THE FUNCTIONING AND PERCEIVED EFFECTIVENESS OF DISTRICT HEALTH SYSTEM GOVERNANCE STRUCTURES IN GAUTENG PROVINCE

Khanyisile Tshabalala

Supervisors

Professor Laetitia Rispel

Dr Mary Kawonga

A research report submitted in partial fulfilment of the requirements for the degree of Master of Medicine (Public Health Medicine) in the School of Public Health, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg

Johannesburg, South Africa

September 2019

DECLARATION

I, Khanyisile Tshabalala, declare that this thesis is my original work. It is being submitted for the degree of Master of Medicine (Public Health Medicine) in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other University. I am aware that plagiarism (the use of someone else's work without their permission and/or without acknowledging the original source) is wrong. I confirm that the work submitted for assessment for the above degree is my own unaided work except where I have explicitly indicated otherwise.

I have read the sections on referencing and plagiarism in the Wits Plagiarism Policy and I have followed the required conventions in referencing the thoughts and ideas of others. I understand that the University of the Witwatersrand may take disciplinary action including suspension or permanent expulsion against me if there is a belief that this is not my own unaided work or that I have failed to acknowledge the source of the ideas or words in my writing.

Signature: 

Khanyisile Tshabalala

26 September 2019

DEDICATION

This work is wholeheartedly dedicated to my family

To my girls, Malaika and Imani, for their unconditional love, patience and understanding. You have been my biggest source of inspiration.

To my parents and siblings, for their willingness to babysit on demand and endless words of encouragement. I am certain that a few of your grey hairs can be attributed to walking this journey with me.

To my sister-circle, you are the family that chose me. In the process of becoming family, you have loved me in the most non-judgemental way, and provided a safe space for me to share my thoughts and regroup whenever I needed to.

Above all, this work could not have been possible without the grace of God. His love and mercy have been with me even during the times I felt I did not deserve it.

Ngiyabonga

PRESENTATIONS ARISING FROM THIS MASTER'S RESEARCH STUDY

1. Tshabalala K, Kawonga M, Rispel LC. *Perspectives on the functioning and effectiveness of district health governance structures in Gauteng Province*. Oral presentation at the Gauteng District Managers meeting, Ekurhuleni, 15 August 2018.

2. Tshabalala K, Kawonga M, Rispel LC. *Perspectives on the functioning and effectiveness of district health governance structures in Gauteng Province*. Oral presentation at the Wits Faculty of Health Sciences Research Day, 6 September 2018.

3. Tshabalala K, Kawonga M, Rispel LC. *Perspectives on the functioning and effectiveness of district health governance structures in Gauteng Province*. Oral presentation at the Annual Conference of Public Health Association of South Africa, 11 September 2018. Received award for best oral presentation

4. Tshabalala K, Kawonga M, Rispel LC. *Perspectives on the functioning and effectiveness of district health governance structures in Gauteng Province*. Oral presentation at the LESEDI closing symposium: Generating evidence to support health system transformation, 16 October 2018.

ABSTRACT

Background: Leadership and governance are critical for achieving universal health coverage (UHC). In South Africa, aspirations for UHC are expressed through the National Health Insurance policy, which underscores the importance of primary health care, delivered through the district health system (DHS). In light of this, the aim of this study was to determine the existence of legislated District Health Councils (DHCs) in Gauteng Province, and the perceptions of members on the functioning and effectiveness of these structures.

Methods: The study was done in all five districts in Gauteng. The population of interest was members of existing governance structures. Members completed an electronic-self-administered questionnaire (SAQ), which collected perceptions on the functioning and effectiveness of the governance structures, using a seven point Likert scale. STATA® 13 was used to analyse the survey data. In-depth interviews with the chairpersons of the DHCs and the District Health Council Technical Committees complemented the survey. Interviews were analysed using thematic content analysis.

Results: Only three districts had constituted DHCs. The survey response rate was 73%. The mean score for perceived functioning of the structures was 4.5 (SD=0.7) and 4.8. (SD=0.7)for perceived effectiveness. The interviews found that enabling legislation and a shared vision on DHS facilitated governance. In contrast, the complexity of two spheres of government, political differences, difficult interpersonal relationships, lack of orientation and insufficient resources constrained governance. The survey and interviews identified gaps in accountability to communities.

Conclusion: The governance gaps identified need to be addressed to ensure the successful implementation of UHC reforms.

Key words: District Health System; governance; accountability; National Health Act; Gauteng

ACKNOWLEDGEMENTS

I am privileged to have been supervised by two power houses, Professor Laetitia Rispel and Dr Mary Kawonga. They have pushed me to strive for academic excellence, and simultaneously demonstrated that it is possible to supervise with integrity and kindness. I am encouraged and inspired by their excellence in everything they do. Moreover, I am grateful to have had the opportunity to walk this journey with them by my side.

I would also like to acknowledge and thank Professor Jonathan Levin for the guidance he provided in the quantitative analysis. I was not his student but he provided support as though I was.

I am eternally thankful for all the research participants who not only shared their time with me, but also shared their rich experience and opinions on a topic which is typically difficult to discuss. This research could not have been possible without their willingness to participate in a meaningful way.

My Master's study was part of the LESEDI project funded by the Atlantic Philanthropies (Grant ID: 21408). The views expressed in this study are my own and not those of the funder. I am also thankful for my colleagues within the LESEDI project who provided encouragement, support, and useful tips throughout the journey. Special thanks to Miss Takalani Netshiomvani, for her assistance with the field work and data collection.

Last, I would like to thank my colleagues from the Department of Community Health. They encouraged me when self-doubt crept in, and brought in a laughter and light in the moments when adult life took its toll on all of us.

LIST OF ACRONYMS AND ABBREVIATIONS

ANOVA	Analysis of variance
DHC	District Health Council
DHCs	District Health Councils
DHCTC	District Health Council Technical Committee
DHCTCs	District Health Council Technical Committee's
DHS	District Health System
DMT	District Management Team
HREC	Human Research Ethics Committee
KI	Key informant
KIIs	Key Informant Interviews
MEC	Member of the Executive Council
MMC	Member of the Mayoral Council
MMed	Master of Medicine
NHA	National Health Act
NHI	National Health Insurance
PHC	Primary Health Care
REDCAP	Research Electronic Data Capture
SAQ	Self-administered questionnaire
SD	Standard Deviation
SDGs	Sustainable Development Goals
UHC	Universal Health Coverage
WDR	World Development Report
WHO	World Health Organization

Table of Contents

List of Tables

List of Figures

CHAPTER 1: INTRODUCTION

1.1. Background and context

Health systems are the vehicle for the delivery of equitable and quality health care. Good leadership and governance are essential for the effective functioning of a health system (1, 2). Although there are differences in the definition of governance, the one of the World Health Organization (WHO) is used commonly. WHO defines health system governance as “the existence of strategic policy frameworks, combined with effective oversight, coalition building, regulation, attention to systems design, and accountability”(1). Brinkerhoff and Bossert expanded the definition of governance to include the interactions, roles and responsibilities of societal actors both within and outside the health sector (3). Both the United Nations Sustainable Development Goals (SDGs) and the 2017 World Development Report (WDR) underscore the critical role of governance in addressing poor service delivery, and achieving social and economic development goals (4, 5). The WDR suggests that political will, cooperation, commitment and good coordination among governance actors are necessary for the effective implementation of local policies and laws (4).

In South Africa, the National Development Plan also emphasises the important role of governance in reducing inequities, achieving faster economic growth, and enhancing the capabilities of people (6). The importance of governance in strengthening the public health system is re-emphasised in the National Health Insurance (NHI) policy paper which seeks to move South Africa toward universal health coverage (7). The success of the NHI in delivering health services that improve health, and impact on the social and economic life of South Africans, will rely on robust health systems, including strong governance mechanisms across all spheres of government (7).

The South African Constitution outlines the roles and responsibilities of the different spheres of government, which are envisaged as*“distinctive, interdependent and interrelated”* (8). Health services are listed as a concurrent functional area, and legislation can be passed at

both national and provincial levels (8, 9). The NHA provides for the establishment of governance structures at the national, provincial and district levels (9). The Act further emphasises the District Health System (DHS),under the authority of the provincial government, as the main vehicle for the delivery of primary health care (PHC) (9). The latter is at the core of health sector transformation in the country, enunciated in numerous policy frameworks since 1994 and reaffirmed in the 2017 NHI White Paper (7). At the district level, District Management Teams (DMTs) are responsible for the planning and management of all PHC services within the districts as articulated in the White Paper for the Transformation of the Health System in South Africa (10). However, it is the NHA that makes provision for the establishment of DHS governance structures called *District Health Councils* (DHCs)to "promote cooperative governance and ensure co-ordination, planning and monitoring of health services for the residents of their district"(9):21. The Act prescribes the membership and responsibilities of the DHCs and emphasises cooperative governance between provincial and local spheres of government (9). Section 42 of the Act also provides for the establishment of community level structures named clinic committees (9). The purpose of the clinic committees-which include community members-is to enable community participation in the planning and delivery of health services (11).

Notwithstanding the legislative framework that outlines the mechanisms for the governance of the DHS, existing evidence suggests that there is fragmentation between provincial and local government and weaknesses in leadership and governance (12-14). The NHI policy underscores the governance challenges in the public sector, as well as weak accountability mechanisms across the spheres of government (7). Research has shown that there is an association between weaknesses in governance and poor health outcomes (15). Hence, weaknesses in leadership and governance in South Africa are likely to influence the country's ability to manage its quadruple burden of disease, reduce health inequities, and improve health system performance for optimal population health outcomes (14, 16-19).

In light of the central role of good governance to the successful implementation and performance of the DHS and delivery of PHC, this study examined the perceived functioning and effectiveness of DHS governance structures in Gauteng Province. Given that Gauteng

Province is the economic powerhouse of South Africa, DHS developments in this province are of strategic importance to the rest of the country.

This chapter provides the context and background to my Master of Medicine (MMed) research study. Section 1.2 contains the definition of terms, while section 1.3is a critical review of the literature on the DHS, the NHA and research on health system governance. This is followed by the problem statement and the rationale for the research in section 1.4. Section 1.5 highlights the significance of the study. The concluding sections contain the aim and objectives of the study (section 1.6.) and the structure and outline of the remainder of the research report (section 1.7).

