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The integration of the District health system in South Africa.

Negotiating the boundaries between researcher and facilitator

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> «An anthropology of modernity would employ ethnographic holism to dissolve the illusions that convince us the 'we' are modern, unprecedented but objective observers of other people's cultural worlds. As yet such an anthropology hardly exists [...] it would be far more empirically challenging [...]» (Jonathan Spencer 1996).
> «The ethics of Anthropology is bound up with ethnography as a discourse of responsibility, in the sense of a discourse of reflexive awareness achieved across difference.» (Debbora Battaglia 1999).

The topic of this paper is the active part the researcher can have in the project he/she is involved in, the advantages and constraints of this active part and the need for a discourse of reflexive awareness to guide this active role. Participant observation in the anthropological tradition as a mainly passive observer has always been problematic. The researcher has never been able to blend into the background (Putnina 2001). Moreover, in the changing environment of globalisation and issues such as HIV/Aids, which transgresses all boundaries, being objective and a passive observer has become a luxury our world cannot afford. Within an anthropology of modernity and addressing the illusions of objectivity, we need to look into new methods of research, which are more empirically challenging (Spencer 1996 p. 379). Research based on active participation in the sense that the researcher takes an active participatory role may be a step in the new direction This sort of research can provide a unique picture, as Putnina experienced when she started to work for the organisation she had done research with previously. She felt that working with the people involved in the research gives you a completely different dimension and point of view (Putnina 2001). Over the past year, I have been involved in a research project that required me to adopt an active role. In the initial stages of the research an agreement was reached with the parties involved (i.e. the project initiators

and the NGO) that I would be a researcher as well as a facilitator affiliated to change management. However, I do believe that the active role within research calls for a dynamic discourse of responsibility and a self-reflection and self-awareness of the researcher. At this moment, as the NGO pulls away from the project and I am left alone in the research field it is time for me to reflect how the active role has affected my research (February 2001) and to explore the boundaries of the relationship between researcher and facilitator.

Firstly, it is necessary to describe the integration of the health system in South Africa and discuss the creation of comprehensive services through this integration process. This section will describe the existing services and the implication of the idea of comprehensive services. Secondly the paper outlines the integration process in one of the pilot sites and the workshops and joint planning workshops I was involved in. This part outlines the connected role of the researcher and facilitator. Finally the paper negotiates the active role within the research, paying particular attention to the boundaries between the researcher and the NGO, the pitfalls of this type of research and the problems encountered.

The Integration of the District health system

> *«It won't make any difference, we all have our duties...they can swap us around as much as they like but it will be back to square one. If we take someone from TB to do dressings, we are just left with no one to fill the TB duty. If they think they can improve things without bringing in more money and more staff, they are fantasising.»*
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> The reaction of one of the nurses in Site A when asked about the integration of the district health system (HST Update 1999).

The integration of the district health system in South Africa is a consequence of the new constitution of 1996, which legislates a transformation and decentralisation of administrative systems. This includes the health services that are currently under provincial authority (i.e. mainly curative services such as hospitals) and services under local authority (i.e. mainly preventative services such as family planning services. The transformation of the health system as stated in the White Paper (1997) opts for the integration of the services now run on provincial and local level. The fragmentation of the health services signifies that two administrative and managerial systems are required. In this system, staffs are subject to different salaries, benefits and working conditions depending on which authority employs them. In addition, patients are able to obtain some services at both

facilities but mainly patients cannot have all their health needs attended to at one facility. They are required to travel to a certain facility on a certain day to have their health needs attended to.

During the integration of the district, health system all services will come under one authority and in the future a more comprehensive service will be offered to patients. Over the last five years health officials have been working to bring the health services under one system. The final date for integration in South Africa was set for July 2001 but was recently extended to September 2001. In the Western Cape, a number of sites have been set up to pilot the integration of the district health services. Most of these sites have failed and have abandoned integration. Problems encountered during integration are staff resistance to change and power-struggles between local and provincial government. It is not clear who should take over the new management of the district. Although the process favours local government, they often do not have the capacity or the finance.

