HEALTH MANAGERS' EXPERIENCES AND PERCEPTIONS OF INTERSECTORAL COLLABORATION AT THE PRIMARY HEALTH CARE LEVEL IN TWO URBAN SUB-DISTRICTS OF THE WESTERN CAPE PROVINCE, SOUTH AFRICA.

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- Intersectoral collaboration
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- Intersectoral action
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ABSTRACT

Background: Actions on addressing the social determinants of health are necessary for reducing health inequities and improving health outcomes. These actions can, however, fall outside the scope of the health sector alone and require collaborative actions across sectors. Through the Western Cape Government's stated commitment to following a whole-of-society approach to increase the wellness of people, this Province has committed to exploring intersectoral collaboration and action for health. This study is therefore aimed at exploring the experiences and perceptions of intersectoral collaboration and action for health amongst mid-level and frontline health managers working at the primary health care level in two sub-districts within the City of Cape Town, Western Cape Province.

Methodology: The study design was qualitative and explorative in nature, using non-probability sampling to deliberately select study participants that were both relevant to the study and represented a diversity of views. Semi-structured interviews were conducted with seven health managers and non-participant observation of one intersectoral meeting was utilised to observe interactions that were relevant to the study. A thematic coding analysis approach was followed to inductively determine themes and analyse the data.

Results: Intersectoral collaboration for health at the primary health care level tends to take the form of collaborations between government departments, between the department of health and non-governmental organisations, between the public and private health sectors and between the Department of Health and the communities it serves. These collaborations overwhelmingly focus on expanding health services provision rather than addressing the social determinants of health.

Conclusion: The concept of intersectoral collaboration and partnerships at the primary health care level in two sub-districts of the City of Cape Town, Western Cape, is perceived by health managers as being critical in addressing the social determinants of health. In practice, however, intersectoral collaboration and partnerships tend to focus on expanding health service provision and have limited value for addressing social determinants of health.

DECLARATION

I declare that this thesis titled "Health managers' experiences and perceptions of intersectoral collaboration at the primary health care level in two urban sub-districts of the Western Cape Province, South Africa" is my own work, that has not been submitted before for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged as complete references.

Signed: NY Van der Walt

November 2020

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I wish to acknowledge my family and partner for their continuous support throughout this journey.

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
COPC	Community-Oriented Primary Care
GP	General Practitioner
HIV	Human Immuno-deficiency Virus
ISA	Intersectoral Action
ISC	Intersectoral Collaboration
NGO	Non-Governmental Organisation
NPO	Non-Profit Organisation
SAPS	South African Police Services
SASSA	South African Social Security Agency
SDG	Sustainable Development Goal
TB	Tuberculosis
WHO	World Health Organisation
WoSA	Whole of Society Approach

Definitions of Key Terms

Intersectoral action (ISA) is defined by the World Health Organisation as "a recognised relationship between part or parts of the health sector with part or parts of another sector which has been formed to take action on an issue to achieve health outcomes (or intermediate health outcomes) in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone" (WHO, 1997:3).

Intersectoral collaboration (ISC) is defined in health literature as the collective and coordinated actions of more than one specialised agency or sector, performing different roles for a common purpose (Adeleye & Ofili, 2009).

For the purpose of this research study, the terms intersectoral action and intersectoral collaboration were used interchangeably.

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CHAPTER 1: INTRODUCTION

1.1 Introduction

Health has a central place in the Sustainable Development Goals (SDGs), which are a set of seventeen goals that United Nations member states have agreed to try to achieve by the year 2030 (WHO, 2020a). Whilst health is central to the third SDG, almost all the other goals are either directly related to health or will contribute to health indirectly (WHO, 2020a). The complex challenges that the SDGs aim to address call for an intersectoral and multi-sectoral approach as these challenges cannot be addressed by a single sector acting on its own.

Health is not only influenced by the existence or absence of disease but also by social determinants that must be addressed as part of a public health strategy. The World Health Organization (WHO) defines the social determinants of health as the conditions in which people are born, grow, live, work and age (WHO, 2019). This means that factors such as people's income, level of education, environment and access to opportunities and services impacts on their ability to lead healthy lives. If one looks at education for example, there is a correlation between low education levels and poor health, higher stress levels and lower self-confidence (WHO, 2020b).

Addressing these social determinants can however fall beyond the scope of the health sector alone and the Alma Ata Declaration on Primary Health Care acknowledges that an effective primary health care approach includes the involvement of all related sectors, not only the health sector (WHO, 1978). The Declaration also called for policies, strategies and plans of action for sustainable primary health care to be formulated in coordination with other sectors (WHO, 1978). However, in the years that followed the Alma Ata Declaration, intersectoral collaboration and action for health was not really put into practice (WHO, 2008). Some of the factors impeding the effective implementation of intersectoral actions include resource constraints, lack of political will, low capacity and weak governance (Watkins, et al., 2017).

Intersectoral action is defined by the World Health Organisation as "a recognised relationship between part or parts of the health sector with part or parts of another sector

which has been formed to take action on an issue to achieve health outcomes (or intermediate health outcomes) in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone" (WHO, 1997:3). Intersectoral action or intersectoral collaboration could therefore take different forms and consist of different types of collaborations. Intersectoral action can have a range of foci that may span addressing the broader social determinants of health or a narrower focus on improving specific health outcomes, depending on the specific priorities that are being pursued (WHO, 2016). The effectiveness of intersectoral action or intersectoral collaborations may be dependent on the context in which it is applied and the enabling factors that support it or the barriers that may impede it (Anaf et al., 2014).

The National Department of Health in South Africa acknowledges the importance of intersectoral collaboration in its most recent 5-year strategic plan. This plan explicitly states that health outcomes can only be improved if strengthened health systems are further fortified by effective intersectoral collaboration (National Department of Health, 2015). The plan does not, however, describe how this collaboration should be practiced or implemented and does not provide a conceptual framework for intersectoral action for health in the South African context.

At the Provincial level, the Government of the Western Cape Province is committed to increasing the wellness of the people of the Province, through what it terms a "whole of society approach" (Western Cape Government Health, 2014:38). In the South African context, the Western Cape Province is unique in this regard as this approach has not been adopted by any other province in the country. The "whole of society approach" includes wider engagement with other government departments and building strategic partnerships with stakeholders outside of government (Western Cape Government Health, 2014). Through this stated commitment, the Western Cape Department of Health has therefore committed itself to exploring intersectoral collaboration and action for health. Commitment to the principle of intersectoral collaboration, however, does not automatically translate into practice at the level of implementation. In order for intersectoral action and collaboration to be effectively practiced, a supportive

environment, adequate resources, political will and support and good governance is required.

1.2 Problem Statement

In order to address the complex social determinants of health, the health sector must collaborate with other sectors. Despite the general agreement that intersectoral collaborations and actions can improve health outcomes and reduce health inequalities, few studies are available that document these initiatives where they are practiced (Potvin, 2012).

The day-to-day practice of intersectoral collaboration remains largely unexamined and shows indications that many intersectoral collaborations are being practiced in the absence of supportive policies to formalise and sustain them (Chircop, Basset & Taylor, 2015). There is some indication that effective intersectoral collaboration remains a challenge for primary health care at the district level in South Africa (Dookie & Singh, 2012). The district level is a critical player in the health system as primary health care services are delivered at this level and it is often the first point of contact by the public with the health system. It is therefore assumed that intersectoral collaboration remains a challenge at a local level within the South African health system and that there is little evidence to demonstrate the outcomes of intersectoral collaboration at this level.

1.3 Purpose of the Study

This study explored the experiences and perceptions of intersectoral collaboration and action for health amongst mid-level and frontline health managers working at the primary health care level in two sub-districts within the City of Cape Town, Western Cape Province. These managers are directly involved in the daily decision-making that impacts programme implementation. Programme managers are responsible for contracting non-government organisations to expand health service delivery and are also responsible for building relationships with donor-funded partners, liaison with government departments and exploring opportunities for partnerships in the private sector. Health facility managers are primarily responsible for ensuring the smooth operation of primary health care facilities and for ensuring that the immediate health

needs of the communities they serve are met. This role exposes them to building partnerships with community structures, civic organisations, government departments and private entities within the facility catchment area.

