Code of Conduct for the Team

In order to focus action, operationalise the mission, and facilitate a ‘culture of collaboration’ within each district health management team, members are required to reach consensus upon the core values that should underpin behaviour at all times within each project. This process of achieving consensus on the behavioural norms and values required for the successful implementation of strategic action by the team is re-enacted at the commencement of each new project. As such, this list of core values constitutes an up-to-date code of conduct for which all team members are held accountable.

The establishment of a set of core values within each team has proved to be a critical factor in the strategic implementation of the projects as almost every team has listed the positive role of the established core values in its analysis of the ‘key learning’ gained from the project experience. An example, taken from the first project report of District Team F, conveys their experience on this issue:

When the core values of the team are internalised, exciting things start to happen:

- *At a meeting of the project team, one of the members excused herself on grounds that she had other commitments. The team questioned this, as it did not agree with the core value that we would function as a team with each member participating fully. She was called to account.*

- *A team member made other arrangements for the day of a team meeting. He tried to motivate members to accept his excuses, but they pointed out the core values. He left. This worried the team and they discussed ways to discipline him. After a while he returned and joined the meeting. This showed that the core values alone had the power to discipline without resorting to harsher measures.*

As teams progress through the strategic action cycle, they re-work their core values according to the learning gained from the experience of collaboration towards the achievement of a meaningful workplace goal.

3. Contextual Analyses of the District Health Management Teams

The central role of human resources as both a positive and a negative contextual factor in the provision of a quality service is a feature of all the contextual analyses conducted by the district health management teams. The fact that all teams recognise people as, by far, the most important determinant of success/failure in their projects, encourages team leaders to focus upon processes of enablement, empowerment and encouragement of their members along the lines of the transformational leadership theory covered in the module lectures. This focus upon the role of people, and especially the potential for effective action that *trust* between them builds, in the successful implementation of strategic action highlights the need for the development of social capital within and across the districts. Defined as the ‘sum of the actual and potential resources embedded within, available through, and derived from the network of relationships possessed by an individual or social unit’ (Nahapiet & Ghoshal, 1998: 243), social capital is critical to successful collaboration in any social context. As a

consequence of the learning gained by the district health management teams from their contextual analyses, social capital theory has been introduced into the module lectures.

4. Setting Objectives and Implementing Strategic Action Plans

Despite the guidelines - that each project should have a measurable, realistic and achievable objective - the initial choice of objective by most teams has been grossly unrealistic. This suggests that, historically, the strategic process in the ECDOH has been superficial and viewed by most teams as yet another 'paper exercise' demanded by the bureaucracy. It also demonstrates that the locus of control of individuals and teams is very strongly external - as a consequence of past experience most staff in the ECDOH perceive themselves as powerless to impact their environment. They thus have little experience of thinking strategically (to do so requires some sense of personal or collective efficacy) and, as a consequence, are strategically naïve. An important role of the leadership coach is to assist each team to craft a realistic 'bite-size' objective that is measurable in some way.

Each team's strategic action follows the conventional format of an action plan that is specifically designed for each of the key strategies selected. Each action plan indicates the actions to be taken and lines of accountability, time frames, and expected outcomes from the execution of such action.

5. Evaluating the Achievements of the Strategic Action

The formal evaluation by teams of each cycle of strategic action shows promising signs of them developing into cohesive units whose workplace behaviour is focused upon organisational results and learning. For example, the evaluation of the first cycle

of strategic action undertaken by District Team A, shows clearly the crucial role of focus and collaboration in achieving the team's set objective:

Short-Term Objective:

To ensure availability of drugs for the treatment of sexually transmitted diseases (STDs) in all four clinics within the Butterworth sub-district by 13 November 1998.

Evaluation

- A co-ordinator has been appointed to liaise between the clinics and the hospital-based pharmacy to ensure that all STD drugs are ordered in time by the clinics.
- The pharmacist has been convinced on the importance of supplying the four STD drugs to all clinics.
- The transport officer is now co-operative and involved in the delivery of STD drugs to the clinics on a monthly basis.
- The prescription of correct STD protocols at the clinics has been monitored through attendance registers.
- The team has adhered to its core values and hence the attainment of the project objective.

6. Key Learning Gained by the District Teams

The documentation of the learning gained from the projects is a product of collective discussion and debate among the team members. Through these interactive social processes, knowledge bases that may have been embedded in 'deep' cognitive and/or

social structures become accessible to conscious formulation and, thus, explicit endorsement or transformation.