Among the lessons learned from the failed projects in the Western Cape and from case studies in the Free State and the Kalahari district in the Northern Cape is the lack of consultation and support for the staff involved (HST Update 1999). In September 1999 the latest pilot site was identified, Site A[(1)], and it was decided that the emphasis would be on those points. To aid the process of integration, Health Systems Trust (HST) and the Initiative for Sub District Support (ISDS) appointed a facilitator to be involved in change management. The facilitator was to monitor the process and the needs of the staff. The introduction of the Site A community health centres as the next pilot site for integration took place in September/October 1999.

Recently, March 2001, the pilot project in Site A was called off by the NGO when the facilitator left the organisation and a new facilitator was appointed. Supposedly this was an opportune moment for the NGO to evaluate the existing position of the facilitator in the light of the reported achievements in Site A. At the same time the district structure on organisational level in the Western Cape changed with the introduction of the Unicity. The NGO came to the conclusion that the pilot project in the community health centre (CMC) had failed and the new facilitator should be concentrating on a higher level to facilitate the transformation. The official report to go out to the CMC emphasised that the staff had been empowered to negotiate with management. Staffs were encouraged to use the tools and communication structures given to them during the facilitated period of integration in further negotiations.

I became involved in the Site A pilot as a PhD researcher through the Admin. South Africa Project [2] when the pilot was introduced in 1999. The introduction of my involvement was twofold. The project facilitator took both Dr. Jan Froestad [3] and myself to be introduced at a management meeting where we were to announce our intentions and answer any questions. The facilitator stressed the importance of my active role of facilitator within my research. She emphasised that my 'being inside' would give this pilot project an advantage. I would be able to observe the staff's experiences and possible needs and objections. This would give her, as a facilitator, insight in the dynamics of the integration.

With their permission I was then taken to the CMC for a lunch meeting at the CMC, which served as the introduction of the integration process and was at the same time my introduction to the staff at Site A.

Comprehensive services

Site A, the final pilot site chosen, is a mainly coloured township in the Western Cape originating from forced removal under the apartheid regime. In connection with this, the population of Site A faces a high prevalence of TB and respiratory diseases, high unemployment and subsequent psychological illnesses. In the pilot site, the clinic and the day-hospital reside in one building, which the local authority officially owns.

The day-hospital staffs serve as a gateway for the doctor in the facility. Patients come in to the facility with an appointment or a complaint, they are given a number and their folder at reception and then they wait for the nurse outside the room, after depositing their folder in the slot of the door, which is reserved for the day-hospital. The nurse will then proceed to call the patient in, hear their complaint and send them through to the doctor. In the case that the patient has made a previous appointment the nurse will do the necessary screenings, i.e. blood pressure and send the patient on to the doctor. The day-hospital is doctor-driven. The nurses do the screening and other investigations available in the facility, dressings and injections ordered by the doctor but no diagnosing, prescribing or referral.

The service basis of the clinic is different. Patients do not make an appointment for the clinic. Specific services are rendered on specific days and specific hours. However, staff will always make exceptions for people who need their services at other times or are unable to come at the clinic times.

The staffs often know the situation of the patient and will make arrangements accordingly. A patient will come into the clinic and the nursing assistant at reception will receive their cards and dispense the folder among the three available nurses according to their area of speciality; family planning, primary paediatrics, new-baby clinic or TB. However, all the nurses will take each other's patients in case of an overflow. Clinic staffs are able to prescribe and diagnose according to their training.

The first nurse is specialised in DOTS (Directly Observed Treatment Shortcourse for TB patients) and is able to prescribe and diagnose with the help of a TB doctor attending the clinic once a week. The second nurse is trained in primary paediatrics and she will see most of the children attending the clinic. The third nurse is specialised in family planning. She will take all the women needing their family planning and women with reproductive problems. All the nurses will help out at the new-baby clinic, which is always very busy. The clinic is nurse-driven and highly specialised in their services.