1.2. Definition of terms

District health system (DHS)	A more-or less contained segment of the national health system. It comprises of a well-defined population, living within clearly demarcated administrative and geographical area. It includes all institutions and individuals providing health care in the district (20). A network of primary care health facilities, providing a comprehensive range of promotive, preventive and curative health care services to a defined population with active participation of the community and under the supervision of a district hospital and district health management team(21).
Effectiveness of governance structure	The degree to which governance structures successfully carry out their delegated functions including oversight, accountability, and co-operate governance in the delivery of District Health Services. In the context of this study, effectiveness is a composite score of 12 items rated on a scale of 1 to 7.
Functioning of governance structure	The existence and execution of rules, procedures, and activities of the governance structures. Functioning in the context of this study is a quantifiable composite score of 17 items rated on a scale of 1 to 7.
Governance	The act of ensuring strategic policy frameworks exists and are combined with effective oversight, coalition building, regulation, attention to systems design, and accountability(1), as well as the

	roles and responsibilities of, and relationships among, policy actors(3).
Health district	Well defined, appropriately-sized geographical areas demarcated for the purpose of delivering decentralised health management in relation to primary health care (22).
Primary health care (PHC)	Primary health care is essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination (23).
Decentralisation	The transfer of authority and power from higher levels of government to sub-national levels (2).

1.3 Literature review

1.3.1 Overview of the District Health System in South Africa

The DHS is the vehicle for PHC delivery and facilitates the decentralised management of health services (24). It is organised by geographical area, and the boundaries of health districts (managed by provincial government) are coterminous with those of municipalities (local government), thus serving well-defined populations (11, 22). The WHO identifies the benefits of decentralisation as improved effectiveness, efficiency in service delivery, and increased accountability through public participation (22). In 1997, the White Paper for the Transformation of the Health System in South Africa emphasised the importance of the DHS in ensuring the successful implementation of PHC (23). The principle of decentralisation of health services has been adopted and is enshrined in the NHA (6), and is further articulated in policies and national health plans (23, 24). In reality DHS decentralisation is only implemented partially, with ongoing centralisation of decision-making on human resources and finances at provincial government level (9, 11).

The de facto organisation of the DHS, the governance structures and key role players are depicted graphically in Figure 1.

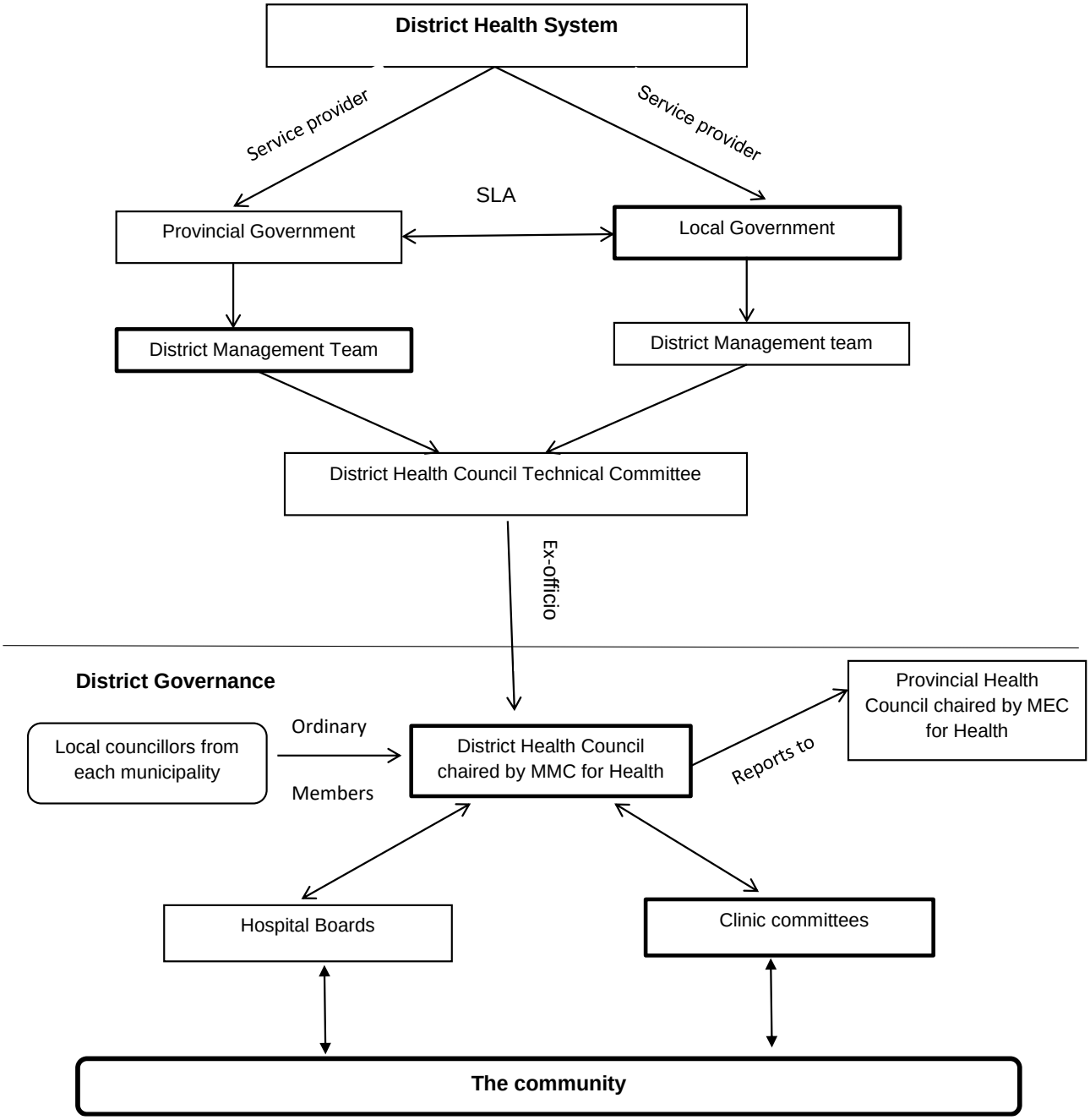

Figure1: Overview of the DHS; role players and governance structures

Source: Adapted from Health Systems Trust, 2007(25)

As depicted in Figure 1, according to the NHA, the delivery of PHC services in health districts is the responsibility of provincial government (9). The provincial government is expected to

pass legislation to guide DHS development, and ensure its relevance to local context. In practice, both the provincial and local government provide PHC services, facilitated by service level agreements (SLA) between the two spheres of government (8).

The extent to which each sphere provides PHC services differs depending on the province and/ or district in the country, and depends on resource availability (9). Existing evidence suggests that the role players involved in the delivery of district level health services have different reporting lines, they have misaligned priorities, which render coordination in service delivery and co-operation a complex and difficult process (11, 21). Consequently, the DHS has struggled to live up to the aspirational goals articulated in national policy and legislation (14), reflected in poor or lack of implementation (22).

Section 31 of the NHA provides a framework for the establishment of DHCs by the Member of the Executive Council (MEC) for Health together with the MEC for Local Government, with council members appointed as prescribed by the Act (9). According to the prescripts, these councils may also create sub-committees to advise them on any matter related to the district health system (9). The composition of the DHCs and their functions, as elaborated in the NHA, are depicted in the table 1 below (9).

Notwithstanding the prescripts of the NHA, the required governance structures to ensure co-operative governance, co-ordination and planning of district health services have not been established in all districts (13). Capacity development of district managers who form part of the governance structures has not been aligned towards their needs, while the institutional environment has not encouraged community participation (13). Thus the effectiveness of existing governance structures and accountability to communities are doubtful (14).

Table 1: Legislated composition and functions of District Health Councils

Composition	Functions
Member of the metropolitan or district municipal council (chairperson)	• Co-operative governance • Co-ordination, planning, budgeting, monitoring of health services • Advise the provincial MEC for Health
Person appointed by MEC to represent him/her	
Member of council of each local municipality	
Not more than 5 others appointed by the MEC for health	

Source: National Health Act, 2003(9)

1.3.2. Studies on health system governance

Research on health system governance is important as it generates empirical information and allows for debate on governance issues, which are often not given appropriate priority (26). Assessments also raise awareness among key policy makers on the state of governance and its potential impact on the delivery of health services (26).

Using the WHO definition of governance, a literature review was conducted on the governance of district health systems in different countries, specifically the nature and composition of governance structures, their functioning and effectiveness, community participation, accountability, and roles, responsibilities and interactions of policy actors. Databases such as PubMed and Google Scholar were used in the search for appropriate literature, as well as the websites of the WHO, Health Systems Trust and the South African Department of Health.

There is an emerging body of literature on health system governance that explores the varying definitions of governance in health, types of governance structures, the role of governance structures, and the challenges of governance (15, 27-32). The types of

governance structures are influenced by country context, legislative and policy frameworks, and resource availability (33). Nonetheless, there is increasing emphasis on health system governance in light of the SDGs that emphasise the achievement of UHC (34), and WHO's programme of action on UHC (35). This section highlights lessons from both developed and developing countries on the different ways in which governance for health can be measured, the types of structures that have been constituted, their advantages, disadvantages and challenges experienced.

A 2016 systematic review on frameworks to assess health systems governance concluded that this concept is complex, and neglected in health systems research. The review also pointed to the lack of evidence on how governance can and is assessed at both national and subnational levels (27). The review found that there is no agreement on which framework or methodology should be used to assess governance and that this flexibility in methodologies is likely to continue. It also highlights the need for countries to monitor and evaluate governance in order to contribute to health systems strengthening (27).

Serapioni et al reviewed mixed advisory committees in Italy, and their role in the governance of district health (28). These mixed advisory committees are composed of representatives of patients or users as well as health authorities (28). These structures operate at health district and hospital level (28). The purpose of these committees is to foster citizen participation in health-care decision-making by allowing them a platform to engage and analyse aspects of health service delivery (28). Using semi-structured interviews conducted with 39 members of the committees and direct observations of meetings, the researchers studied public participation within their health-care system (28). The researchers found that amidst conflicts and disagreements within the committees, there was consensus among study participants of the value of these committees and representation of all stakeholders in decision-making (28). However, in practice the advisory structures had little influence on decision making (28). While this study contributes to knowledge on the types of governance structures in a high-income country, and the benefits and challenges of such structures, it did not measure their effectiveness.

In Brazil, Health Councils have been established to provide a platform for ordinary citizens to get involved in the monitoring of health policies and health-care delivery (30). These councils operate at the national, state and municipal levels (30). Their purpose is to oversee policy implementation and budget allocations (30). Martinez et al interviewed health council members to explore the gaps and weaknesses of these councils (30). Although these structures were envisioned to have representation of government officials and civil society, in practice there was poor representation of civil society, in part due to lack of interest from community members (30). One of the key weaknesses identified by council members was that there was poor follow-up of decisions made in meetings (30). This was attributed to lack of support from senior officials, differences in interests and unequal power dynamics (30). The study found that insufficient resources for these health councils were a key constraint (30). According to key informants, lack of financial resources limited their ability to hold meetings and their capacity to disseminate information to the greater public (30). Hence, the study identified the constraints to governance in a middle-income country setting.