Findings from this study can be used to inform decision-making on strengthening intersectoral collaborations for health at the primary health care level in urban areas of the Western Cape and other parts of South Africa.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This literature review covers conceptualisations of intersectoral action for health, the policy environment, the focus of intersectoral collaborations, coordinating mechanisms and governance and enablers and barriers to effective intersectoral collaborations.

2.2 Conceptualisations of intersectoral action for health

The first systematic attempt at emphasising the importance of intersectoral action to improve health outcomes was contained in the Declaration of Alma-Ata in 1978, which called not only for the provision of health services but also for the need to address the underlying causes of poor health (Kickbush and Gleicher, 2012). This recognition of the need to address underlying causes of poor health also acknowledged that many of these fell outside the scope of the health sector. Whilst initial interpretations of intersectoral action for health placed the health sector as the lead sector for coordinating these kinds of collaborations, the term was later broadened to include actions initiated by sectors outside of the health sector and actions that contributed towards reducing health inequities (Kickbush and Gleicher, 2012).

The need for intersectoral action and collaboration was once again underscored in the mid-to-late 1980's when the Ottawa Charter for Health Promotion introduced the concept of Healthy Public Policy as one of its action areas (Kickbush and Gleicher, 2012). Healthy Public Policy is about ensuring that health is a priority for policy-makers in all sectors and requires that policy-makers are aware of the health consequences of their decisions (WHO, 1986). Health promotion encouraged innovative approaches that re-established the importance of local action and links between different sectors and in different settings (Kickbush and Gleicher, 2012). Within this approach to intersectoral action and collaboration, the health sector plays the role of advocate and mediator and recognises the complexities contained in ensuring successful collaborations (Kickbush and Gleicher, 2012). Healthy Public Policy, which calls for all sectors and government departments to consider the possible health implications and impact of the work that they carry out, helps to position health as being the responsibility of all sectors and not only the health sector and also allows for other sectors to be held accountable.

The concept of intersectoral action or intersectoral collaboration for health has evolved over time and can take various forms, depending on the need and context. Intersectoral actions for health equity that have been implemented includes the actions that involve the participation of government sectors, community, civil society groups, the private sector and academic institutions (Shankardass et al., 2010) and the nature and strength of collaborative relationships can vary by area and partner type. The practice of intersectoral collaboration is therefore not restricted to particular settings, to particular types of partnerships or addressing particular health outcomes.

Rasanathan, et al. (2017) identified four broad types of intersectoral action for health where i) the health sector is either a minimal actor in contexts where other sectors undertake their core business which has effects for health, ii) the health sector is a supporting actor for cross-sectoral policies to address structural and social factors, iii) the health sector is a bilateral or trilateral partner in two or more sectors for mutually beneficial outcomes and iv)the health sector leads in contexts where collaboration with other sectors is essential for the health sector to deliver its core mandate. Across these different types of intersectoral action for health, the actors involved, the competencies and experiences vary greatly (Rasanathan, et al., 2017). This illustrates the diversity of ways in which intersectoral collaboration for health is practiced and how intersectoral action can be adapted to specific contexts and needs.

A study conducted in sixteen municipalities in the Netherlands that looked at collaboration between the public health policy sector and other policy sectors within the municipality found that health sector policy workers collaborate more explicitly with social policy sectors than other sectors (Storm et al., 2016). The study found that sectors relating to the environment, transport, housing and spatial planning were least likely to be involved in the public health policy network despite evidence that shows the involvement of these sectors are vital to reducing health inequalities (Storm et al., 2016).

In a study undertaken to determine how intersectoral collaboration functions in everyday circumstances in Cuba, it was found that no single model of intersectoral action is

applied to health actions or programmes in the country but rather that different sectors interact in flexible ways as they work towards a common goal (Spiegel et al., 2012).

2.3 Policy Environment

At the Eighth Global Conference on Health held in Helsinki in 2013 a "Health in all Policies" approach was adopted, which called for an approach to policy-making across sectors that takes into account the health implications of decisions, seeks synergies and avoids harmful impacts in order to improve health and health equity (WHO, 2020c). Resolution 67.12 of the World Health Assembly requested the Director-General of the World Health Organisation to prepare a Framework for Country Action aimed at supporting countries to improve health and ensure health equity through action across sectors on determinants of health (World Health Assembly, 2015). Subsequently, this framework was duly developed and adopted by member states.

Health in All Policies is a network approach to policy-making throughout all spheres of government that draws on the strengths and lessons learned from the approaches of comprehensive primary health care and health promotion (Gleischer and Fisher, 2012). This is a whole-of-government approach with a focus on health that urges government departments to work in an integrated manner in response to particular issues (Gleischer and Fisher, 2012). When government departments work together in an integrated manner, this can facilitate better collaborations with non-governmental actors.

In South Africa, The National Health Act of 2003, explicitly states that the functions of national and provincial health departments includes participation in intersectoral and interdepartmental collaboration (South African Government, 2003). This Act provides the framework for a uniform health system in the country and health departments have an obligation to perform the required functions contained therein. In addition, addressing the social determinants of health is entrenched in South Africa's National Development Plan (National Planning Commission, 2011).

At a provincial level the Western Cape Government has adopted a whole of society approach which calls for collaboration across the spheres of government, the private

sector, civil society and individual citizens to reach the strategic goals of the province (Western Cape Government Department of the Premier; 2014). Inherent in this approach is the understanding that government needs to collaborate with all sectors of society to make a positive contribution to the development of the province.

The provincial Department of Health has committed to following an approach that includes wider engagement with other government departments and stakeholders outside of government (Western Cape Government Health, 2014). Implied in this commitment is the expression to work across sectors and to form intersectoral collaborations with the aim of improving health outcomes. To this end, the Western Cape Department of Health has begun to pilot Community Oriented Primary Care, which is an approach that aims to pool resources from different sectors and community assets within a demarcated geographic area to respond to the health needs and address the social determinants of health within the affected area.

2.4 The focus of intersectoral collaborations

There is some evidence to suggest that intersectoral initiatives are feasible in a variety of social, economic and political systems and have largely been used to address downstream and midstream determinants of health (Shankardass et al., 2010; National Collaborating Centre for Determinants of Health, 2012). Upstream and midstream interventions have focussed on employment, working conditions, early childhood development and improving the physical environment, whilst downstream interventions have focused on increasing access to health services (National Collaborating Centre for Determinants of Health, 2012). In low- and middle-income countries the focus of the health sector is overwhelmingly on health care services (Rasanathan, et al., 2017).

Intersectoral collaborations can also focus on improving health outcomes related to a particular health programme. The major health programmes that the practice of intersectoral collaboration for health equity tend to focus on, are nutrition and mental health, whilst research from South Africa showed a repeated focus on primary health care solutions, HIV/AIDS and sexual health (Chircop, Basset & Taylor, 2015). It has been found that collaborations between the public and private healthcare sectors have

been mainly to expand health service provision and to improve the quality and cost-effectiveness of health programmes, particularly tuberculosis (TB) and sexually transmitted diseases (Kula & Fryatt, 2014).

The implementation of the First 1000 Days Initiative in the Western Cape is an example of intersectoral action for health that focusses on maternal and child health but requires collaboration with the education sector and social development sector. The goals of this initiative are to improve outcomes for children related to nutrition, health, education, parenting, protection and safety (Okeyo, Lehmann & Schneider, 2020). This initiative, led by the health sector, therefore follows a comprehensive preventative approach that strives to look at the long-term development of the child.

A study that aimed to assess South Africa's progress in intersectoral collaboration for mental health found that whilst formal intersectoral collaborations exist between different government departments at the national and provincial levels, these formal collaborations were largely absent at the district level (Skeener et al., 2010). This study also found that despite the awareness of the cross-cutting nature of mental health issues and the need for collaboration across sectors, such collaboration remained limited.