The integration and the creation of a comprehensive service will entail the de-specialisation of services and the transformation of the trust relationship between nurse and client. The impact of the integration on nursing knowledge and practice will not be dealt with in this paper (see Parr, 2000).

The idea of a comprehensive service entails that clients can come into the clinic, fetch their folder and be seen by any nurse, have all their needs seen to and be dispensed medication by that same nurse. This means that all nurses must have a similar knowledge base and no nurse has a specific specialisation. It also implies that the comprehensive health service will be primarily nurse-driven. At this moment, two nurses, one from each facility, have been nominated for the one-year Clinical Nurse Practitioners (CNP) course. A CNP is allowed to prescribe and diagnose under the supervision of a doctor or in absence of a doctor. This arrangement naturally leaves space for interpretation. The need for a CNP was voiced as follows by one of the SPM managers:

> *«What we would like is have a clinical practitioner. So, that Dr. F is not so busy. He could go to Site B and spend some time there. He can give more care to the patients. A clinical practitioner could sit in with the doctor and learn and take over cases.»* (Fieldnotes March 2000).

It seems the intention of the comprehensive services is to make the health centres nurse-driven, freeing up the doctors to do curative services.

Comprehensive services also imply that each nurse should be able to do all the tasks. Currently when one nurse leaves she needs to be replaced by a

nurse similarly educated/specialised from another facility. Under the new system, any nurse can replace the other. The notion that nurse practitioners in one profession are interchangeable is a part of the idea behind the suppressed body, practitioners as a uniform body, interchangeable. There is the underlying idea that this will free up nurses to do more outreach. One can leave and another can take over in her place; it does not matter. No nurses from outside have to come in. Training of clinical nurse practitioners, to free up the doctor enforces this. These nurses will be able to do all that the doctor does basically. Two out of five nursing staff members will be trained at Site B. Comparing this to the statistics from 1998 when only 3 nurses in all the SPM clinics were trained (SPM 1998). This enforces the idea behind the creation of comprehensive services that all nursing staff should become CNP's so that the community based clinics become nurse-run. The doctors, then, will only be active in curative services (hospitals). It is expected that nurses will work the preventative services in the community and doctors the curative services in the hospitals. The expectation is that the health services will run more smoothly and the boundaries between nurses and doctors will be clearer. However, it looks as if this will actually lead to vaguer boundaries between nurses and doctors. The new training of nurses will be on a larger scale to get as many CNP's as possible. A CNP has to work under supervision. They are allowed to prescribe and diagnose up to a level but these boundaries shift under different circumstances. The official practice is 'under supervision' of a doctor, which can of course be interpreted in different ways. In rural areas, nurses are even doing small operations.

In addition, a uniform body implies a tightening of protocols and a medicalization of practice. A question that comes up from this is what the role of the nursing assistants will be who have no 'book' training as one nursing assistant put it. She put emphasis on her training inside the hospitals and clinics and the importance of her knowledge by experience. Clients for certain procedures seek her because of this accredited knowledge by experience, which legitimises her practice. With this new system in the health services, the protocols will become stricter and more medicalised, new emphasis will be placed on formal education and her position will have to be re-negotiated.

Comprehensive services and the notion of the suppressed body as the uniform body do not consider the acquirement of accredited knowledge by experience. Accredited and applied knowledge (Friedman 1970) (Lawler 1990) form the basis of legitimisation of practice by other nurses and clients. Neither do comprehensive services acknowledge the existing spe-

cialisation. The managing bodies with specific specialisation of practice as they currently exist set up the health services. This specialisation and the set-up of the services as either doctor- or nurse-driven resulted in a specific use of knowledge and provided the staff with a legitimisation of their knowledge and practice for other nurses and for their clients. It also created a distinctive hierarchy in the health services. The proposed new services with their tightening of protocols and medicalization of practice will create a 'professional closure', which is a type of 'Cultural Closure' (Meyer and Geschiere, 1999) (Parr 2000). When confronted with change, nurses react by creating new boundaries and re-affirming existing ones (Parr 2000). The firming of protocols and medicalization of service will fail to acknowledge the body of applied knowledge:

> «The course of applying that (scientific knowledge) to concrete patients in concrete social settings.» (Friedman, 1970).