A comparative case study of the link between UHC reforms and health system governance in Thailand, Vietnam and China found that each country adapted the design of their UHC programmes to accommodate their specific institutional arrangements (36). The review found that Thailand was prepared to adopt new governance models, while China and Vietnam have tended to persist with traditional hierarchical governance models. The study highlights the importance of context in explaining UHC reforms, governance structures, and interactions among stakeholders (36).

In 2013, Cleary et al conducted a literature review to explore accountability mechanisms in low income countries. They used Brinkerhoff and Bossert's definition of governance namely: "putting in place effective rules that condition the extent to which the various actors involved fulfil their roles, responsibilities, and interact with each other to achieve public purpose" (29). The study found that the negative attitudes of public servants and health providers to citizen involvement, and institutional culture of healthcare influenced the functioning of governance structures in these settings (29). They also described how a lack of resources allocated to accountability initiatives hindered citizen involvement (29).

In 2015, Makuta et al published a study that assessed the impact of public health spending and the quality of governance on health outcomes across 43 countries in Sub-Saharan Africa (15). Using data from the World Bank Governance indicators, they demonstrated that Sub-Saharan countries generally have poor governance scores across key governance principles of: governments' ability to formulate and implement quality policies and regulations; quality service provision independent of political pressure; and accountability and citizen involvement in decision making (15). They also assessed healthcare spending and health outcomes using mortality data (15). They were able to demonstrate that although overall spending on healthcare improves health outcomes, such improvement is mediated through the quality of governance (15). They concluded that high healthcare spending in the absence of good governance, does not improve health outcomes (15). Using quantitative measures, the study makes an important contribution to the assessment of governance in Sub-Saharan African countries, and in demonstrating the links between governance, healthcare spending and mortality.

In 2016, Herrera *et al* conducted a systematic review of the available evidence from 19 systematic reviews about the effects of governance arrangements for health systems in low-income countries (37). The governance focus and key findings in the literature that are relevant to my MMed study are summarised in Table 2.

Table 2: Effects of governance arrangements for health systems in low-income countries

Governance Focus	Number of Reviews	Main Results
Effects of different ways of organising authority and accountability for health policies	3	• Collaboration between local health agencies and other local government agencies may lead to little or no difference in physical health or quality of life (low-certainty evidence)
Effects of different ways of organising authority and accountability for organisations	2	• Contracting non-state, not-for-profit providers to deliver health services may increase access to and use of these services, improve people's health outcomes and reduce household spending on health (low-certainty evidence). • No evidence was available on whether contracting out was more effective than using these funds in the state sector.
Effects of different ways of organising authority and accountability for healthcare providers	7	• Training programmes for district health system managers may increase their knowledge of planning processes and their monitoring and evaluation skills (low-certainty evidence)
Effects of different ways of organising stakeholder involvement in governing health services	4	• Participatory learning and action groups for women probably improve newborn survival (moderate-certainty evidence) and may improve maternal survival (low-certainty evidence) • Disclosing performance on individual healthcare providers to the public probably leads people to select providers that have better quality ratings (moderate-certainty evidence). • No studies evaluated the effects of stakeholder participation in policy and organisational decisions.

Source: Herrera et al, 2017(37)

Gilson et al conducted a study on everyday resilience in the DHS in South Africa and Kenya using a flexible study design including data from interviews, document reviews and direct observations. While the study focus was on health systems resilience, it identified the challenge of unstable and evolving governance structures (31). This study describes how in the South African context, the split of PHC services and the management thereof between

provincial and local government has caused uncertainty about provincial and local government roles in the provision of health services (31). The blurring and the uncertainty in roles led to tensions between colleagues from local and provincial government, with consequences for stability for the delivery of PHC and good governance(31). The study found that the incomplete process of decentralisation from province to district level in one district in Gauteng Province created confusion in the balance of responsibilities, reporting lines, and accountability (31).Although the study did not focus on district-level governance structures, the findings offer useful insights into the challenges of co-operative governance between the provincial and local government. Hall et al wrote in a 2005 review on the spirit and intention of the Health Act in relation to the DHS, in fostering cooperative governance between provincial and municipal health departments (11). Specifically they addressed the potential role of s of the DHC are in promoting cooperative governance (11). In this review, they also highlighted the need for provincial legislation to provide for the functioning of DHCs (11).

In South Africa, Meier and London examined community participation and in particular the role of community level governance structures (facility level health committees and sub-district level health forums) in the governance of health services (32). These researchers reviewed the policy and legislation around community participation, and combined this analysis with stakeholder interviews and observations of dialogues between health officials and communities (32). The study found challenges in the establishment of these structures and the appointment of appropriate members who represent the views of the community (32). In those places where these structures were in existence, there was uncertainty on what their role is and how to integrate them into the DHS (32). Furthermore, the researchers identified unclear commitment from government officials in supporting these structures and creating a conducive environment for their full participation in the delivery of health services (32).The authors recommended that the DHCs should facilitate community engagement, but did not assess or provide details on how this could be achieved.

Collectively, these South African studies highlight the potential of the DHS and community structures such as clinic committees in enhancing community participation. At the same time, these limited studies highlight the challenges of cooperative governance and

decentralisation and the constraints to community participation, including the lack of role clarity, power imbalances between government officials and community members, and the appropriateness of the selection of community members onto these structures. Importantly, most of these studies have focused on limited aspects of governance, namely community participation and/or accountability. I could not find studies that have examined the functioning/and or effectiveness of DHCs, or that have analysed these legislated structures according to the NHA prescripts.

1.4 Problem statement

The South African laws and policies as outlined in the literature review, have given effect to the establishment of districts, and defined the functions of districts. Similarly, district health services have been defined and the management thereof delegated to DMTs. To this end, much has been published on the central role of DMTs in the successes and failures of the DHS, as well as the challenges they face in executing their functions (38, 39). However, DMTs albeit an important component of the DHS, cannot take on the function of governance of the districts. Successive volumes of the South African Health Review have emphasised the importance of improving governance, leadership and accountability at strategic, district and facility levels (40), Given that the NHA both creates the DHCs for governance of the DHS, and prescribes the roles and responsibilities of these DHCs, it is important to research DHS governance to assist policymakers, and stakeholders with the development of strategies for addressing problems and improving the governance of health systems (37).

There is a dearth of information on whether: governance structures have been established in Gauteng's health districts; whether these structures are performing the functions mandated by the NHA; what challenges or constraints they experience; and what progress they have made. Hence, this study is premised on the dearth of empirical information on these issues.

1.5 Significance of the study

The WHO has noted that good governance is essential for the achievement of the health system goals of: improving people's health; ensuring responsive and quality health service delivery; and protecting citizens against the financial costs of illness (18). In South Africa, good governance at the district level is of particular importance because of the proposed NHI system and the long-standing policy intent to decentralise the management and leadership of health services to district level.

It was envisaged that this MMed research study will generate new knowledge on the existence of district health system governance structures in Gauteng Province, and the perceptions of the functioning and effectiveness of health system governance structures in one South African province. The research will contribute to the growing body of health policy and systems research, with a specific focus on DHS governance.

1.6 Aim and objectives

The aim of the study was to assess the functioning and perceived effectiveness of DHS governance structures in Gauteng Province. The specific objectives of the study were to:

1. Describe the governance structures in the five districts in Gauteng Province, against the provisions of the National Health Act.
2. Examine the functioning of the governance structure(s) in Gauteng Province.
3. Explore the roles and responsibilities of members of the governance structures in Gauteng province.
4. Determine the perceptions of the members of the governance structure(s) regarding the effectiveness of the governance structure(s).

1.7. Structure of the research report

The research report is divided into 5 chapters. It begins with the introductory chapter above, which is followed by the outline of the study methodology in chapter 2. In this chapter, the study design and setting, methods of data collection and analyses are presented. Chapter 3 presents the findings of the study, while Chapter 4 provides the discussion of the findings in line with the study objectives. The concluding Chapter 5 outlines the conclusion and recommendations of this study.

CHAPTER 2: METHODOLOGY

2.1 Introduction

This chapter describes my MMed research study methodology, which combined qualitative and quantitative research methods to examine *the functioning and perceived effectiveness of district health system governance structures in Gauteng Province*. Section 2.2 presents the ethical considerations and steps taken to ensure that my research was conducted according to the highest ethical standards. In section 2.3, I have provided an overview of the study setting, followed by the study design (2.4), study population (2.5), and study sample (2.6). This is followed by the description of the quantitative component (section 2. 7) and then the qualitative component (Section 2.8) of the research. Section 2.9 describes the potential sources of bias and limitations and how these were addressed. The concluding section 2.10 highlights the strengths of my research study.

2.2. Ethical considerations

The University of the Witwatersrand's Human Research Ethics Committee (Medical) provided ethical approval for the study (M17071) (Appendix 1). Permission to conduct the research was also obtained from the Gauteng Department of Health and the five participating districts (Appendices 2 A-E.

In line with the standard ethical principles, I ensured the voluntary participation of all the study participants. Each participant was provided with an information sheet (Appendices 3&4). My contact details, those of the Human Research Ethics Committee (HREC) and my supervisors were provided to all study participants in case of any questions or requests for further information. I obtained written informed consent from every participant (Appendices 5A and B) as well as separate consent forms for the interview and the audio-recording of interviews. Participants were informed that their participation in this study was strictly voluntary and that there were no incentives for participation, nor any penalties for non-participation.

Confidentiality of data was maintained. Each participant was provided with a unique study number. Only members of the research team have access to personal identifying information. All study data are kept in a secure, password-protected computer. Only aggregate data are presented, and no participant names or other identifying information is used in any publication arising out of the study.

2.3. Study setting

Gauteng Province was the setting for my study. Notwithstanding its economic and social importance, access to participants due to the location of the researchers was a key consideration for the study setting.

Gauteng has the largest share of the South African population with approximately 13, 3 million people (25,4% of the national population) living in the province and the highest population growth rate at approximately 2% annually(41). The province contributes approximately one third of South Africa's Gross Domestic Product (GDP)(42). Gauteng has five health districts, three are metropolitan municipalities (City of Johannesburg, City of Tshwane and Ekurhuleni) and two are district municipalities (Sedibeng and West Rand). The district municipalities are each further divided into three local municipalities (Figure 2).