2.5 Coordinating Mechanisms and Governance

Structures such as different types of intersectoral committees, councils, units, networks or programmes are a common mechanism for coordinating intersectoral collaborations (Rantala, Bortz & Armada, 2014). These structures can provide a platform for joint decision-making, planning and implementation of programmes and activities. Having formal and transparent accountability structures for the coordination of intersectoral collaboration at primary health care level has been found to be a sustaining factor for intersectoral collaborations (Anaf et al., 2014). These structures are usually multi-sectoral in nature and can also serve as the formal forum for communication (National Collaborating Centre for Determinants of Health, 2012).

Central to Cuba's successful intersectoral initiatives is the existence of a formal structure to coordinate intersectoral action for health, the Health Council (Spiegel, et al, 2012).

This Health Council is headed by a political leader, which underscores the value placed on health by the country's political leadership (Spiegel et al., 2012). Cuba's Health Council, as the central coordinating body for intersectoral action at the municipal level, also highlights the importance of political will and leadership in ensuring that intersectoral collaborations are pursued and become sustainable.

Uganda adopted a multisector response to HIV in 1986, which saw the creation of a National Committee for the Prevention of AIDS established in the office of the President and chaired by the President himself (Emerson, 2018). This committee proved to be hugely successful in addressing the AIDS pandemic in the country but when efforts were made to institutionalise the structure, it failed to have the same effect as a committee chaired by the leader of the country and was disestablished in 1997 (Emerson, 2018). This illustrates the effect that high-level leadership can have in sustaining intersectoral collaborations.

Similarly, British Columbia in Canada implemented a structure headed by a special Minister presiding over a council of Assistant Deputy Ministers representing all departmental sectors to address key risk factors related to the burden of disease with the aim of making British Columbia the healthiest jurisdiction in North America (Matzopoulos, Myers, Butchart, Corrigal, Peden & Naledi, 2008). This structure illustrates strong political leadership in the coordination and management of intersectoral action.

Inter-ministerial committees and formal steering committees were identified as the most effective way to ensure action across sectors in South Africa's experience of implementing the First 1000 Days Initiative (Okeyo, Lehmann & Schneider, 2020).

The need for a more formally coordinated process to facilitate better use of policies and activities to reduce health inequalities and strengthen intersectoral collaborations for health was identified in sixteen municipalities in the Netherlands (Storm et al., 2016). In Denmark, many municipalities have established interdepartmental committees or founded units with intersectoral mandates to coordinate policy-making processes with

the aim of ensuring healthy public policy (Holt, Frohlich, Tjornhoj-Thomsen & Clavier, 2016). It is therefore apparent that whilst municipalities may be well-placed to work across sectors to address the social determinants of health, this work must be aided by effective coordination mechanisms.

In a study conducted amongst mid-level health, agriculture and social protection officials in Ethiopia, mid-level managers reported that whilst coordinating committees were formed at all levels to improve multi-sectoral collaboration, officials did not consider these to be effective or authoritative (Warren & Frongillo, 2017). Mid-level managers in this setting instead indicated that intersectoral collaboration should be mandated from a higher level and be included in the job descriptions of managers (Warren & Frongillo, 2017). It is therefore important that consideration be given to the context and setting when determining the most effective means of coordinating intersectoral collaboration.

2.6 Enablers and Barriers

Elements of effective intersectoral collaboration have been identified to include planned action and sustained outcomes as part of the conditions required for succeeding and coordination, governance and accountability mechanisms as being key tools to supporting intersectoral action (Dubois, St.Pierre & Veras, 2015).

The practical implementation of intersectoral collaboration remains largely unexamined (Chircop, Basset & Taylor, 2015) and therefore it is important to explore enablers and barriers to effective intersectoral collaboration at the primary health care level. One potential constraining factor or barrier could be the lack of a supportive policy environment (Chircop, Basset & Taylor, 2015).

Barriers to effective intersectoral action for health are not only technical but also political. The manner in which challenges are framed and the degree to which it is aligned with high-level political agendas are critical to obtaining buy-in from different sectors (Rasanathan, et al., 2017). The importance of improving health outcomes should therefore be framed in its broader context of development and equity.

The importance of the relationship among partners has been identified as a crucial enabler or potential barrier to ensuring the success of intersectoral collaborations at primary health care level (Anaf et al., 2014; Danaher, 2011). Successful working relationships among partners include having a clearly articulated and shared vision, trust between partners, strong interpersonal relationships, all partners feeling that their needs are being met and effective leadership (Anaf et al., 2014; Danaher, 2011). Because intersectoral collaborations essentially bring together a range of stakeholders, each with an equally important role to play, the importance of partnership relations cannot be underestimated.

Formal communication processes as well as clear roles and responsibilities of partners involved in intersectoral collaborations has been described as beneficial for supporting the implementation of intersectoral collaborations (Danaher, 2011; National Collaborating Centre for Determinants of Health, 2012).

It has been found that the facilitating and sustaining factors affecting intersectoral collaborations include having sufficient human and financial resources, accessing diverse skills, getting some reward for participation, receiving management support and having formal and transparent accountability structures (Anaf et al., 2014). Other potentially facilitating or constraining factors include national or international influences on local policy-making, political context and political will, relations with other governance levels, information sharing, monitoring and evaluation (Rantala et al., 2014).

The literature does not reveal much about the implementation of intersectoral action at primary health care level or about how health managers at the implementation level, i.e. primary health care level, perceive intersectoral collaborations. The practice of intersectoral collaboration for health as experienced and perceived by health managers therefore requires further exploration.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Aim and Objectives

The aim of the study was to explore how mid-level and frontline health managers working at the primary health care level (inclusive of health care services provided outside of health facilities) experience and perceive intersectoral collaboration.

The study objectives were:

- To describe the actors involved in intersectoral collaborations practiced at the primary health care level
- To describe the coordination mechanisms that have been employed to manage intersectoral collaborations that are practiced at the primary health care level
- To explore the themes and/or programmes that intersectoral collaborations for health focusses on at the primary health care level
- To explore the barriers, enablers and potential for intersectoral collaboration at the primary health care level from the perspective of mid-level and front-line health managers

3.2 Study Design

The design of this study was qualitative and explorative in nature. Exploratory research is designed to shed light on how a phenomenon is manifested and is useful for providing new information on topics that remain relatively unexamined (Hunter, McCallum & Howes, 2019). For the purposes of this study intersectoral action for health was defined as a recognised relationship, whether formally or informally established, between part or parts of the provincial health department with part or parts of another sector. Other sectors may include other government departments, non-governmental organisations, private and commercial entities, civil society organisations and community representatives. An intersectoral meeting must include a meeting between the department of health and one or more sectors, related to taking action to improve health outcomes.

This approach enabled the researcher to generate an in-depth understanding of a complex issue in its real-life context.

3.3 Description of Study Setting

Geographically, the study setting included two sub-districts in the City of Cape Town, Western Cape Province. These are two urban sub-districts with high population density. Within these two sub-districts, there are three health facilities offering a 24-hour service at the primary health care level. Health managers from all these three facilities participated in the study. All these three 24-hour health facilities serve communities of lower socio-economic status, with relatively high rates of crime and poverty.

3.4 Population and Sampling

The study population was mid-level and frontline health managers working at the primary health care level (inclusive of health care services provided outside of health facilities) within two sub-districts within the City of Cape Town District of the Western Cape Province. These included health managers that have responsibility for planning, coordinating and/or implementing intersectoral collaboration at primary health care level.

A purposive sampling method was used to select all study participants to ensure that participants were relevant to the study but also representative of a diversity of views. The following inclusion criteria was used:

- Participants with at least three years' experience in the planning, coordination and/or implementation of intersectoral collaborations at primary health care level in the Western Cape Province;
- Participants who function at the managerial level within the sub-district, regardless of the duration.