Lawler (1991) adds to this the three characteristics of accredited knowledge:

> «Becoming an accredited knower of the world [...] requires one to learn ways of seeing, ways of knowing and ways of sharing that knowledge.»

By not acknowledging the acquirement of knowledge by daily experience, one goes beyond the true legitimisation of knowledge that is given by other nurses and clients. These are real considerations when creating a comprehensive service and considering the idea of interchangebility.

The research project: workshops and research

The main objective of the research from the start was, firstly, to explore the construction of knowledge and practice by nurses themselves, patients and the community, doctors and health management. Secondly, to observe the relationships with other nurses in different categories of the hierarchy, patients and the community, doctors and health management which influence nursing knowledge and practice. At the start of the research, I envisioned that this project would give me a multilevel perspective because of my involvement with change management and as a participant observer in the every day setting of the clinic. This was and is a unique opportunity to observe a change process for the beginning to the end. Below I will outline the highlights of the pilot project and my involvement in these.

The pilot project ran adjacent to the research project. The project started in November 1999 with a day-workshop for the staff of Site A at a beautiful

location away from their normal environment. The purpose of this meeting was for the staff to share their fears and wishes in connection with the proposed integration. At this stage, it was important to encourage the dialogue between staff members. This workshop, for me, served to become more closely acquainted with the staff. In deliberation with the facilitator, it was decided I should only take up a small role in the workshop. I was to do the playful introduction serving as a 'get to know each other', and work as an assistant and a scribe. Prior to the workshop, I developed a small workbook for staff with several exercises for personal use and an evaluation form. This workshop was the opportunity for me to start observing at the clinic. The reason given to the staff for my presence was quite honestly that I wanted to observe the changes that would take place with the transformation. At the workshop, staff voiced their concerns about salaries and benefits, loss of jobs and the management of the new CMC after integration. The outcome of the workshop included:

- The lack of consensus on what will happen.
- Misinformation from management which induces mistrust.
- The feeling of powerlessness, not having a choice, not knowing what is going to happen.
- The need for visible support.
- The question of availability of sufficient staff and capacity.
- The opportunity for staff to develop with training.

In July and August 2000, the facilitator organised a series of workshops that would facilitate the completion of a functional integration and would lead to full integration. Leading up to this series of workshops were scattered meetings with staff in order to address the issues of collaboration and co-operation. During this time, a steering committee was chosen among the staff from both services with representatives from administration, household and nursing. This committee was to serve as a mechanism for the encouragement of discussion with management. At the same time, this committee was to discuss possible ways forward and notice any problems. Some training took place with staff from both services. I continued my observations and did interviews with the nursing staff to discuss nursing practice across the divide of the two services.

The July/August workshops were to be the last in the series and included the following:

- Identifying current problems and strengths of Site A CHC/clinic and the community.
- Area mapping of Site A.

- Mapping of client service delivery pathways.
- Primary health care and the comprehensive care.
- Client experience and customer care [4].
- Service provision.
- Redesign and changes to health service delivery and structures at Site A.

The aim of this series of workshops was to give staff the opportunity to work through the perceived needs of the community and review the current services on offer. This would make the staff able to evaluate their own service in connection with the community and propose changes in the service.