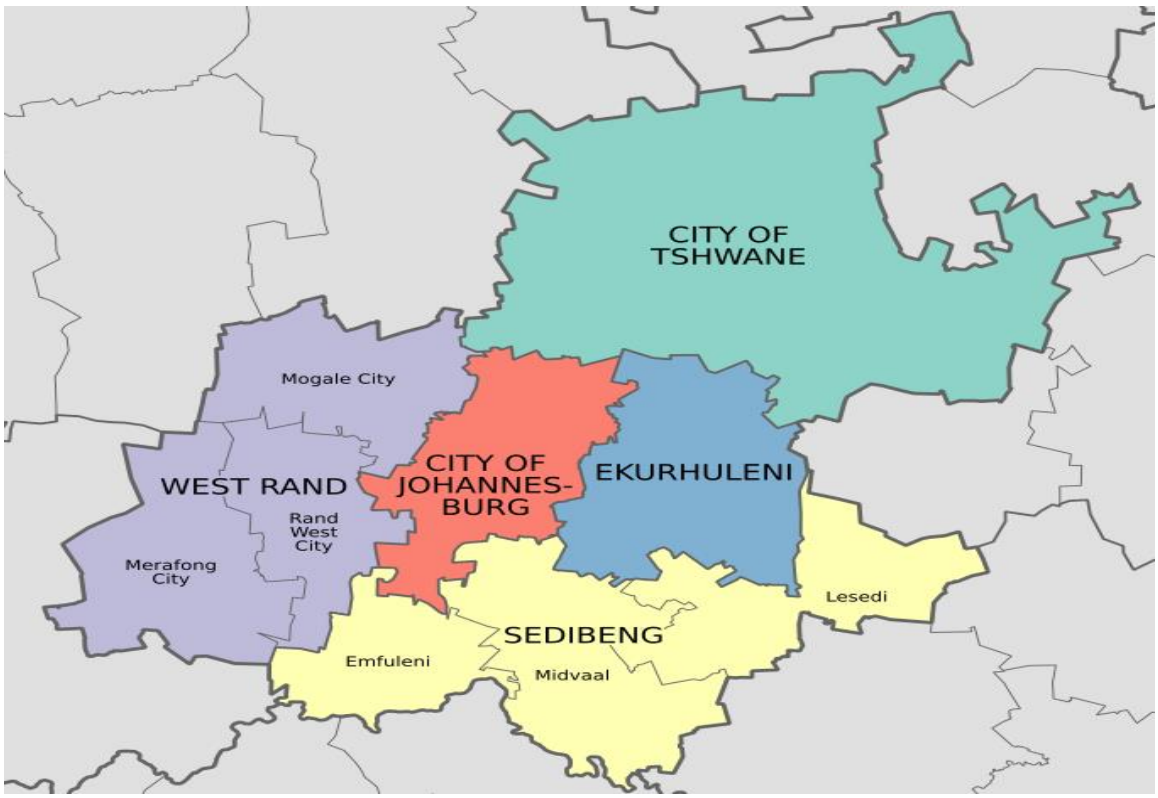

Figure 2 Map of Gauteng province with districts and local municipalities

In each district, both provincial and local governments are responsible for the management of personal health services. Each district therefore has a provincial manager i.e. a chief director or director, and local government manager i.e. Head of Health at its helm. Both provincial and local government have their respective district management teams (DMTs) to manage district health services. The NHA makes provision for district health councils (DHC) to govern district health services (9). The legislation allows for the DHCs to establish sub-committees as advisory structures. In Gauteng these subcommittees are named the District Health Council Technical Committees (DHTCTs). The DHCs are chaired by the Member of the Mayoral Committee (MMC) for Health who is a politician at local government level in the district. The DHTCTs are chaired by the provincial and local government heads alternately.

2.4. Study design

This cross-sectional study collected both qualitative and quantitative data. The combination of methods is presented in Figure 3 below.

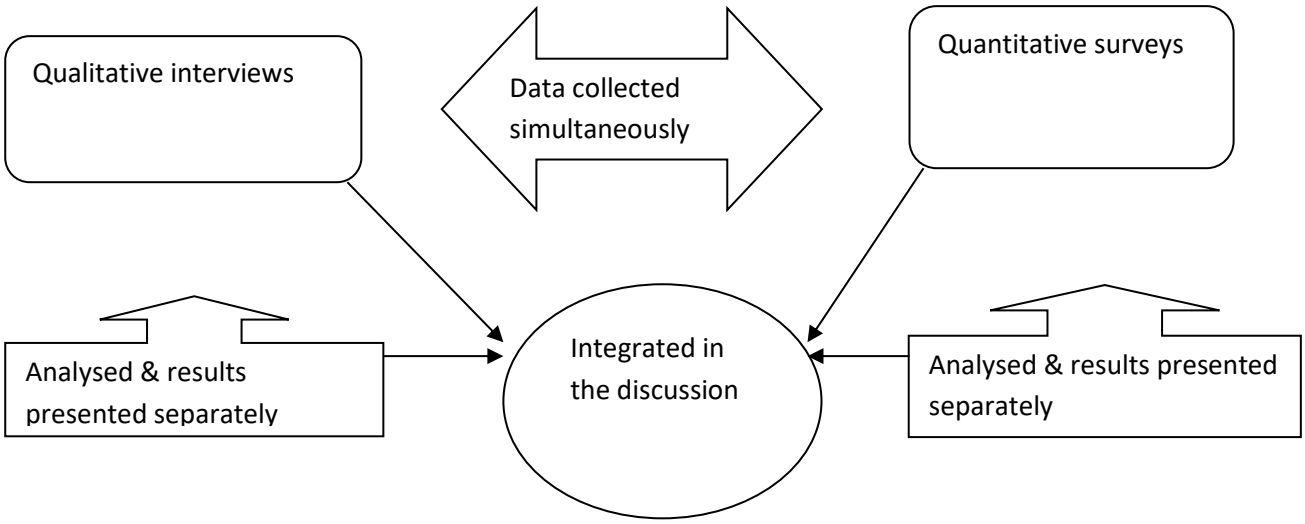

Figure 3 The mixed methods study design

The details of the methodological approach are shown in Table 3.

Table 3. Methodological overview

Objective	Questions and issues explored	Data collection methods	Data analysis
1. Describe the governance structures in the five districts in Gauteng Province against the provisions of the National Health Act.	a. The existence of governance structure(s) b. Type of governance structures c. Composition of the governance structure (s): number of members, socio-demographic characteristics of members, designation of each member d. Alignment of the governance structure(s) with the prescripts of the National Health Act (NHA) regarding composition	Quantitative component: Survey (Likert scale)	1. No. of governance structures per district, by type of structure 2. Socio-demographic characteristics of members of the structures • Gender (#&%) • Age (mean &SD) • Designation (%) • Length of service (mean no. yrs.)
2. Examine the functioning of the governance structure(s)	a. The existence of guidelines and/or terms of reference b. The existence of sub-committees c. Frequency of meetings d. Record keeping or documentation of meetings e. How the structure exercises oversight in the following areas in the district: co-ordination of services; planning; budgeting; monitoring. f. How the structure promotes co-operative governance, including relationship with the District Management Team g. Existence of mechanisms for coalition building h. How accountability to communities served is ensured i. Existence of indicators or criteria used to measure the performance of the governance structure	Survey using a semi-structured questionnaire: quantitative data (Likert scale) and in-depth interview guide to collect qualitative data	1. Quantitative • No. / % of Governance structure(s) who have the following: • Guiding documents / terms of reference • Sub-committees • Meetings as frequently as mandated • Minutes of meetings for stipulated time period The 17 individual items measuring functioning were summed to calculate an overall mean score for functioning. Significance testing for differences in means scores between districts using ANOVA and

Objective	Questions and issues explored	Data collection methods	Data analysis
	j. Achievements of the governance structure(s) k. Challenges or barriers experienced in fulfilling their duties as members of the governance structure	Review of minutes of any meetings held between Jan-Dec 2017)	difference by gender, member type, structure type using two sample t-test. 2. Qualitative: Thematic content analysis of oversight, co-operative governance, accountability, achievements and challenges
3. Explore the roles and responsibilities of members of the governance structures	a. Members' perceptions regarding the role of governance structures b. Perceptions regarding the clarity of their roles and responsibilities c. Perceptions regarding their ability to influence decisions	Qualitative component: in-depth interview guide	Thematic content analysis of: • Roles and responsibilities • Contrasted against envisioned role as described in the NHA
4. Determine the perceptions of members regarding the effectiveness of the governance structure (s)	1. Perceived effectiveness of governance structures regarding these functions: a. Oversight function b. The advisory role to the Member of the Executive Council for Health c. The promotion of cooperative governance d. Ensuring accountability to communities served 2. Perceived effectiveness of governance structure meetings 3. Factors associated with perceived effectiveness	Quantitative component: survey semi-structured questionnaire (Likert scale)	1. The 12 individual items measuring effectiveness were summed to calculate an overall mean score for effectiveness 2. Significance testing for differences in means scores between districts using ANOVA and difference by gender, member type, structure type using sample t-test. 3. Linear regression modelling relationship between socio-demographic variables (age, gender, structure, district, portfolio, membership time & district orientation) and outcome (perceived effectiveness score).

2.5. Study population

The study population consisted of all the members of the DHCs and members of its technical arm the DHTCTs in the five Gauteng health districts (or municipalities) for the period January to December 2017. Together all members constituted the total study population (n=115).

2.6. Study Sample

All the members of the DHCs and DHTCTs in the five Gauteng health districts were invited to participate in the study; hence there was no sampling (n=115). The main inclusion criteria for survey participants were membership of a DHC or DHCTC in Gauteng, and having served a minimum of three months as a member. The main inclusion criterion for the in-depth interviews was being a chairperson of a DHC or DHCTC in the five districts (n=10).

2.7. Quantitative component

2.7.1. Recruitment

Following preliminary consultation (Appendix 6) with the chairpersons of the DHCs and DHTCTs in each district, the list of governance structure members and their contact details was compiled on a excel spread sheet. All members on the list were approached via email and telephonically and invited to participate in the survey. The results of the quantitative data survey are based on 93 completed surveys. Respondents could complete the survey twice if they were members of both structures, thus the response was calculated from number of participants rather than

number of surveys. The total number of participants completing the survey was 85 of 115, equating to a 73% response rate.

2.7.2. Data collection tool

I could not find a standardised tool to measure the functioning and effectiveness of district health governance structures, except the WHO Tool for assessing the operationality of district health systems (43).The tool focuses on assessing district management structures and their managerial processes. Following an extensive literature review, I designed a self-administered questionnaire (SAQ) in English (Appendix 7) for use in the survey. The SAQ incorporated relevant elements of the WHO Tool.