A total of nine managers were identified to participate in the study. Of the nine managers, a total of seven managers agreed to participate in semi-structured interviews. One manager declined to be interviewed and one post was vacant at the time the research was being conducted. Of the seven health managers interviewed, five were female and

two were male. All the health managers interviewed were qualified professional nurses or clinical nurse practitioners with post-graduate qualifications in either public health or public administration.

One intersectoral meeting was observed. This meeting was recommended for observation by one of the health managers in the sub-district as the meeting participants would include representation from both sub-districts that form part of the study setting. This is a regularly scheduled meeting that usually takes place on a quarterly basis. This was confirmed by another health manager. Approximately twenty-five people participated in the meeting. Participants consisted of health managers, representatives from NGOs and community members. Although representatives from other government departments and the private sector were invited, they did not attend the meeting.

3.5 Data Collection

Data collection for this study was done through semi-structured interviews and one non-participant observation of an intersectoral meeting. All interviews were conducted in person by the researcher in English and written informed consent was obtained from all participants. Meetings were scheduled in advance at a time and location preferred by the interviewee. All interviewees indicated a preference to be interviewed at their respective places of work. In instances where the interviewee did not have his/her own office in which the interview could be a conducted, a small meeting room was utilised to conduct the interview. All interviews were audio-recorded and interview notes were captured by the researcher using the interview guide. Interviews were scheduled for one-hour and the length of the interviews ranged from 40 minutes to one hour. All interviews were conducted over a period of six months. All audio recordings of interviews were transcribed by the researcher.

Detailed notes were taken by the researcher at the observation of an intersectoral meeting, where the researcher was a participant in the meeting proceedings. The researcher documented the meeting process and participation by attendees. The meeting content was not documented. All attendees were informed of the researcher's presence

in the meeting and verbal consent was received to carry out the non-participant observation.

3.6 Data Analysis

Thematic Coding Analysis approach was followed to analyse the data. This approach allowed for themes to be determined inductively from the data (Robson & McCartan, 2016) and these themes then formed the basis for further analysis and interpretation.

3.6.1 Thematic Coding

All interviews were transcribed by the researcher. This provided the initial opportunity for the researcher to familiarise herself with the data. On completion of the transcriptions, the researcher re-read all the transcriptions and observation notes to further familiarise herself and develop a deeper understanding of the data.

The researcher manually coded all the transcripts of the semi-structured interviews. In order to do this, hard copies of all the transcripts were printed and the page margins were used to jot down codes. A code memo containing all code definitions was developed in order to ensure that the code was applied in a consistent manner.

Broad themes were identified from the complete list of codes by grouping similar codes. These groups were then categorised and the following thematic networks were identified:

- Types of intersectoral collaborations
- Focus of intersectoral collaborations
- Policy Environment
- Leadership, Governance and Coordination of intersectoral collaborations
- Sustainability

3.6.2 Reporting of Findings

Themes that matched the research aim and objectives were selected by the researcher for the final report. The researcher then reflected on each selected theme to elaborate on the content and meaning.

Quotations were selected to be used as evidence to support the themes. In order to protect the anonymity of participants, each participant was assigned a numerical code. These codes were used to present the identified quotations in the findings section of the report.

3.7 Credibility and Trustworthiness of Findings

Systematic application of the Thematic Coding Analysis approach lends credibility to the study. An audit trail was maintained by the researcher with detailed record-keeping of the research process and can be reviewed by an external auditor to ensure that results are valid and credible.

The researcher was aware that her own experience of intersectoral collaboration as an employee of the Western Cape Department of Health was fraught with difficulties in obtaining buy-in from non-health sectors and a lack of management support to aid the sustainability of intersectoral collaborations. The researcher therefore practiced reflexivity to limit the influence that these experiences may have on the interpretation of the data. Being an employee of the Western Cape Department of Health was also advantageous as the researcher had an existing trust relationship with managers which made the managers more agreeable to participating in the research.

3.8 Ethical Considerations

Ethics clearance for this study was received from the Biomedical Research Ethics Committee of the University of the Western Cape and Western Cape Department of Health's Health Research sub-directorate. The anonymity and confidentiality of participants was protected throughout the research process and in reporting its findings. Participation in the study was voluntary and participants were each provided with a participant information sheet detailing the study aims and objectives, requesting their voluntary participation and informing them that every effort would be made to protect their confidentiality. Written informed consent was obtained from participants who agreed to participate in the study. For the meeting observation, all participants were informed that the meeting was being observed and were verbally informed of the

purpose, aims and objectives of the research study. Verbal consent was received from the participants for the researcher to observe the meeting.

To protect the identity of participants and to ensure that they remain anonymous, the sub-districts that formed part of the study are not identified.

3.9 Limitations

The small sample size of the study population was a limitation to the study. This was mitigated by the richness of data that was obtained via the semi-structured interviews and the researcher's comprehensive knowledge of the context. Whilst the participants were able to provide a detailed account of their perceptions and experiences, it is likely that new information or themes would have been observed if additional participants were interviewed.

CHAPTER 4: RESULTS

This chapter presents the findings of the semi-structured interviews with health managers and the observation of an intersectoral meeting. These findings are reported under the themes that emerged during the process of thematic coding analysis, namely: Types of intersectoral collaborations, the Focus of intersectoral collaborations, Policy environment, Leadership, governance and coordination of intersectoral collaboration and Sustainability.

4.1 Types of intersectoral collaborations

Health managers interviewed identified four main types of intersectoral collaboration and two approaches to intersectoral collaboration. The types of intersectoral collaborations were inter-departmental collaborations, collaborations with non-governmental organisations, collaborations with the private sector and collaborations with communities and health committees. The two approaches identified were Community-Oriented Primary Care (COPC) and a Whole-of-Society Approach (WoSA). These are described in more detail in the sections that follow.

4.1.1 Inter-departmental collaborations

Inter-departmental collaborations are collaborations that take place between different government departments. Health managers' descriptions of inter-departmental collaborations indicated that this type of collaboration takes place mostly between departments that fall within the social cluster, that is, between the Department of Health, the Western Cape Education Department and the Department of Social Development. Collaborations within the Justice cluster include partnerships with the South African Police Services and the Department of Correctional Services. None of the managers interviewed mentioned any partnerships with government departments in the economic cluster or with departments responsible for housing, infrastructure development, town planning or transport.

One reference was made to forced intersectoral collaboration where different government departments are compelled to work together via a court order aimed at improving the quality of life of citizens.

"…sometimes we are also forced to have partnerships as departments. A few years back we had a court order….Right to Education is the NPOs name, so they took the Department, Education and Social Development and, uhm, Health to court, because they felt that we were not looking after children with intellectual disabilities….So we then had to, specifically, we then had to have an integrated policy."

- *Respondent 4*

4.1.2 Collaborations with Non-Governmental Organisations

Collaborations with non-governmental organisations (NGOs) were mostly limited to organisations working within the health sector. The relationship between the Department of Health and NGOs funded by it appeared to be almost paternalistic, with the Department seeing these NGOs as an extension of the Department itself. One interviewee referred to "*our NPOs*", implying that the Department of Health had a level of ownership over these organisations.

Health managers differentiated between formal partnerships, funded partnerships and informal partnerships with non-governmental organisations. Formal partnerships refer to partnerships that are governed by a formally signed Memorandum of Understanding between the Department of Health and an NGO. Funded partnerships refer to partnerships where the Department of Health provides funding to an NGO to provide a specific service and this is governed by a Service Level Agreement. Informal partnerships refer to partnerships with NGOs where there is no formal agreement between the Department of Health and the respective organisation/s.

" …some of these collaborations or partnerships is sometimes formal through, uhm, memorandum of agreement or memorandum of understanding or sometimes we provide funding."

- *Respondent 4*

One health manager mentioned regular engagement with local religious leaders to promote health education. According to the health manager interviewed, this is an ad-

hoc engagement but engagement takes place frequently. This engagement does not take place with religious leaders as a group but rather on a one-on-one basis with individual leaders.