In September 2000, a meeting took place between staff and management where staff presented their progress and future plans. Staff presented the following:

- Clients have one folder instead of two (formerly clients had a folder for each service).
- The pharmacy would start to order and supply the drugs for both services ('would', because the pharmacist was taken ill soon after the meeting and this has not taken place).
- A new telephone system has been approved connecting both services in one switchboard and under one telephone number. (The telephone arrived in March 2001).
- Two nurses will be attending the Clinical Practitioners Course next year, one from each service. This will enable them to prescribe and diagnose under doctor's supervision. This means that the doctor could be freed up for other tasks and could attend other clinics. (This has happened and both nurses are doing the course).

Both nursing and household stated at this meeting that they would remain the same for the present. Nursing staff stated that if cross training and information were to be made available they would start outreach programs into the community. Household staffs have been against the integration from the beginning. They stated that all three staff members were necessary and could not be asked to do each other's jobs. Unofficially they spoke about the situation where one member would be taken ill and the others would be asked to take over. This would then imply that the third member is not necessary and could be fired.

After this meeting, the site was officially regarded as integrated. However, this entailed only the changes mentioned above. The integration not completed and comprehensive services far from accomplished, the final meeting on 1 March 2001 came as a complete surprise to staff. As stated above the facilitator was leaving and a new facilitator was taking her place. Staffs

were told that the 'ball was now in management's court' and over the last year they had been equipped with tools to negotiate with management. This also meant that the proposed client satisfaction survey, proposed by the NGO and completely supported by staff, was now cancelled. However, this survey will take place in the week before this conference. It will take place with my own funds and assistants. This gives me a chance to expand the survey and make more non-structured interviews, which will be more useful. The goals for the survey are the following:

- Who visits the clinic and whom do they see?
- Are clients 'playing the system'?
- What are the clients' attitudes towards staff members?

The interviews will allow the interviewers to select clients for in-depth interviews and perhaps find candidates for the proposed life histories.

Summarising, the integration at the CMC started with a workshop in November 1999 in which staff voiced their fears and wishes for the integration. It was then followed by a number of workshops encouraging co-operation and communication and ended with a series of workshops in July 2000 reviewing the needs of the community and the current services. The progress of the integration at Site A was then presented to management in September 2000 and the pilot project finished in March 2001 with the NGO stepping back.

Joint planning for the district

On a higher level, two Joint Planning meetings for the district took place, which involve the pilot project. The first was held in March 2000. This was after the plans for integration had been introduced at Site A. The Joint Planning Workshops are larger meetings with staff from all levels from the whole district and management. The goal of this meeting was to define several priority areas and to appoint task groups, which would work on these areas for the following year. The workshop was organised and facilitated by the NGO. My task in this workshop was to facilitate one of the groups to discuss the possible priority areas. I carefully chose a group that did not include any of the Site A staff. The priority areas chosen at this point were HIV/Aids and TB, Disability and Rehabilitation, Drug Management, Healthy Cities and Violence and Substance Abuse. Management later added two additional priority areas, i.e. Health Information Systems (HIS) which aims to develop statistics, which can be

easily collected at the level of the community centre, and Comprehensive Services.

The taskgroup for the development of Comprehensive Services includes the integration of services and the development of services in under-services areas. The goal of this taskgroup is to support integration of services and train Clinical Nurse Practitioners who are able to prescribe and diagnose, officially under supervision of a doctor. This entails that the doctor is free to visit CMC's in under-serviced areas. Areas were there is no doctor.

On 14 March 2001 the second Joint Planning meeting was organised. This time the meeting was organised and facilitated from within, by staff and management. The goal of this meeting was to assess the progress of the taskgroups chosen in the first Joint Planning meeting. Each task group was asked to report on goals and aims, progress over the last year, problems experienced and their future plans. All task groups experienced problems with funding and finding dedicated individuals to drive the process. The task group for Comprehensive Services reported that they had succeeded in identifying staff members for CNP training. These individuals had been chosen from the areas with an under-serviced area close-by like Site A. The outcome of the training and the actual change in practice will take until the end of the year 2001. All CNP's will finish their course and a new nursing practice will be installed.