Various important learning areas are identified by the teams, but the focus here will be on that learning that seems to have contributed to, or been directly related to, the development of procedural and strategic knowledge:

The Development of the Capacity to Think Strategically

All teams' prior limited experience in implementing strategic action resulted in the setting of unrealistic initial objectives; poor insight into strategic options; little cognisance being taken of contextual analyses; and poor management of project time-frames. The setting of a 'bite-size' objective was particularly important. In terms of strategy, it forced teams to utilise their contextual analyses in the formulation of achievable goals. This aspect of the strategic process provided a revelation to most team members, as District Team E explained in their first project report:

The power of short-term objectives was an eye-opener as this brought about real action to implement strategies instead of these (objectives and strategies) never coming to fruition.

The experience of success generated greater enthusiasm, commitment, and confidence amongst team members. As District Team B put it:

Achieving the set objective improves self-esteem and gives job satisfaction.

The Development of a Sense of Social Agency

The development of an internal locus of control is a prerequisite for the capacity to think strategically: until a group (or a person) takes responsibility for its situation, and recognises its agency-in-the-world, strategic action is impossible. The ability to take direct responsibility for one's actions is a necessary preliminary to engaging constructively with other groups, as District Team C explain:

The members see problems now as challenges and are no longer afraid of problems and conflicts ... (they have learnt that) there are no quick fix solutions, but with a strong belief in oneself and with perseverance and the full support of the team, goals and objectives can be reached.

New levels of confidence to deal with more complex, conflict-ridden problems appear to be a direct result of the enthusiasm and commitment that successive cycles of effective strategic action have built in the teams.

The Recognition that all Workplace Problems are Shared Problems and Require Positive Collaboration from all Stakeholders for their Resolution

The ability to enact strategy with respect to the resolution of shared problems, in an unequal and competitive social setting, requires the effective mediation of power across vertical and lateral associations in order to achieve voluntary cooperation between parties holding unequal power resources. This appears to be the core learning of district health management teams with respect to the need to leverage social capital in the resolution of shared problems. Initially, a culture of competitive individualism was a feature of many of the district health workplaces, resulting in a lack of cooperation, collaboration and encouragement. Generally, teams discovered that

working collaboratively, although difficult at first, eased the workload and the pressure on individuals and generated higher levels of job satisfaction. This experience impacted their values, especially those influencing their perception of other team members, and transformed interpersonal competitiveness and mistrust into acts of mutual recognition and support. This proved to be a major source of motivation, as articulated by District Team D:

We also felt a change in attitude in that there is nothing impossible in the world when people put their minds together to solve difficult problems.

The success of the key strategies of District Team A (referred to above) was largely a factor of their ability to manage power effectively: first with the pharmacist (who initially refused to supply the clinics with the necessary drugs), and then with the hospital transport officer (who garnered available vehicles for hospital use rather than for the delivery of drugs to clinics). Furthermore, their appointment of a coordinator to liaise between the clinics and the pharmacy indicates their awareness of the need to maintain and develop the social capital required to sustain efficient levels of service.

District health management teams learned that existing mental models of leadership were inadequate (and usually destructive). Leadership, as a form of coaching, became a valued alternative model as JLDI staff guided teams through processes of collective reflection and debate in relation to the team's work practices and strategic action. Importantly, the coaching process transformed mental models of criticism as an instrument of attack to that of critique as an important source of shared learning.

The Development of Transformational Leadership Capacity

Two factors, in particular, are singled out in the two independent DHMC evaluation reports commissioned thus far, as being critical to the success of the transformational leadership module. The Kelly & Senekal Report, commissioned by MSH and conducted by the Community Development Unit of the Faculty of Health Sciences at the University of Port Elizabeth, identifies the committed coaching role played by the JLDI staff and the work-based learning methodology as the primary reasons for this module being the most successful of all the modules of the DHMC (see Kelly & Senekal, 2001).

The Onyx Report, commissioned by Rhodes University after the first run of the module, singles out the coaching role of the JLDI academic coordinator as a key factor in the development of the capacity of the district health management teams to manage successfully the ‘politics of implementation’ of district health management team strategies:

(The academic coordinator) modelled the team culture ... (and) ...his enactment of transformational leadership provided a clear example for the participants to follow. ... He demanded commitment to the process, requiring honesty and integrity of the participants as well as himself. As one participant put it ‘when someone is so committed, you try to meet them halfway’. (Onyx, 1999: 8)

Through committed coaching and an innovative work-based learning methodology, the module has built leadership capacity at, and between, several levels of the each district health management team’s operations.