4.1.3 Collaborations with the Private Sector

Private sector collaborations were limited to collaborations with the private health sector for the expanded delivery of health services. Within these collaborations the private sector often provides the infrastructure and human resources, whilst the public sector provides the consumables and medicines. These collaborations are tightly managed through signed agreements by both parties and include monitoring compliance with those agreements.

" We also have, uhm, memorandums of agreements with private providers, like your pharmacies and private GPs, where we provide them with consumables…. they would then manage that part of the dependent population where people can still pay but they're not on medical aid."

- *Respondent 4*

"…there are SLAs in place and there's compliance issues. And there's monitoring and evaluation and those kind of things around it.

- *Respondent 2*

One health manager indicated that regular engagements are held with private General Practitioners (GPs) in the community. Such engagements provide an opportunity to facilitate referrals from private GPs to public health facilities and for the health facility to engage private GPs on emerging health trends within the community.

4.1.4. Collaborations with health committees and communities

Collaborations between the Department of Health and the community it serves were limited to Health Committees and public community engagements.

The Health Committees described by the health managers either had limited functionality or were in the process of being formally established. This was a direct result of a new Act adopted by the Provincial Legislature that required the Department of Health to formally establish health committees according to a set criterion. Political processes, however, hampered the implementation of health committees on the ground.

"The committee members have received their appointment letters but because we are waiting for, uhm, local government to appoint their representatives, the committees cannot function yet"

- *Respondent 2*

"They used to just say I want to be on the health committee, now it's formalised, there is an Act for that ... the health committees are not functional as yet because the councillors are not appointed yet to be part of the committee. So we're waiting for that."

- *Respondent 4*

Health managers, however, indicated that they appreciated the importance of health committees and felt that these committees definitely have a role to play in fostering better relations between health providers and the communities they serve. There was also a general acceptance amongst health managers that health committees are well-placed to provide guidance to health services on how to engage communities.

"It is for them to actually identify the health needs of the communities and then to give us guidance and to say who should play a role. And they are the ones that could help hold those different departments and NPO's accountable."

- *Respondent 2*

This shows an understanding amongst health managers that health committees can help to strengthen intersectoral collaborations and partnerships at the primary health care level.

One health manager reported attending monthly meetings of the Community Police Forum. This is a meaningful platform for engagement for health managers as crime and

violence in communities often result in an increase of trauma cases at health facilities and functioning partnerships between the health facility and the Community Police Forum can benefit both parties.

During a intersectoral meeting between the Department of Health, NGOs, community members and other government departments, which was observed by the researcher, it appeared that the Department of Health determined the meeting agenda and inputs made by the Department of Health dominated the engagement. At this meeting community members complained that when they invite the Department of Health to their engagements and/or meetings, the Department fails to send a representative. The Department of Health did not immediately respond to this complaint during the meeting. All parties in the meeting generally agreed that in order to reduce the burden of disease in communities, the Department of Health needs to form partnerships with other sectors, including water and sanitation, housing, education and economic sectors.

4.1.5 Community Oriented Primary Care (COPC)

One health manager described following the guiding principles of what is termed the Community Oriented Primary Care (COPC) approach. This approach is currently being piloted in select sub-districts of the City of Cape Town in the Western Cape and seeks to address the holistic needs of the community. One of the sub-districts that formed part of the study setting is included in this pilot. As described by the health manager interviewed, COPC essentially involves a team of community health workers supported by a nurse, working in a defined geographic area to promote health and prevent disease. The team leverages off existing community organisations and structures to support its work.

"The COPC process strengthened the community collaboration….With COPC it is not only collaboration with the health facility, it involves collaboration with all organisations, for example, SAPS, SASSA, Social Development, City of Cape Town for housing challenges patients might experience in the community."

- *Respondent 1*

"…especially with the COPC model, you have to work with what you have in the community and based on the community needs, so we cannot do it without the partners in the community. I mean, there is so many structures there already, uhm, that we can just work closer together."

- *Respondent 3*

This approach holds huge potential for strengthening intersectoral collaboration at the primary health care level in the Western Cape as it is supported and promoted by senior management within the Department of Health and explicitly calls for collaboration with non-health sectors. A key characteristic of this approach is that it seeks to address the holistic needs of the community and does not focus exclusively on health-related concerns and challenges.

4.1.6 Whole of Society Approach (WoSA)

Some of the managers interviewed for this study made reference to the Whole of Society Approach. This is an approach to working in an intersectoral manner that is advocated by the Western Cape Government. The application of this approach in the province is, however, in its infancy and none of the managers interviewed were able to provide concrete examples of how the approach is being applied or implemented. Despite this, there is a general optimism amongst the managers interviewed that following this approach in the Western Cape will create new opportunities for intersectoral action for health.

"So I think that's a, that's a good space because in the WoSA framework our senior managers are quite involved in it, you know, and trying to unpack some of it. I'm sure they're trying to open a lot of unfamiliar spaces, uhm, untapped spaces at this point in time."

- *Respondent 2*

4.2 Focus of intersectoral collaborations

Intersectoral collaborations described by the health managers interviewed focussed primarily on specific health programmes or on expanding health service provision. These collaborations, which were mostly with other government departments or non-governmental organisations, therefore focus more on the downstream determinants of health and less on the social determinants of health and ill-health.

Partnerships with NGOs are mainly focussed on expanding health services outside of health facilities to community-based and other settings. These settings include providing health services at old-aged homes, schools and mental health homes. There is also close collaboration with NGOs that are funded by international donors to support specific health programmes, for example, HIV and TB programmes.

"Like PEPFAR, USAID, CDC, Global Fund, NGOs that we don't fund but that we have partnerships with. We engage them regularly, we've got our forums. Because they are mostly for HIV and TB, we include them in relevant platforms…"

- *Respondent 6*

Partnerships and collaborations with the private sector tend to focus mostly on the private health sector, such as partnerships with private pharmacies, general practitioners and private hospitals. Collaborations with the private sector did not extend to collaborative actions with businesses or private entities not active in the health sector.

"So basically we have all these private hospitals coming to the party, private practitioners."

- *Respondent 6*

The intersectoral collaborations described by health managers also tended to focus mainly on specific population groups, e.g. teenagers, children in conflict with the law and persons with disabilities.

4.3 Policy environment

Within the theme of policy environment, two distinct policy matters emerged. The first policy matter is related to policies that make provision for and support intersectoral collaboration. The second matter pertaining to the policy environment that emerged, is that different sectors or different government departments may have conflicting policies or policies that are not aligned.

4.3.1 Supportive Policy Environment

Integrated policies exist that stipulate roles and responsibilities for different government departments in one policy document. These policies explicitly make provision for inter-departmental collaboration as they stipulate what is required from different government departments. These integrated policies tend to be aimed at addressing particular challenges amongst specific population groups, e.g. improving service delivery to persons with disabilities or implementing a school health programme for children in primary schools.

"So, we then had to, specifically we then had to do also an integrated policy. How, what is our responsibility as the Department of Health, what is Education's responsibility, what is Social Development's responsibility. So now there is that type of intervention."

- *Respondent 4*

Health managers also draw on broad policy guidelines and frameworks to help drive and support intersectoral collaborations at the primary health care level. Some managers indicated that where policy documents and/or frameworks exist, they enable intersectoral collaboration.

"These partnerships are supported by service level agreements, the Health Committee Act and the National Health Act, whilst initiatives such as the Community Oriented Primary Care (COPC) is guided by a framework."

- *Respondent 1*

4.3.2 Conflicting Policy Environment

Conflicting policies exist amongst government departments, as each individual department tends to focus on its core mandate. One such example is the Department of Education's policy to restrict access to learners and to limit activities related to health promotion and health education. Health promotion activities and the provision of health services to learners, especially sexual and reproductive health services for high school learners where teenage pregnancy rates are high, are either restricted to taking place after school or is not allowed to take place on school premises.