At this occasion, I was asked to facilitate one of the groups to discuss the reported progress of the task groups and to bring forward possible solutions to their problems. The overall group was smaller and none of the Site staff members were present. Personally, the group discussion served to gain understanding about the issue of community participation. The participants in my group were all from areas where interventions were taking place. They all agreed that the problem with community participation was one of ignorant organising. Meetings are organised by people from outside the community, often in places where it is not safe to travel to at night. Additionally members of the community often do not have the means to travel to the location. Moreover, members of the community are expected to participate on Saturdays, usually reserved for family activities (Joint Planning Notes March 2001). Another consideration is that participating in a clean up or an education programme is to admit the community has major problems, which it cannot solve without the help from outsiders (Fieldnotes May 2001).

To summarise, both Joint Planning Workshops were concerned with the larger district development. The first workshop served to identify priority areas and the second assessed the progress of the assigned taskgroups in these

priority areas. My task in these workshops was one of scribe, observer and facilitator. In these meetings, I did not engage with the staff members of Site A. however; I did ask the staff about their experiences after the meeting.

Active participation

The active role of researcher brings up the question of boundaries. The researcher is both observer and active participant. The question of boundary pertains to the extent of the participation in the context of observation. The researcher has to actively engage with this question in the sense that each action needs to be seen with its possible consequences. It is of vital importance to contemplate whether the research or those involved are compromised by any of the decisions made by the researcher. In the following section, I will investigate the negotiation of these boundaries within the context of my experience and fieldwork. This includes legitimisation of the research, identity construction, and the pitfalls and the maintenance of these boundaries in the changing environment. A connected issue is the written material issued during the period of integration and research. This includes my reports and conference papers and the reports issued by the various institutions involved.

First, there is the relationship with the NGO that acted, to a certain extent, as the legitimating factor for the research. Although the senate reviewing my research proposal wouldn't agree, the active role was seen as an advantage and served as a legitimating factor for my research. Both the introduction to management and the CMC staff included this active role. The part of the co-facilitator was seen as a potentially positive position.

The relationship with the NGO was mostly limited to interaction with the facilitator. My main concern here was not to be involved too much and not to be identified with them. The interaction with the facilitator included mainly workshop preparation, as discussed below.

Workshops were planned by the facilitator and then discussed with me. We would discuss the goal of the workshop compared to the current situation at the CMC. I would brief her on the situation at the CMC pointing out the problem areas. This information the facilitator could then use to talk about the real issues and 'workshop' through these. Obviously, this is a very sensitive issue and a precarious position to be in as a researcher. This type of interaction brings up issues of confidentiality and the betrayal of trust towards the staff. However, the facilitator proved to be very sensitive. She

would work with the information in such a way that staff would tell her about the issues themselves. Moreover, I would only give her information pertaining the integration. No personal information about staff was ever imparted to the facilitator.

At each meeting, my involvement in the workshop was carefully discussed. The schedule of the workshop would be reviewed and the possible result for the fieldwork and my position discussed. The activities selected for me would be mainly introductory exercises and scribe. These activities were designed to give me a legitimate part in the workshops and yet maintain my position.

A more problematic side of the co-operation with the facilitator was inside knowledge. One of the major benefits of active participation in this project was the multileveled access. I was often aware of thoughts, policies and actions from one of the three levels i.e. management, the NGO and the CMC, that was not known to any of the other levels. Some of these could have a potentially negative outcome for staff. One such example was that staff was ensured at the start of the facilitated integration process that no jobs would be lost. Later on in the project, it became clear that this was by no means certain. Within the creation of comprehensive services, the position of staff with accredited knowledge by experience could be potentially precarious. At this moment in the integration, no jobs have been lost but then nothing has really changed at the CMC. However, one of the nursing assistants has started her nursing course to become, as she calls it, 'a book nurse'. She started fighting for her right to do the course shortly after the start of the guided integration process. Another example was that I was aware of the conclusion of the pilot days before the meeting. At the meeting, itself it was quite clear that none of the staff had anticipated this. Moreover, I was aware of the discrepancy in the unofficial reason for the stop of the pilot and the reported reason presented to staff. (See above p.3 The Integration of the District Health System). This is probably the most challenging part of active participation. As the researcher, you are often party to information from more than one level of the organisation/community.