The SAQ consisted of the following sections:

a. *Socio-demographic variables* such as age, sex, relevant district, portfolio on governance structure and length of time served as a member of the governance structure.
b. *Participants' perceptions regarding functioning* (administration, processes) of the governance structures (17 items). The tool contained 17 semi-structured items related to operational matters such as meeting scheduling, meetings minutes, clear agenda, participation in meetings, and discussion of health outcomes and regular review of data. The participants' responses to the statements were scored on a 7-point Likert scale between 1 (strongly disagree) to 7 (strongly agree).
c. *Participants' perceptions regarding effectiveness* of the governance structures. The tool contained 12 semi-structured statements related to core governance issues such as cooperative governance, district health planning, knowledge of budget, and accountability to community. The participant responses to each statement were again scored on a 7-point Likert scale between 1 (strongly disagree) and 7 (strongly disagree).

2.7.3. Piloting of data collection instruments

Prior to data collection, I piloted the survey tool in Ekurhuleni and Johannesburg districts among two members of the DHTCTs. This was done to determine the clarity of questions, whether any adjustments were needed and the time taken for completion. Following testing, adjustments to the wording of two statements were made on the SAQ prior to the commencement of the study. The individuals who participated in the pilot study as well as the results from the pilot were excluded from the main study results.

2.7.4. Data collection

I used the secure, web-based Research Electronic Data Capture(REDCap), programme hosted at the University of Witwatersrand for the survey. Primary data collection took place during January and June 2018. One field worker was recruited and trained to assist with collection of the quantitative data.

An appointment was made with each participant for the purpose of meeting and facilitating completion of the survey. Following informed consent, each participant completed the SAQ(Appendix 3) on REDCAP(using a hand-held device (a tablet) (44). In those instances, where I was unable to secure an appointment, I delivered a hard-copy and collected the questionnaire, or an electronic link was sent to participants via email for completion.

2.7.5 Quantitative data management and analysis

Upon completion of the questionnaire, I checked each one for completeness. The data were password protected and only the researcher had access to this password. Data were labelled and exported into STATA® 13 for analysis (45).

i. Determining reliability and inter-item correlation

I calculated Cronbach's alpha coefficients on the SAQ to determine reliability and coherence between items. The overall Cronbach alpha score for reliability for the 29 items questionnaire for governance was 0.81. This score indicates good reliability as evidenced by the high inter-item correlation.

ii. Descriptive statistics: socio-demographics

For the descriptive analysis, the whole study sample was used (n=93). Age being a continuous variable was described using the mean and standard deviation. Categorical variables such as sex, district represented, governance structure type, and portfolio on the governance structure were described using percentages. The duration of membership was described using means and standard deviation.

I checked the minutes of meetings held between Jan-Dec 2017 to validate meeting dates reported by participants for the period under review. The content of the minutes was not analysed.

iii. Descriptive analysis: structure functioning and effectiveness

The analysis of participants' perceptions of the functioning and effectiveness of governance structures was done at different levels. Descriptive statistics (means and standard deviation) were used to describe perceived functioning and perceived effectiveness scores. The items on the questionnaire that had been asked negatively were individually reversed in the analysis in order to calculate the appropriate means. In STATA, the alpha command was then used to calculate the reliability of the 17-itemscale measuring functioning as well as generate the overall mean score for perceived functioning based on the construct. Using the alpha command, a score is

created for every observation for which there is a response to at least one item. The summative score is divided by the number of items over which the sum is calculated. Similarly, the alpha command in STATA was again used to calculate the reliability scale of the 12 items measuring effectiveness as well as calculate the overall mean score for perceived effectiveness. The maximum possible score per item was seven and the minimum score one.

iv. Bivariate analysis: structure functioning and effectiveness

A two sample t-test and ANOVA were used to assess for significant differences in mean perceived functioning scores (from the Likert-scale) between groups categorised according to socio-demographic variables, governance structure type, member type, gender, and district. The same was done for the perceived effectiveness score. The significance level was set at 5%.

v. Multiple linear regression model: structure functioning and effectiveness

I conducted linear regression analyses to assess the association between socio-demographic characteristics and perceived functioning and effectiveness scores, respectively. The two outcome variables were perceived functioning and perceived effectiveness score. Both outcome scores were numerical values. The explanatory variables included in the models were: age (categorised in ten year intervals), gender, governance structure type, district, portfolio, and whether an individual had orientation on the district health system. These variables were selected based on the study objectives as well as recommendations from previous research assessing factors that influence governance (46). The R^2 value measuring proportion of variance explained was calculated as part of the model. Finally, the F-test for the overall model and the coefficient estimates for each predictor were calculated. All tests were conducted at 5% significance levels.

2.8. Qualitative component

The qualitative component consisted of in-depth interviews with chairpersons of the DHCs and DHCTCs. The main purpose of the interviews was to explore the perspectives of policy actors or stakeholders on the functioning and effectiveness of the DHS governance structures, with a focus on exploring their roles, factors influencing functioning or effectiveness of these structures, as well as their challenges and achievements.

2.8.1. Recruitment

Participants for the in-depth interviews were selected purposefully because of their positions as chairpersons. All chairpersons of the DHCs and DHCTCs were approached through the district offices via email and telephonically and invited to participate in the study following approval of the study from the respective research committees in the districts. In total, ten in depth interviews were conducted, including chairpersons of both the DHCs and the DHCTCs.

2.8.2. In-depth Interview guide

I developed a semi-structured interview guide (Appendix 8) to obtain qualitative information that would add depth and possibly explain some of the findings of the SAQ. The interview guide focused on the roles of the structure, relationships between or among members of the governance structures, community members, and politicians, achievements as well as challenges.

2.8.3 Piloting

Prior to data collection, I piloted the interview guide in Ekurhuleni and Johannesburg districts among two members of the DHCTCs. This was done to determine the clarity of questions, whether any adjustments were needed and the time taken for completion. Following the pilot, minor corrections were made in terms of informing participants of the time taken to complete the questionnaire, as the time was longer than anticipated. The adjustment in the introduction of the interview guide to participants was made accordingly.

2.8.4 Data collection

I contacted each chairperson to set up a suitable date and time for the interview. Following informed consent, I conducted all the interviews face to face in English with the chairpersons of the relevant governance structures, using an in-depth interview guide (Appendix 8). The questions were open-ended allowing the participants to direct the flow of responses. Following informed consent, the interviews were recorded digitally. Each interview lasted between 30-60 minutes, depending on the responses of the participants. In addition, I made detailed field notes following each interview. The interviews were audio-recorded (with informed consent).

2.8.5 Data management and analysis

Following the interviews, the recordings were transcribed verbatim and transcriptions kept in a locked cupboard. The audio files were stored on a password-protected computer and will be destroyed after the time period prescribed by the HREC.

I analysed the transcribed data using thematic analysis. The analysis was an iterative process beginning with familiarisation with the data through reading and re-reading

the transcripts. The narrative text was then coded. Through this process numerous codes were identified. These codes were then grouped and organised into categories which were then defined as themes and sub-themes. Credibility and trustworthiness were established through inter-coder agreement between the researcher, one other researcher, and the supervisors through the independent coding of a sample of the transcripts. The four individuals then compared the coding and inter-coder agreement was confirmed when consensus on the themes was reached. Once there was agreement on the themes, I used MaxQDA to assist with the qualitative data analysis.

2.9. Addressing potential sources of bias and study limitations

This section outlines potential sources of bias, as well as study limitations and steps taken to address bias or these limitations.

2.9.1 Bias and remedies

Bias is defined as: “any systematic error in the design, conduct, or analysis of a study “which results in deviation from the truth (47, 48). In this study, the potential sources of bias were: non-response bias, and social desirability bias. *Non*-response bias occurs when individuals who participate in the survey are different to those who do not respond, resulting in potentially biased estimates (49). Non-response bias can be minimised by ensuring a high response rate (47). In this study, I attempted to minimise non-response by extensive consultation with relevant stakeholders, careful explanation of the study to the possible participants, relationship building, and attending relevant governance structures meetings. Despite these efforts, the overall response rate was 73%, due to refusal by some study participants, and the fact that two of the five districts did not have formal DHCs.

Social desirability bias refers to the tendency of participants to answer in a manner perceived to be socially acceptable or politically correct(48). I minimised this potential bias by careful design of the questionnaire, piloting of the questions prior to the survey, the self-administered nature of the survey using REDCap and a tablet for the majority of survey participants. I also ensured that the study participants were at ease during data collection. The individual appointments with study participants also facilitated data collection.

2.9.2. Study limitations

A limitation is the selection of Gauteng Province, which might not be representative of the rest of South Africa. This is because the province is urban, and relatively well resourced, and hence differs from the rural provinces of the country.

2.10. Study Strengths

The strengths of my study are both in its scholarly, and health policy contribution. This was one of the first studies to examine the functioning and perceived effectiveness of district health governance structures in Gauteng, which is the economic hub of South Africa. The study has generated new knowledge on these aspects, especially in light of the impending health sector reforms in South Africa, enunciated in the National Health Insurance Bill(50).The study provides baseline data, that could be used in future studies on DHS governance. The SAQ could be used by other researchers, both in South Africa, and in Africa, to examine the functioning and perceived effectiveness of governance structures. The study has also contributed to the growing body of health policy implementation research, especially on health system governance. The results of the study provide useful and practical areas for intervention, at a critical time of South Africa's health sector reforms.

CHAPTER 3: RESULTS

3.1 Introduction

This chapter describes my MMed research study findings, both the qualitative and quantitative results. Section 3.2 presents the overview of the existing governance structures in Gauteng and the composition of these structures. In section 3.3, I have provided a summary of the socio-demographics information and characteristics of study participants. Section3.4outlines the perceptions of members of the governance structures on the functioning and effectiveness of the governance structures based on the quantitative survey. In section 3.5, I present the differences in governance scores by socio-demographic characteristics of participants, and in section 3.6, the association between socio-demographic characteristics and the perceived functioning and effectiveness scores. The findings of the qualitative component follow in section 3.7, and are presented in themes and sub-themes derived from ten in-depth interviews.

3.2. Governance structures in the five districts of Gauteng

Only three out of the five districts in Gauteng- Sedibeng, West Rand, and Tshwane districts - have formally constituted DHCs. The DHCs consist of health officials from both provincial and local government, as well as members of council (politicians at local government level) from local municipalities within the districts. The respective Members of the Mayoral Committee (MMCs) for health in each district chair the DHC.

The District Health Council Technical Committees (DHCTC) which serve as technical advisory committees, were present in all five districts. These technical committees consist of health officials from both provincial and local government. In all the districts,

these structures are chaired on a rotational basis by the director or chief director from provincial government, and the head of health from local government.