An example of conflicting policies is the legislation pertaining to alcohol sales versus the Department of Health policies aimed at promoting healthy lifestyles. Current regulations around alcohol sales makes alcohol more accessible in terms of trading hours for liquor sales and the licensing of shebeens in many poorer communities. This adds to the complexity of having to form intersectoral partnerships. Another example of conflicting policy environments is the policy of the Department of Education to restrict access to learners instead of enabling access to sexual and reproductive health services which could reduce the incidence of teenage pregnancies and sexually transmitted infections amongst young women, including HIV.

"Because having to bring different departments together, uhm, each has got their different mandate, uhm, whether the provincial policies and things are not aligned to, the provincial focus is not aligned or even the national focus is not aligned, uhm, for people then on the ground level to speak the same language and pulling in one particular direction, it becomes a little bit complex."

- *Respondent 2*

4.4 Leadership, Governance and Coordination of intersectoral collaborations

At the time of conducting the research, none of the health managers interviewed were aware of any functional coordination structures for intersectoral collaborations. Intersectoral collaborations are mostly driven by the Department of Health, which takes responsibility for calling meetings and setting the agenda.

Political leadership of intersectoral action for health at the local level appears to be largely absent, with none of the health managers indicating active participation in intersectoral activities by local councillors.

"So we've got a quarterly community engagement with the, the community leaders, uh, for health, and the councillors are supposed to be part of that. But then they are not always there. So I don't see them as active as they should be."

- *Respondent 4*

Coordination of intersectoral actions between government departments takes place through meetings where relevant departments are supposed to come together and discuss intersectoral actions. These meetings, however, tend to be fragmented, e.g. separate meetings between the Department of Health and the Department of Education and between the Department of Health and the Department of Social Development. Whilst these meetings are scheduled in advance they are sometimes cancelled or do not take place as frequently as they are meant to take place. Since there is no formal oversight of these collaborations, there are no consequences for cancelled meetings or failure to honour engagements on the part of individual departments.

"So there is this quarterly meetings that we, we have. So some of them sometimes doesn't materialise then it's postponed but it's supposed to be set engagements that we have with them."

- *Respondent 4*

Several managers made mention of multi-sectoral action teams that previously functioned at sub-district level. These teams were responsible for coordinating multi-sectoral activities within the sub-district aimed at improving outcomes for HIV and TB. Whilst these structures performed a much-needed coordination function at the local level they were funded by an external funder for a limited time period only. When the funding ended no alternative mechanism was put in place to ensure that this structure was able to continue its work and the coordination function then ceased leaving a gap that still persists.

4.5 Sustainability

The general perception amongst health managers was that intersectoral partnerships or collaborations are not sustained for lengthy periods of time and are often formed to address specific short-term objectives. Once these short-term objectives are achieved or are no longer relevant, partnerships and collaborations tend to cease.

"I would like to see it more structured. Currently it only happens when the need arises."

- *Respondent 1*

"…often, there is a, a ignition point and when the situation has calmed down everyone filters back and into its normal situation and normal functioning again."

- *Respondent 2*

Efforts at establishing more sustainable structures with long-term vision and aimed at creating regular platforms for different sectors and different government departments to come together and develop joint strategies do not appear to be successful. It is not clear whether this is as a result of the time required to sustain such structures or whether intersectoral structures are not considered a priority within government.

"A few years ago, ja, probably between 2010 and 2012, uhm, there was intersectoral collaboration meetings where all the different departments came together and tried to unpack some of the issues. I must say, it hasn't been very successful and I think it fell flat very soon…"

- *Respondent 2*

Health managers felt that partnerships and collaborations were better sustained when governed by a policy, Memoranda of Understandings or Service Level Agreements between parties.

"And there should be some, at a high level, maybe not a political level, but even in our senior leadership positions across those different sectors, that there is that, uhm, memorandum of understanding or service level agreement in terms of collaboration."

- *Respondent 2*

"Unless there is a policy or circular, even if it's not a policy document, a circular that is an official communication that mandates this…that all the managers at this level must engage like this and this is the proposed frequency of that engagement, this is the proposed terms of reference, I don't think it's going to happen at that level."

- *Respondent 6*

There is a misalignment of geographic boundaries according to which different government departments divide the City of Cape Town into more manageable areas. This makes the establishment, functioning and sustainability of intersectoral partnerships across government departments difficult to maintain. As a result of this misalignment, health managers can find themselves having to work with several other managers in other departments to ensure that their managerial area is adequately covered.

"And I think that's the other difficult part hey, is that the, the different boundaries different, uhm, departments. So if we talk Health, just for instance if we talk to Education, you're probably going to have to engage three or four different circuit managers, uhm, to make sure that our area is covered."

- *Respondent 2*

"…our biggest challenge is probably the boundaries. Our boundaries differ significantly…So when we have an engagement, we often have to engage like three different Education Departments."

- *Respondent 6*

Intersectoral structures established at the primary health care level do not appear to have linkages to similar structures that are functional at the provincial or national level. This means that there is no flow of communication from intersectoral structures or partnerships at the local level to corresponding structures at higher levels within

government. Some health managers felt that such linkages could help to sustain intersectoral collaborations.

"It doesn't have to be on my performance plan but if there is a reporting structure and there is a feedback mechanism, then you can keep things alive."

- *Respondent 2*

In summary, health managers perceive intersectoral collaborations to be critical in addressing the social determinants of health but in practice, intersectoral collaborations are formed to address the more immediate needs of the health sector and to expand the provision of health service delivery.

CHAPTER 5: DISCUSSION

This study aimed to explore health managers' experience and perceptions of intersectoral collaboration at the primary health care level. Health managers interviewed for this study identified specific types of intersectoral collaboration and what these collaborations tend to focus on most often. Health managers interviewed in this study highlighted the policy environment and about the need for leadership, governance and coordination of intersectoral collaboration and action for health. Sustainability of these intersectoral collaborations also featured prominently amongst the experiences and perceptions shared by health managers in this study.

5.1 Types of intersectoral collaboration

Through the interviews conducted with health managers, it became apparent that there is a tendency amongst health managers to think of sectors in terms government sector, private sector and NGO sector and not necessarily in terms of health sector, education sector, transport sector, safety sector, etc. The challenges and opportunities for cross-sector collaborations are however similar regardless of whether the term sector refers to public, private or non-profit domains or different public policy domains (Emerson, 2018). In addition to identifying collaborations with other government departments, with the private sector and with NGOs, health managers interviewed for this study also identified collaborations with health committees and communities as a type of intersectoral collaboration.

5.1.1 Inter-departmental collaborations

Intersectoral partnerships and collaborations with other government departments carried out at the primary health care level in these two sub-districts mainly involve partnerships with government departments within the social cluster, i.e. Social Development and Education.

No partnerships or collaborations were identified with government departments responsible for housing, transport, environment and economic development. This is in

keeping with findings from other studies that looked at collaborations between the health sector and other sectors (Storm et al., 2016).

5.1.2 Collaborations with Non-Governmental Organisations

In describing collaborations with the NGO sector, health managers considered contract management of funded NGOs as a partnership between the health sector and the NGO sector without acknowledging the unequal power relation inherent in such a partnership. Collaborations with NGOs that receive funding from international donors also feature prominently.

Collaborations and partnerships with the NGO sector were limited to partnerships with NGOs working in the health sector and did not include any collaboration with NGOs that worked to address the broader social issues affecting communities.

These partnerships with NGOs to extend health service delivery is in keeping with trends in low- and middle-income countries where governments leverage off support received from other sources as a result of reduced personnel and capacity (Emerson, 2018).

5.1.3 Collaborations with the Private Sector

Partnerships and collaborations with the private sector were limited to partnerships within the private health sector to expand health service delivery. This is in keeping with similar findings by Kula and Fryatt (2014), which found that the objectives Public-Private initiatives related to healthcare in South Africa were mainly to provide health services to underserved communities, contract private doctors where public doctors could not be recruited and particularly for the control of TB and sexually transmitted diseases.