My research at the CMC started with an introductory period constructing my identity in the field. The path taken to construct this identity was to spend a day with each member of staff to observe their activities. Gaining trust takes time and I had to prove to each of them that I would not talk to others about what they had said to me in private. Many staff members had entrusted me with professional issues and personal problems. Staff needed time to realise that their thoughts and worries were never disclosed to another staff member. One example of this is that I once found out why a

member of staff had taken leave without consent. I overheard her on the telephone without her realising. Although I had told her many times that I understood Afrikaans perfectly, she would not believe me. Later that day the sister-in-charge asked me if I knew anything about her taking leave. In front of all her friends, I stated that I had no idea. These small incidents help to establish a trusting relationship. This staff member is now the person who will disclose recent problems and staff clashes on my arrival at the CMC. Moreover, staff members have come to realise that I will not give my opinion concerning the integration. I merely listen to their opinion. Thus, it has also become clear to staff that I do not take sides. It has become clear to staff that I am also not with the NGO or with management. I am merely concerned how the process of integration impacts on nursing knowledge and practice.

The pitfalls of active participation in research can include being used by staff members for their hidden agendas. One incident at Site A occurred at a staff meeting. One of the staff members telephoned me and asked me to chair. I only realised while chairing the meeting that this staff member had a personal reason for asking me to chair this particular meeting. It had come to her attention that the other members of staff were going to confront her. She thought that if I were to chair the meeting they would not do this. She was correct and during the meeting everyone stayed very calm and once again focussed on issues, they did not have any power over e.g. the telephone system and training. This obviously is a case in which the 'active participant' part of my research was used against me. However, pitfalls often serve to uncover the hidden dynamics in the organisation or community involved.

The final issue to consider is the papers and reports. Firstly, there are the papers I have written for conferences. It is virtually impossible to disguise where the research is taking place. Site A is the only pilot site in the Western Cape. This pertains to the identities of the informants described in the papers. Fortunately, most papers have been written for conferences abroad where neither the project nor the staff is known. Other reports have been written for colleagues within the research project who understand the problem of identities. Furthermore, the informants' identities are disguised in the papers. If possible the informant's gender is changed or the informant is placed in a different setting. Official reports to the NGO and management have always been without particular incidents between particular individuals. In these official reports, the problems are generalised without details of specific incidents to protect the individuals involved.

Currently, with the ending of the pilot project, the role of the facilitator comes to an end. The legitimisation of the facilitator falls away and I am

left to legitimate my research in a different way. Obviously, it makes the research less complicated but the boundaries have to be re-negotiated with the staff. Fortunately, the NGO never managed to organise the client satisfaction survey. However, staff feels this survey is an integral part in improving the services. It has given me a chance to legitimate my research. More importantly, it serves to reciprocate. The survey will give the chance to gain entrance into the community and identify essential informants for the community research.

Notes

(1) Site A is a pseudonym.

(2) The Admin. South Africa Project is funded by NUFU in Norway and is a collaborative effort between the University of Bergen and the University of the Western Cape. This particular study falls under the Health Section of the project.

(3) Dr. Jan Froestad is a visiting researcher from the University of Bergen. His involvement is on a higher level in the structure of the Health System. His research, that of Dr Diana Gibson and my own are linked within the health section of the Admin South Africa Project.

(4) This includes a client satisfaction survey, which will have taken place in the week before this conference. Originally it was to be in co-operation with the NGO, the clinic staff and UWC.

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