Only three districts - Ekurhuleni, Sedibeng and Tshwane - were willing to share the minutes of the meetings held in the preceding 12 months. These minutes confirmed that meetings had been held on a monthly basis for the DHCTCs and a quarterly basis for the DHCs.

3.3. Socio-demographic information and characteristics of study participants

The mean age of participants in the study was 54 years (SD 7.4). Female respondents constituted 58% of the total sample. Members of the DHTCTs constituted 66% of the total sample while DHC members constituted 34%. The majority of participants were health managers or officials (82%) and the remaining participants were politicians (12%). The mean time served as a member of a governance structure was 6 years (SD± 4.05).

The majority of participants (92%) reported that they were familiar with the National Health Act, and 96% indicated that they understood the role of the relevant governance structures. All participants had attended at least one meeting of the DHC or DHCTC, respectively, with 77% having attended a meeting in the preceding three months. The socio-demographics information and characteristics of all the study participants are presented in Table 4 below.

Table 4. Socio-demographic information and characteristics of study participants

	N (93)	%
Gender		
Male	39	42%
Female	54	58%
Age		
Mean age (years)	54 (SD 7.4)	
Type of structure		
DHC	32	34%
DHCTC	61	66%
Member portfolio		
Politician	11	12%
Ex-officio manager or official	82	82%
Mean time as member	6 years (SD 4.0)	

3.4. Functioning of the governance structures

3.4.1. Perceptions of functioning

The mean score for functioning was 4.5 (SD ± 0.74) out of a possible score of 7. The lowest scoring items on the scale related to punctuality for meeting times, whether council/committees had a relationship with clinic committees, and whether individuals had received orientation on the district health system. The highest scoring items on the scale were individual understanding on district health services, clear understanding of their role on the structure, and active participation in meetings. These results are presented in Table 5 below.

Table 5. Mean scores for the functioning of governance structures

Item	Min	Max	Mean (SD)
Overall perception score for functioning	2.2	5.7	4.5(0.7)
Schedule of meetings received for the year	1	7	5.6 (1.7)
Agenda for meetings clear	1	7	5.3 (1.5)
Meetings start on time	1	7	4.4 (1.8)
Receive documents for meeting timeously	1	7	4.7 (1.8)
Decisions are taken at every meeting	1	7	5.0 (1.5)
Council/Committee decisions are transparent	1	7	5.4 (1.3)
Council/Committee follows up on recommendations made in previous meetings	1	7	5.0 (1.6)
Clear onrole on the council/committee	1	7	5.9 (1.0)
Clear on role of sub-committees	1	7	5.0 (1.3)
Received orientation on DHS	1	7	3.8 (2.1)
Personally understand discussions about DHS	1	7	6.0 (1.0)
Participate actively in meetings	1	7	5.9 (0.9)
Have access to facts that guide decision making at every meeting	1	7	5.1 (1.5)
Regularly review data on DHS performance	1	7	4.7 (1.9)
Health outcomes for the district discussed at council/committee meetings	1	7	5.1 (1.6)
Member perceives hospital boards are important to the DHS	1	7	5.7 (1.1)

* N=93 for all items

3.4.2. Differences in functioning scores by socio-demographic characteristics

There was a significant difference in perceived functioning scores between structure type (p= 0.05) and a marginally significant difference in scores between districts (p= 0.08). The mean score for the DHCs (4.46 ±1.09) was slightly higher than that of DHCTC (4.35 ± 0.84). The district municipalities obtained higher mean scores than the metropolitan municipalities. These are presented in Table 6 below.

Table 6. Differences in functioning means scores by socio-demographic characteristics

Socio-demographic variable	Functioning mean score	Standard deviation	P-value
Gender			
Male	4.44	0.76	
Female	4.46	0.73	0.89
Governance structure type			
DHC	4.46	1.09	
DHCTC	4.35	0.84	0.05*
Districts			
Ekurhuleni	3.68	0.73	
Johannesburg	4.27	0.62	
Tshwane	3.99	0.74	
Sedibeng	4.43	0.59	0.08

Socio-demographic variable	Functioning mean score	Standard deviation	P-value
West Rand	4.47	0.85	
Member type			
Chairperson	4.72	0.51	
Ex-officio manager	4.41	0.76	0.47
Politician	4.49	0.74	

*These variables are significant

3.4.3. The association between socio-demographic characteristics and perceived functioning scores

The multiple linear regression analysis conducted to model the relationship between socio-demographic characteristics and perceived functioning was significant (F 1.9, p=0.05), with an R^2 of 0.18. The significant predictor variable in the model was district (p=0.05). The relationship between socio-demographic characteristics and functioning scores from the linear regression model are presented in Table 7 below.

Table 7. Relationship between socio-demographic characteristics and functioning scores from linear regression model

Characteristic	Co-efficient	95% CI	Adjusted p-value
Age	0.09	-0.13 - 0.31	0.45
Gender			
female	Ref		0.17
male	0.08	-0.23 - 0.41	
Governance structure			
DHC	Ref		0.33
DHCTC	-0.094	-0.47 - 0.28	
District			
Ekurhuleni	Ref		
Johannesburg	0.49	-0.01 - 0.98	
Tshwane	0.33	-0.15 - 0.82	0.05
West Rand	0.70	0.09 - 1.30	
Sedibeng	0.73	0.19 - 1.28	
Portfolio			
Chairperson	Ref		0.30
Politician	-0.54	-1.26 - 0.17	
Ex-officio member	-0.29	-0.78 - 0.19	
Membership time	0.05	-0.03 - 0.04	0.78

3.5. Perceptions on the effectiveness of the governance structures

3.5.1. Perceptions of effectiveness

The mean score for effectiveness was 4.8 (SD± 0.7) out of a possible 7. The scores for the highest and lowest scoring items are presented in Table 8 below.

Table 8. Mean scores for the effectiveness of governance structures

Item	Min	Max	Mean (SD)
Overall perception score for effectiveness	1	5.5	4.8(0.7)
Chairperson keeps members focused on DHS developments	1	7	5.1 (1.5)
All committed to co-operative governance	1	7	5.0 (1.7)
All participate in development of district health plan	1	7	5.6 (1.4)
There is tension among council/committee members and the provincial executive management	1	7	3.4 (1.6)
There is tension among council/committee members and local government managers	1	7	3.4 (1.6)
Personal knowledge on budget for district health services	1	7	5.3 (1.8)
Council/committee is accountable to community	1	7	4.6(1.7)
Council/committee has a good working relationship with MEC for Health	1	7	5.0 (1.2)
Council/committee has criteria to monitor progress toward its goals	1	7	4.6 (1.7)

Item	Min	Max	Mean (SD)
Collectively examine progress against agreed upon targets	1	7	5.2 (1.5)
Collectively interrogate deviations from targets	1	7	5.0 (1.5)
Collectively interrogate deviations from budget	1	7	5.0 (1.7)

n=93 except the last statement where n=92

As shown in Table 8, the lowest scoring items on the scale related to structures not having criteria to monitor progress toward their goals and accountability to community. The tension among structure members variable received a score that is mid-point on the 7-point scale. The highest scoring items on the scale were participation in district health planning, knowledge and engagement with district health budget, and engagement on targets for district.

3.5.2. Differences in effectiveness scores by socio-demographic characteristics

For effectiveness, there was a significant difference in score between the districts ($p<0.01$) with district municipalities having a higher mean score than the metropolitan municipalities. These results are presented in table 9 below.

3.5.3.The association between socio-demographic characteristics and perceived functioning scores

The regression analysis conducted to model the relationship between socio-demographic characteristics and perceived functioning was significant (F 2.61,

p=0.008), with an R^2 of 0.25. The significant predictor variable in this model was district (p=0.005).

Table 9. Perceived effectiveness mean scores by socio-demographic characteristics

Socio-demographic variable	Effectiveness mean score	Standard deviation	P-value
Gender			
Male	4.60	0.84	0.02*
Female	5.01	0.56	
Governance structure type			
DHC	4.78	0.77	
DHCTC	4.90	0.68	0.48
Districts			
Ekurhuleni	4.5	0.73	
Johannesburg	5.1	0.50	
Tshwane	4.5	0.77	
Sedibeng	5.0	0.85	<0.01*
West Rand	5.1	0.55	
Member type			
Chairperson	4.85	0.79	0.82
Ex-officio manager	4.88	0.70	
Politician	4.73	0.76	

Table 10. Relationship between socio-demographic characteristics and effectiveness scores from linear regression model

Characteristic	Co-efficient	95% CI	Adjusted p-value
Age	0.11	-0.08 - 0.32	0.24
Gender			
Male	Ref		0.20
Female	0.19	-0.11 - 0.48	
Governance structure			0.53
DHC	Ref		
DHCTC	-0.12	-0.49 - 0.26	
District			
Ekurhuleni	Ref		
Johannesburg	0.64	0.19 - 1.18	0.005*
Tshwane	0.18	-0.26 - 0.63	
West Rand	0.85	0.29 - 1.41	
Sedibeng	0.66	0.12 - 1.10	
Portfolio			
Chairperson	Ref		
Politician	-0.28	-0.93 - 0.37	0.61
Ex-officio member	-0.03	-0.47 -0.42	
Membership time	-0.01	-0.04 – 0.03	0.79

3.6. Results of the qualitative component

Although inter-related and not mutually exclusive, the three major themes that emerged from the interviews were: facilitators or enablers of governance; constraints to governance; and accountability gaps. These themes are shown in Table 11 and presented separately for the sake of clarity.

Table 11. Emerging themes from interviews

Theme	Sub-theme
Governance enablers or facilitators	• Enabling legislation • Prescribed roles and responsibilities • Shared vision on the DHS and PHC service delivery
Constraints to governance	• Complexity of governing across two spheres of government • Political differences • Difficult inter-personal relationships • Lack of orientation • Lack of or insufficient financial resources
Gaps in accountability	• District health governance structures: relationships, interactions, and challenges • Inconsistent relationship between communities, individuals and governance structures • Forums for community engagement: synergy with DHCs

3.6.1. Governance enablers or facilitators

Key informants highlighted the enabling nature of the NHA in terms of defining their roles, responsibilities, and terms of reference. They were of the opinion that a shared vision among governance structure members on the DHS facilitates governance, and assists with the achievement of DHS goals.

Enabling legislation

The NHA was highlighted by participants as an enabler for good governance. Several DHCs and DHCTCs have not developed terms of reference that define their purpose and membership. However, participants felt that the National Health Act and its prescripts provide sufficient guidance on what they ought to be doing as governance structures. Some structures have expanded on the NHA but have by and large embraced its prescripts.

*I think our terms of reference would be what is legally required. We didn't create a separate one [terms of reference], if you ask me what should I do, I go to the National Health.***(Key informant 2)**

Participants felt that their role and responsibilities are well articulated in the NHA and they have embraced these. They understood their role to include coordination and planning for the delivery of primary health care services to the residents of their districts.