None of the health managers interviewed identified partnerships with the private business sector aimed at increasing resources or addressing more upstream determinants of health. Corporate social responsibility initiatives within the private sector present an opportunity for public sector health facilities to leverage private sector resources to achieve goals and build capacity within the public sector (Kula & Fryatt, 2014). The

lack of identified partnerships with the business sector therefore presents a missed opportunity for health managers in this study.

5.1.4 Collaborations with health committees and communities

Community participation is a strategy that involves communities in addressing their problems through reflection and collective action and can result in a heightened sense of responsibility regarding health (Zakus & Lysack, 1998). Ideally community members should therefore be involved in the planning and decision-making processes related to the delivery of services in their respective communities.

Whilst the health managers interviewed generally acknowledged the critical role that community members can play in strengthening intersectoral collaborations and improving the quality of services, no mention was made of attempts to actively involve community members in planning and decision-making. Instead, community members are invited to participate in public engagements where the agenda has been pre-determined by the Department of Health. Worse still, community members complained that the Department of Health does not attend their meetings when invited to do so. This indicates an unequal power relation between the Department of Health and the community it serves, with the Department of Health perhaps viewing themselves as superior and not obligated to attend meetings called by community structures.

People are more likely to use and respond positively to health services if they have been involved in decisions about how these services are delivered and are also more likely to change risky health behaviours when they have been involved in deciding how that change might take place (Rifkin, 2009). The paternalistic manner in which the Department of Health currently engages communities could be potentially damaging to building a trust relationship with communities where communities are confident in the health service being delivered.

Health committees, which are meant to provide a platform for community members to hold service providers accountable and also provide an opportunity for communities to participate in decision-making processes, are not functional. This is directly as a result

of political factors at the local level. The effect of intersectoral collaboration between the Department of Health and health committees in this study setting could therefore not be determined.

5.2 Focus of intersectoral collaborations

In examining the focus of intersectoral collaborations and partnerships at the primary health care level, there does not appear to be any attempts to address the upstream factors or social determinants of health. Intersectoral collaborations and partnerships tend to focus mostly on addressing downstream factors by increasing access to health services and expanding the health service delivery platform. This is in keeping with findings by Rasanathan et al (2017) which found that in low- and middle-income countries the focus of the health sector remains almost exclusively on health care services.

This focus on addressing the downstream factors results in several missed opportunities for intersectoral collaborations to have a meaningful impact on health outcomes in the longer term. An example of such a missed opportunity is that collaborations with the South African Police Service tend to focus narrowly on how crime in communities affects access to health facilities and does not explore the broader impact that high levels of violence and crime have on the ability of health services to provide quality care. A reduction in violent crimes will reduce the burden on trauma and emergency care units and reduce pressure on over-burdened health services. Within this context, the Department of Health is not exploring the potential benefits to the health system if it collaborates with SAPS more broadly in terms of crime and violence prevention initiatives.

Another missed opportunity exists in collaborations with the Department of Education. Current collaborations are focussed on expanding health services via the Integrated School Health Programme and the implementation of some programmes related to Sexual and Reproductive Health services. Absent from these collaborations are the linkages between teenage pregnancy and school drop-out rates amongst young girls. Making these linkages will help the Health and Education sectors to forge stronger partnerships and collaborative programmes that will benefit both sectors.

None of the health managers interviewed mentioned partnerships that were aimed at implementing interventions to improve the physical environment, to increase employment opportunities, to improve working conditions or to increase road safety, for example. Such interventions hold potential to improve health outcomes in the longer term.

5.3 Policy Environment

The policy environment pertaining to intersectoral collaboration for health at the primary health care level in the two sub-districts included in this study was largely non-existent. Healthy Public Policy as advocated for in the Ottawa Charter has not been adopted at this level and a Health in all Policies approach is not followed.

Despite national and provincial strategic health documents stating a commitment to intersectoral collaboration for health, this is not translated into the development of policies to support the implementation thereof at the primary health care level. Similarly, in a study on the implementation of the First Thousand Days Campaign in the Western Cape, it has been found that documents may contain reference to the need for an intersectoral approach but does not elaborate on how collaboration is expected to unfold (Okeyo, Lehmann & Schneider, 2020).

A conflicting policy environment, where different sectors focus on their individual mandates instead of collaborative action is a barrier to effective intersectoral collaboration. The lack of policy alignment across sectors alluded to by health managers in this study is not new and it has been found to be a constraining factor in the effective implementation of intersectoral collaboration (Okeyo, Lehmann & Schneider, 2020). Intersectoral partnerships should therefore include collaborative policy development processes that involve all stakeholders so to ensure that an enabling policy environment is created to promote and sustain intersectoral actions.

5.4 Leadership, Governance and Coordination

Dubois et al. (2015) identifies coordination, governance and accountability mechanisms as being key tools to supporting intersectoral collaboration. These tools, however, need to be improved upon in the manner in which intersectoral collaboration is practiced at the primary health care level in these two sub-districts.

Health managers interviewed in this study identified the participation of political leadership at the local level as being integral to ensuring successful buy-in and involvement from non-health sectors in addressing the underlying factors that influence health and wellbeing in communities.

None of the health managers interviewed were able to identify successful coordination mechanisms that have been established to support intersectoral collaboration. This could be a contributing factor that impacts negatively on the functionality and sustainability of intersectoral collaborations implemented at the primary health care level.

Coordination structures and political will have been identified as being integral to ensuring the sustainability and accountability within intersectoral collaborations (Rantala, et al., 2014, Anaf et al., 2014, Spiegel et al., 2012 and Matzopoulos, et al., 2008). A prime example of this, is Cuba's Health Council which is headed by a political leader and acts as the central coordinating body for intersectoral action at the municipal level (Spiegel, et al., 2012). This body has been central to Cuba's successful intersectoral action for addressing the burden of disease in that country. Formal structures headed by some form of political leadership appear to be absent in intersectoral collaborations and action for health that take place at the primary health care level. This could be a barrier to ensuring good governance of intersectoral collaboration and accountability across sectors.

5.5 Sustainability

A key finding from this study is that a major impediment to the development of successful intersectoral collaborations and partnerships in the City of Cape Town District, Western Cape, is the misalignment of geographic boundaries. Health districts differ from

education districts which differ from social development districts. This makes it very difficult for health managers to initiate and sustain intersectoral collaborations as it often requires having the same conversations with several stakeholders from the same sector, resulting in a tangled web of meetings and engagements that are too time consuming to sustain.

Partnerships appear to have varying levels of functionality. Some partnerships and collaborations take place on an ad-hoc basis only, whilst others are more structured with regular meetings and engagements between stakeholders. It has been found that protocols that have formal institutional arrangements are important to sustaining collaborative networks (Emerson, 2018.) The lack of accountability structures and formal arrangements could therefore be a barrier to establishing, sustaining and ensuring the functionality of intersectoral collaborations and partnerships.

CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

Intersectoral collaborations for health at the primary health care level in two urban sub-districts of the Western Cape occur mostly with the public health sector collaborating with NGOs working in the health sector or collaborating with the private health sector, rather than collaborations with non-health sectors. Overwhelmingly, these collaborations focus on expanding health service provision beyond public health facilities and making healthcare more accessible. Addressing the social determinants of health to obtain long-term impact appears to be overshadowed by the urgent need to achieve short-term outcomes.

The policy environment to support intersectoral collaboration for health is scant with several documents expressing the need for intersectoral collaboration without providing details on how this should occur. This can be improved with intersectoral action starting at the level of policy development to help foster a shared vision, shared goals and a culture of collaborative policy making.

The current situation, where the policy environment is inadequate and resources are limited, places a limitation on the outcomes that health managers are able to achieve via intersectoral collaborations. The findings of this study should therefore be seen in the broader context of the policy and resource-limited environment in which attempts are made at establishing and sustaining intersectoral collaborations.

Leadership and governance is key to implementing intersectoral action and in this context the importance of political leadership to support intersectoral collaborations at the primary health care level was identified. The establishment of formal governance and coordination structures was recognised as necessary to ensure the sustainability of collaborations across sectors.