A detailed example, from District Team B, illustrates the importance of coaching in the building of capacity for the achievement of strategic objectives in challenging operational contexts. In their work-based project in 1999, District Team B attempted to address the dangers to which health workers at a district hospital were unwittingly exposed. The team's survey of the hospital, regarding this issue, provided evidence of gross negligence in the management of the sluice room (lock on door broken; dogs feeding on uncleared human remains); the incinerator (dysfunctional - half-burned needles and other materials dumped in back yard of the hospital, amongst which small children played); the infectious diseases ward (no control over staff and public movements in and out of the ward); basic hygiene (staff moved from working in the sluice room and infectious diseases ward to serving food in the kitchen without washing themselves or changing their clothing); and basic protective materials (no surgical gloves; hard gloves for working in the incinerator room; protective gowns and masks; and ear muffs for those working in the engine room).

Initial attempts by the district health management team to gain the support of the superintendent of the hospital failed. After consultation with the academic coordinator, the project coordinator called a meeting at the district office with the hospital's senior management, to which the academic coordinator was invited. At the meeting the project coordinator confronted the hospital superintendent with the evidence of gross negligence regarding worker (and community) safety at the hospital and questioned his inaction on these matters. The superintendent, clearly embarrassed about the evidence being disclosed in the presence of the academic coordinator, almost broke down in tears when attempting to defend his inaction. When asked to speak, the academic coordinator modelled a process oriented around fixing the

problem rather than blaming and punishing individuals and appealed to the district health management team and the senior management of the hospital to work collaboratively in solving the problem and, thereby, in laying a foundation for future cooperation on issues of mutual concern. One week later, the project coordinator phoned the academic coordinator to say that the hospital superintendent had addressed, effectively, all the issues that only required better management practices for their resolution - the sluice room door had been repaired; a pit had been dug for the incinerator refuse; and control had been established over infectious ward entry and exit. Furthermore, he had begun the processes required to address the other issues (ordering of gowns, gloves, ear muffs, etc.) and was discussing the problems surrounding the absence of decent washing facilities for staff, with the regional director.

One month later, the project coordinator demonstrated that she had grasped the concepts of power mediation and social capital generation when she informed the academic coordinator that she had invited the superintendent of the hospital to the district health management team's presentation of their project, and that he had accepted the invitation with the knowledge that his behaviour would be recounted as part of the presentation in front of an audience that included the Minister for Health and other high ranking officials in the ECDOH. On the occasion of the presentation, the team reported on their project and demonstrated how, in achieving their objectives, collaborative bonds had been built between themselves (representing the PHC approach and having lower status in the old departmental power hierarchy) and the hospital superintendent (representing the old curative/custodial approach and having significant status as a medical doctor in the system). After the presentation,

during the time allocated for questions, the project coordinator called the superintendent (sitting in the audience during the presentation) to the front of the hall to assist the team in fielding questions. One member of the audience (an ECDOH official) verbally attacked the superintendent in derogatory terms. The JLDI academic coordinator intervened, and outlined to the audience the principles upon which the work-based projects were based and the underlying strategy of building social capital (exemplified by trust, voluntary cooperation, and norms of reciprocity) through them. The audience applause for this intervention indicated, in theory at least, the endorsement of these principles by those with the most formal power in the department. Thereafter, the hospital superintendent made a kind of 'confession' about having learnt, through this work-based project, a new way of addressing the health problems the district faced and, again, the applause from the audience indicated general approval and support.

Thus, through an act of generosity oriented towards a win-win outcome, the project coordinator's gesture of inviting the superintendent to the presentation ceremony at which an honest disclosure of events would be made, and the superintendent's courage in accepting the invitation and viewing it as a breakthrough in collaborative learning (rather than a form of public humiliation), demonstrated the capacity of the work-based projects to build important strategic resources, particularly those required for collaboration, within the district health management teams of the ECDOH.

Conclusion

The process that has been commenced can be thought of as a series of 'waves' of strategic action: each module involves the entire district health management team in a

new project (which constitutes one 'wave' of strategic action) and each project builds upon the learning gained from previous projects. Thus far, in the space of four years, the teams have completed four projects for the transformational leadership module. In all of the project presentation sessions they have shown evidence of the development, within their districts, of a 'culture' of workplace learning and sustained collaborative strategic action.

As a consequence of these processes of building 'distributed leadership' capacity in the district health management teams and of introducing a team culture through well-managed work-based projects, service delivery problems 'on the ground' are being addressed and team members are acquiring new and more complex knowledge bases. The work-based learning methodology has allowed for the achievement of objectives ranging from the treatment of scabies and the preparation of safe drinking water, to the supply of drugs for the treatment of sexually transmitted diseases to isolated clinics. At the same time it has promoted the development of strategic thinking skills and inclusive power management practices within district health management teams. These will be needed for, as the district teams slowly build strategic leadership capacity, the capacity of the senior management of the ECDOH to solve the complex problems of the department remains in question. Thus far, attempts to involve them in similar work-based learning initiatives have failed. Failure to transform the leadership capacity of the Head Office of the ECDOH will put the capacity building gains in the districts at risk

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