*We plan, and we do coordinate in terms of geographical areas to ensure that our district is well covered with primary health care services.****(Key informant 2)***

The DHCTCs similarly have adopted their role for technical committees as outlined in the NHA as advisory structures to the DHCs. Two quotes from participants that illustrate technical support and guidance to political principals provided by managers are presented below.

For me the technical committee is an advisory structure to the District Health Council. So we'll deal with all technical work related to planning, and delivery of services in the district. Then advise the District Health Council on the plans, on the budget, on emerging conditions that might impact on the performance of the district. ***(Key informant*1)**

*There's a clear change that we want to bring in people's lives. So we need to have a plan and a vision. That's why we have to meet because that vision we need then to share it with the politicians but also give the politicians something they can bite on. So we have to meet and agree, what we are all going to be selling to the politicians for us to be able to move and get somewhere.***(Key informant 5)**

Shared vision on the DHS and PHC service delivery

Participants felt that the achievements of the governance structures cannot be distinguished from the achievements of the district health system, as the latter is the vehicle for the successful implementation of primary health care. They described a number of progress areas in the district health systems, such as expanding primary health care services and improving performance in key programmes. Participants felt that expanded PHC services are a major achievement for local government facilities that had a limited service package and service hours in the past. Integration of support services such as pharmacy services and sharing of human resources have helped to improve efficiency across all facilities. The following quotes illustrate these sentiments.

*In the last twelve months' we've extended services hours. We've got now 13 clinics that are rendering extended service hours.***(Key informant 8)**

The pharmacy that we own as the city [local government], we decided will supply all the clinics…We supply all clinics regardless of who pays the salary and they have given ussome staff. We've even got a vehicle now with a driver that supplies to all the clinics through us [meaning local and provincial government] working together.

(Key informant 5)

Participants pointed out that these achievements were made possible through the engagement at council and committee levels, joint planning for the district health services and the signing of the service level agreement between the two spheres of government.

*[Speaking on achievements] Expanding the service package, especially in local government facilities because that was always a sore point that some of the facilities don't provide all services. So in these engagements mostly it's about that, to push to make sure that we all provide all the relevant services.***(Key informant 2)**

[Speaking on achievements] It's the approval of the District Health Plan itself because it's a joint process. Then this team [speaking of the DHCTC] plays a very important role in making sure that there's agreement of the plan. And finally getting the service level agreement signed…Between the two authorities on what should be expected in local government facilities for the subsidy that province is paying. **(Key informant 1)**

3.6.2. Constraints to governance

Participants commented on the constraints to governance, such as the complexity of governing across two spheres of government, difficult political and inter-personal relationships, and the lack of orientation of members on the DHS.

Complexity of governing across two spheres of government

Participants highlighted the complexity of having two spheres of government operating in the same "space". At the same time, they articulated their frustrations with the duplication of management structures and people working in silos. Participants pointed to the fact that this is driven by different priorities between provincial and local government.

We have the two centres of power, maybe that I would say that, and different mandates. For instance they look at their own specific areas as we would have ours. **(Key informant 3)**

*At our previous meeting I focused on that [speaking of local government priorities] and I realised but we're a bit one-sided. We are here to serve the district as a whole. So yes, me being new, I'm learning, to expand my own frame of reference with regards to District Health Services.***(Key informant 2)**

Political differences

According to participants, differences are not as easy to bridge when they are along political lines and alliances. This is evident in the fact that some districts have not been able to set up and have functional District Health Councils due to tensions along

political lines. A participant from one such district is quoted as saying:

*Unfortunately we did not start off on a very good footing. We have not had a single sitting since the new administration .You know the psychological climate between us and Province was not good, you know, especially at a political level.***(Key informant 6)**

Difficult interpersonal relationships

The working relationships are further complicated by egos and attitudes of individuals, which create a tense working environment. Participants reported finding themselves having to navigate and negotiate personality differences and communication styles prior to delving into issues affecting district health services. Despite this, the chairpersons appeared to have developed mechanisms in dealing with the differences in order to put service delivery at the fore. Two quotes from chairpersons that demonstrate this commitment are shown below.

*Sometimes our egos control how we respond to issues in a meeting because sometimes we don't feel like…we don't want to be seen to be taking instructions from others in front of our subordinates. Then you engage separately in an informal way. Maybe you can have lunch or breakfast together just to talk outside the work pressures.***(Key informant 1)**

*Like any working relationship I normally say it's…it's a marriage where you are…you are in a marriage, sometimes you want to walk away, but you've got children to look after so you can't walk away.***(Key informant 5)**

Lack of orientation of members

Notwithstanding the enabling nature of the National Health Act, the lack of orientation of members emerged as a constraint.

*What we do is supposed to be a technical assistance to the council, but we are discussing operational issues which is incorrect. Because when we get called, we get caught in a situation where if we have to go to the provincial health council, we start now looking at what the provincial health council actually wants from us without having discussed it in that technical council meeting.***(Key informant 3)**

*We don't really have a very good orientation programme for the new intake of personnel and that I think is also one of the challenges.***(Key informant 4)**

This lack of orientation influenced both the functioning and focus of the meetings. Participants felt that at times, the meetings are operational in nature and deviate from the purposes of the structure.

Lack of or insufficient financial resources

Participants highlighted how lack of resources, particularly in terms of budget has hindered their progress as governance structures but also as districts. All of the participants were of the opinion that districts are not adequately funded to deliver on the requirements and aspirations set by the National Department of Health. Two chairpersons speaking on insufficient financial resources said the following.

As a Council we don't have any budget. Really without budget... everything works with money. So it's difficult for me because now I have ideas and I have got a very flexible executive director that's willing to serve. We have programmes that we

wanted to put them out, but if we don't have budget it's a problem.
(Key informant 7)

Speaking specifically on resources for delivering district health services, two participants said the following:

We have been going through a lot of development in terms of getting new services into the district health services, it has come to a point where what we do today doesn't compare to what we did before. The package has become so big, but unfortunately there was no budget following that. You will take over facilities, render twenty-four hours services on instruction but you don't have doctors, you don't have nurses. **Key informant 3)**

With the program outcomes [speaking of challenges], it's also budget constraints to really implement all the goals and objectives for specific programs. For instance, our events budget and you know with primary health care a large component is preventative and promotive. So with the promotive component you really need to reach out to the community and for that you need budget and that's something that always gets cut the first. **(Key informant 8)**

The frustration came across more so with the smaller municipal districts with their chairpersons conveying a feeling of being forgotten. A participant said the following:

*Most of the time I'm saying to the MEC's that it's like we are the crying babies. [District name] is not being taken seriously in Gauteng. It's like we are Bloemfontein people you know. And we are also a part of Gauteng.***(Key informant 7)**

3.6.3. Gaps in accountability to communities

The participants highlighted several gaps in accountability to communities, such as insufficient community awareness of governance structures, insufficient linkages between district health system governance and community structures, and with surrounding communities.

<u>Inconsistent relationship between communities, individuals and governance structures</u>

In exploring perceptions regarding the interaction and relationship between governance structures and the community, polarised viewpoints emerged. Some participants expressed very close community linkages.

*We have that good relationship. Like in the morning, when we were at a clinic in , myself and MEC will even engage community to say we are having a suggestion box, whatever challenges we have nurses you should not wait for us to go to radio station to complain. We have your suggestion box and when that suggestion box is open, one patient amongst you guys can also be part to…to witness what is happening actually.***(Key informant 7)**

In contrast, other participants indicated that there was no interaction, and that they had not thought what it means to be accountable to communities in practice.

There's no interaction whatsoever [referring to the community]. I wonder how many residents are aware of this entity called the District Health Council. Only the few informed or that might have been involved with it. We haven't even contemplated what is our responsibility, or what should we communicate with, or how should we involve them…I think, if I can say what I sense, is that we need not or we do not

*want to or we do not have to communicate to give feedback in any way. We should take into account their interest, the health needs and as executing authorities, province, ourselves…we need to do what's best for them.***(Key informant 2)**

District health governance structures: relationships, interactions, and challenges

Emerging from the interviews was also the idea that other structures exist at community level (such as clinic committees) to ensure accountability and community engagement.

*It is through the Clinic Committees [speaking on accountability and community participation]. Each Clinic Committee has got a chairperson. And if there are any challenges or any information that needs to be given to the community, the Clinic Committee with the Ward Councillor within the catchment area of that particular clinic then they communicate that at their public meetings.***(Key informant 9)**

Even when these structures were highlighted as ensuring accountability, participants indicated that these structures in themselves had several challenges. There was some scepticism raised on the authenticity in the manner that people were elected as members of clinic committees, and allegations of political interference. A participant said the following regarding the recruitment and appointment of the committees:

When I first started I thought that I would have some level of oversight over the clinic committees as well and I saw them as a tool that I could use to link up with communities. However I was told that these are appointed by the MEC and not by the MMC, even where the service has been delegated to a local municipality. So adverts went out a few months ago for clinic committees and there were problems with that whole recruitment process. A lot of the councillors were wanting to politicize clinic committee's or highjack the work of the clinics through committees. And they

*were wanting to highjack the whole process and make sure that there was cadre deployment.***(Key informant 6)**

Forums for community engagement: synergy with DHCs

Several participants also highlighted that there were other platforms for direct community engagement which they participated in. This included the Gauteng Provincial Government Ntirhisano initiative which gives residents an opportunity to engage with politicians and officials at ward level on matters of concern to them. Similarly, all municipalities produce an Integrated Development Plan (IDP) that in principle takes into account community concerns and integrates them into the plans for the municipality. While several participants praised these initiatives as a positive, some raised concern over the perceived disjuncture between issues raised at community level, issues discussed in the District Health Councils, and issues addressed in the integrated plans.

A governance related issue…its lack of integration of the IDP related issues, especially community issues into the District Health Council as the key Council itself. We appear to be working vertically. And there's no synergy between issues that were raised at the community level that we found and District Health Council for admission to the Provincial Health Council.**(Key informant 9)**

3.7. Summary of key results

The key results that emerged from this study are listed below;

1. Only three health districts of the City of Tshwane, Sedibeng and West Rand had established DHCs, while the Metropolitan Cities of Johannesburg and Ekurhuleni had not
2. The mean score for functioning was 4.5(SD=0.7), with the lowest scoring items for punctuality for meetings, relationship of the DHC with clinic committees, and whether individuals had received orientation on the district health system
3. The mean score for effectiveness was 4.8(SD=0.7)with the lowest scoring items for existence of criteria to monitor progress toward their goals and accountability to communities.
4. The interviews found that enabling legislation, which prescribes roles and responsibilities, and a shared vision on DHS and PHC service delivery facilitated governance. In contrast, the complexity of governing across two spheres of government, exacerbated by political differences, difficult interpersonal relationships, lack of orientation and lack of or insufficient resources constrained DHS governance.
5. Both the survey and interviews identified gaps in accountability to communities.