6.2 Recommendations

The adoption of the "whole of society approach" by the Western Cape Government signals an appreciation and acknowledgement of the need to work across sectors to maximise efficiencies within the province. It also provides a foundation in which intersectoral policies could be grounded as the province moves towards creating an enabling environment for more effective intersectoral collaborations that could begin to address the upstream determinants of health.

The Western Cape Government, non-governmental organisations and stakeholders, should consider the following recommendations aimed at strengthening intersectoral collaboration at the primary healthcare level:

i) The potential of intersectoral collaborations in addressing the social determinants of health at the primary health care level should be further explored in order to determine the long-term impact on improving health outcomes and increasing wellbeing.

ii) The Western Cape Government's adoption of the Whole-of-Society Approach (WoSA) presents a unique opportunity for the province to strengthen intersectoral collaboration and address the social determinants of health. This was evident in the province's response to the outbreak of Covid-19 in 2020. Key lessons from this response should be used to inform this approach going forward.

iii) The Community Oriented Primary Care approach presents an opportunity to establish sustainable intersectoral collaborations at the primary health care level. Key lessons from the pilot sites should be utilised to inform further rollout of this approach.

iv) Health committees hold potential to act as a coordination structure for the implementation of intersectoral action at the primary health care level and for more effective community participation. Health committees should be prioritised to ensure that they become functional and operational.

v) All government departments should ideally operate within the same geographical boundaries. Municipally demarcated geographical boundaries should be considered

as the official geographic boundaries within which all government departments operate.

vi) A supportive policy environment must be created that guides intersectoral collaboration at all levels, including primary health care level, to enable buy-in and support. Such a policy environment would ideally include subscribing to Healthy Public Policy as advocated for in the Ottawa Charter. This will require that policy-makers in all sectors be aware of the possible health implications of their decisions.

vii) Community participation should include the active involvement of community members at the level of policy development, programme planning and programme implementation.

6.3 Areas of further research

To further intersectoral collaboration knowledge exploration, further research is recommended on exploring and examining the implementation of the Whole-of-Society Approach in the Western Cape Province and investigating the potential of Health Committees to facilitate intersectoral collaboration for health. This will contribute to the available knowledge on the implementation of intersectoral collaboration for health.

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8. Appendices

APPENDIX 1: Interview Guide for Semi-structured Interviews

Opening

- Welcome the participant and thank them for making time available
- Explain the purpose of the interview: Part of a research study that forms part of the requirements for completing my MPH. The aim of the study is to explore health managers' experiences and perceptions of intersectoral collaborations at the PHC level.
- Ensure that Informed Consent form is completed

1. **Tell me about yourself, your professional career and the role you currently play within your organisation**
   - *Profession*
   - *Educational background*
   - *Years of experience and Work history*
   - *Career path*

2. **Describe, broadly, some of the work that you have done around intersectoral collaboration in the past or that you are currently involved in.**
   - *What types of collaboration are you involved in?*
   - *What is the policy environment that supports the collaborations?*
   - *How are they initiated?*
   - *Which sectors are involved?*
   - *What is the duration of the collaboration/s?*
   - *How sustainable are the collaboration/s?*
   - *What kind of interventions do they entail?*

3. **In your experience, how are intersectoral collaborations managed?**
   - *Who takes the lead in intersectoral collaborations at PHC level?*
   - *What is the role of political leadership?*

- *What kind of management support is available?*
- *How much time is spent on intersectoral activities?*
- *What are the incentives that attract and/or sustain participation from other sectors*

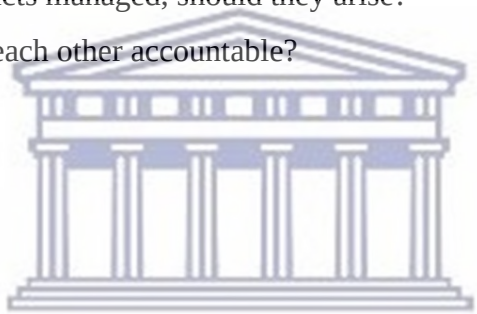
4. **How do you interact with other sectors in the implementation of intersectoral collaborations?**
   - *How do you communicate with other sectors? How does interaction take place? E.g. e-mail, meetings, etc.*
   - *Who communicates with whom?*
   - *How do you communicate with intersectoral platforms that function at provincial or national level?*
   - *What are the platforms for engagement (e.g. regular, scheduled meetings)?*
   - *What is the role of clinic committees/ health facility boards?*

5. **What are your perceptions on the functionality and intersectoral collaborations?**
   - *What are your perceptions about how intersectoral collaborations function?*
   - *What are your perceptions about their ability to fulfil their purpose?*
   - *What do you think are facilitators/barriers to successful intersectoral collaborations?*
   - *What do you think are the benefits or costs of participating in intersectoral collaborations?*
   - *What suggestions do you have as to how intersectoral collaborations can be improved?*

APPENDIX 2: Observation Guide

Whilst observing an intersectoral meeting, record the following information:

1. Location and setting of the meeting
2. What is the purpose of the meeting
3. Who was invited vs. who attends
4. How are meetings arranged (invitations, agenda setting, scheduling)
5. Who chairs the meeting
6. Decision making processes – how is consensus reached on decision-making
7. How are potential conflicts managed, should they arise?
8. How do members hold each other accountable?



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APPENDIX 3: Participant information Sheet
PARTICIPANT INFORMATION SHEET

Project Title: Health Managers' experiences and perceptions of intersectoral collaboration at the primary health care level in two urban sub-districts of the Western Cape Province.

What is this study about?
This is a research project being conducted by Nicolette Van der Walt at the University of the Western Cape. We are inviting you to participate in this research project because of your expertise and knowledge on the subject.

The purpose of this research project is to explore health managers' experiences and perspectives on intersectoral collaboration at the primary health care level.

What will I be asked to do if I agree to participate?
You will be asked to participate in a 60-minute semi-structured interview that will be audio-recorded. The interview will cover the following topics:

- The work that you have done around intersectoral collaboration in the past or that you are currently involved in;
- How intersectoral collaborations are managed at the primary health care level;
- How interactions occur between sectors in the implementation of intersectoral collaborations and
- Your perceptions of the functionality and effectiveness of intersectoral collaborations.

Would my participation in this study be kept confidential?
The researchers undertake to protect your identity and the nature of your contribution. To ensure your anonymity no names or designations will be identified in the study findings.

To ensure your confidentiality all records of the interview, including audio recordings and transcriptions, will be locked away in a secure location accessible only by the researcher.

If we write a report or article about this research project, your identity will be protected. Pseudonyms will be used when writing a report or article.

In accordance with legal requirements and/or professional standards, we will disclose to the appropriate individuals and/or authorities information that comes to our attention concerning child abuse or neglect or potential harm to you or others. In this event, we will inform you that we have to break confidentiality to fulfil our legal responsibility to report to the designated authorities.

What are the risks of this research?
All human interactions and talking about self or others carry some amount of risks. You may feel uncomfortable about sharing some of your experiences with the researcher. We will minimise such risks and you may opt to end the interview at any time.

What are the benefits of this research?
This research is not designed to help you personally, but the results may help the investigator learn more about intersectoral collaborations for improving health outcomes. We hope that, in the future, other people might benefit from this study through improved understanding of intersectoral collaborations for improving health outcomes.

Do I have to be in this research and may I stop participating at any time?
Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

What if I have questions?
This research is being conducted by **Nicolette Van der Walt** at the University of the Western Cape. If you have any questions about the research study itself, please contact **Nicolette Van der Walt** at: nicky213@gmail.com or 083 698 5426.

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

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This research has been approved by the University of the Western Cape's Research Ethics Committee. (REFERENCE NUMBER: *to be inserted on receipt thereof*)

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APPENDIX 4: Consent Form

CONSENT FORM

Title of Research Project: ***Health Managers' experiences and perceptions of intersectoral collaboration at the primary health care level in two urban sub-districts of the Western Cape Province.***

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.

I agree / I do not agree to be audio recorded.

Participant's name……..

Participant's signature…….

Date……