The next chapter discusses the results in light of the South Africa's quest for UHC, and the importance of governance to the achievement of health outcome goals.

CHAPTER 4: DISCUSSION

4.1. Introduction

There is global recognition that leadership and governance are critical for achieving UHC (35). Similarly in South Africa, the envisioned changes to the delivery of health-care services under the NHI system (7) necessitate effective governance of health services at district and sub-district level.

This study set out to ascertain whether DHS governance structures have been established in accordance with the NHA, and to assess the perceptions of the members on the functioning and effectiveness of these governance structures. This chapter draws on relevant literature and the discourse on UHC to discuss the study findings and the implications for district health systems in Gauteng Province.

4.2. Existence of governance structures in Gauteng

The study found that only three of the five districts had established DHCs. These three councils complied with the prescripts of the National Health Act in terms of the Chair (MMC for Health), and membership composition. However, the two large Metropolitan Cities of Johannesburg and Ekurhuleni did not have formal DHCs. Some of the reasons cited for the lack of these structures included political tensions and difficult inter-personal relationships. These findings are similar to those of a comparative study conducted in Kenya and Indonesia in 2018, which found that political differences and power dynamics constrained the ability of people to work together and were threats to good governance (51). These researchers recommended early identification of such problems to ensure remedial action and appropriate intervention (51).

The 2014/15 world economic and social survey also emphasised the importance of effective governance structures to facilitate the implementation of development policies (52). In South Africa, the NHA makes provision for the existence of the DHCs (9). The absence of DHCs illustrates the gaps between policy and implementation that have been described by several authors (53, 54). In 2018, Gray and Vawda highlighted some of the shortcomings of health policy implementation in South Africa, and "the devastating effects of maladministration and blurred boundaries between governance and management in the health system" (55).The absence of the DHCs in the two cities of Johannesburg and Ekurhuleni is of major concern, given their strategic importance to health system developments in Gauteng specifically, and South Africa in general. Given that there is an association between the quality of governance and health outcomes (15), the absence of these structures is likely to hamper efforts to improve PHC service delivery and the health outcomes of communities served in these two health districts.

Officials from both provincial and local government have the greatest membership in the DHC and DHCTC. At the time of the study in 2017/18, there were no community members on the DHCs. While the NHA makes provision for the MEC for Health to appoint "not more than five others", the Act in itself is not clear on the involvement of ordinary community members on the structure. It is possible that the lack of ordinary community member representation on these structures may be a lost opportunity to ensure maximal community participation and involvement in oversight of district health services. However, it has also been argued that when local councillors are empowered and are aware of the preference of their constituents, they represent their constituents accurately, and contribute to effective oversight (56). While local councillors are democratically elected in South Africa to represent the views of their constituents, research studies have found that they are often accountable to their political principals rather than the community members whose views they ought to represent (57).

Nonetheless, the National Department of Health (NDoH) is the custodian of the implementation of national legislation. The Department should develop a set of guidelines for the establishment of DHCs, representation of community members, and monitor the implementation of the NHA in all the health districts of the country.

4.3. The perceived functioning of the governance structure(s) in Gauteng Province.

Governance depends on the operational capacity and/or effective functioning of institutions or governance structures (3). From the survey results, the mean functioning score for all districts was 4.5 out of a possible 7, suggesting room for improvement in the way the governance structures function.

There are some encouraging and positive findings in the individual elements that were assessed in the study. The higher mean scores for participation in meetings means that there is opportunity for meaningful engagement in the meetings. The governance model of Brinkerhoff and Bossert underscores the importance of active engagement among state actors such as politicians and government officials for good governance (3). Herrera et al found that there was evidence that women's participation in policy and organisational decisions improve new born survival (37).A South African study that assessed multi-sectoral collaboration in responding to HIV through local AIDS councils highlighted that the effectiveness of their meetings depended on the participation of members in meetings, as well as their ability to make, and implement decisions emanating from the meetings (58).These studies reaffirm the positive contribution of active stakeholder participation in meetings to good governance.

The lack of formal DHS orientation was identified in the quantitative survey and again in the qualitative data as an area of weakness. Orientation training of new personnel in any organisation or structure is essential (59). It ensures that people understand the fundamental goals of an organisation or structure, and that they understand their role

and responsibilities in ensuring those goals are achieved (59). Studies have shown that what people understand as the role of the organisation prior to and after orientation can differ significantly and that orientation training positively influences job satisfaction (59). More recently, the 2016 systematic review on governance arrangements for health showed that training for DHS managers improved their skills in planning, monitoring and evaluation (37). A study conducted in the Western Cape on community participation in district health governance at a local level confirmed that health committee members have a common desire for training in community representation, the roles of the structures, and their responsibilities (32). Another study conducted by Oboirien et al on the role of district clinical specialist teams in strengthening the DHS reaffirmed the value of induction and orientation in ensuring clarity in roles and standardisation of activities from the perspective of those who have received it(60).

Another element that needs strengthening is the relationships between these structures and clinic committees. In the interviews, community structures such as clinic committees were identified as key mechanisms for facilitating community engagement. The study participants highlighted the challenges of clinic committees in terms of their recruitment and selection, and the lack of oversight over their functions. This was also found in the 2012 study on community participation in the DHS in the Western Cape, which highlighted the lack of clarity in the NHA on how the DHCs and clinic committees should link and interrelate (32).

Although this study did not examine the relationship between the functioning of district health governance structures and the ability of these structures to execute their governance functions, a study conducted on mental health-care review boards found that sub-optimal functioning of these boards led to poor oversight over the provision of mental health care services (61). Poor functioning in this instance was due to limited political support, lack of tools of the trade, and inadequate training and orientation of board members (61).

4.4. Roles and responsibilities of members of the governance structures in Gauteng province.

Role clarity of the DHCsis an enabler of good governance. The majority of survey participants indicated that they were clear on their individual roles. In the in-depth interviews; participants identified the roles of the governance structures in the planning, budgeting and coordination of district health services. Conversely, it also emerged from the in-depth interviews that while high level individuals such as the chairpersons of structures were clear on the role of structures, they were not certain if other members had the same clarity. Under the sub-theme of lack of orientation, it was suggested that meetings often focus inappropriately on operational issues rather than governance issues. A 2008 study that focused on the status of clinic committees found that there was great variation in the understanding of the roles and responsibilities in these structures, and that this hindered progress towards achieving health system goals(25). The authors recommend training and capacity development of members to ensure understanding and alignment of roles and responsibilities (25). The apparent contradictions between the survey results and the interviews with chairpersons in my study suggest that there is need for on-going capacity building and training of the members of DHCs.

4.5. Perceptions regarding effectiveness of the governance structure(s)

The mean score for effectiveness was 4.8 out of a possible 7, showing again that there is room for improvement. In the survey, the responses to the items on tensions within the structures were non-committal, as the mean scores were mid-way on the Likert scale (3.4). However, in the interviews, participants highlighted tensions along political lines and spheres of government, which have had an impact on co-operative governance. Reasons for tensions included but were not limited to having two centres of power and differing mandates. I could not find recent studies that explored relationships among members of the DHCs. A2001 study that captured the voices of district managers also identified tension within the DHS management structures,

exacerbated by lack of role clarity (39). Van Rensburg and Pelser have also highlighted how the tensions between provincial and local government have hampered progress on the DHS development (62). Similarly, Martinez et al described tensions within the health councils in Brazil, fuelled by differences among governance actors (30).

Despite these tensions, it appears that strengthening functional integration through cooperation and collaboration between provincial and local government facilitates and improves service delivery. This was highlighted in the qualitative interviews under the theme of a shared vision for DHS and the delivery of PHC. Participants highlighted district achievements that were made possible through integration and partnership. Functional integration, which refers to "the structured co-operation and collaboration between provincial and local government health for the purpose of decreasing fragmentation and duplication, enhancing service provision" has been proposed as a model to improve efficiency in the provision of PHC. The NDoH guidelines for functional integration identify DHCs as the key role players in facilitating functional integration (63). In a case study of functional integration of the HIV/AIDS/sexually transmitted infections/tuberculosis (HAST) programme in Mitchells Plain Cape Town, Gilson et al shed light on how functional integration between local government and province improved the HAST programme (31). This was done through improved communication across the organisational boundaries and pooling of resources, which facilitated improved collaboration for the improvement of the HAST programme (31).

In the survey results, accountability to community obtained a low score, and this was highlighted in the in-depth interviews with chairpersons. Low accountability to communities is exacerbated by the uncertainty among some participants on how they should interact with communities and what should be communicated to communities. Some participants held the view that they could decide unilaterally what was in the best interest of residents in terms of delivery of health services. This authoritarian view is not uncommon among political leaders and health officials (3). This viewpoint however goes against the principles of citizen participation and responsiveness

(3).Báez and Barron in their 2006 literature review of community participation in health-care across East and Southern Africa similarly found gaps in community participation and accountability (64).They highlighted the importance of two-way communication between governance structures and communities in bridging the gaps and the importance thereof for effective governance (64).They noted that where communication did not happen, it reduced the effectiveness of these committees in the priority setting and response to community needs (64). Baez and Barron recommended that communication strategies be developed and implemented (64).

A positive finding in both the quantitative and qualitative components is the reported high participation in district health planning. In the qualitative data, this was highlighted as a facilitator for district health achievements. The benefits of joint planning at district level have been articulated by district managers in South Africa. Planning helps district managers to create a sense of team-building and overcome fragmentation (64). This reaffirms that agreement, and a shared goal, have a positive impact on cooperative governance and performance of the health system.

While shared goals are important in facilitating performance, there ought to be criteria to monitor progress toward these goals. One of the lowest scoring items was structures having criteria to monitor progress towards their goals. Without a strong monitoring and evaluation framework, it will be difficult for the structures to demonstrate progress towards their goals and demonstrate where progress is made. This viewpoint is reiterated in the policy framework for monitoring and evaluation in all government departments in South Africa (65). The policy identifies monitoring and evaluation as a process that can be used to identify factors which contribute to government's service delivery outcomes, identify challenges and how they can be addressed, and also successes with the aim of replicating them(65). The policy mandates that all government departments are expected to report on their goals, plans and activities using performance indicators that are predetermined and specific (65). While there is information on monitoring of district health plans and the implementation, the monitoring of governance structures and the progress they make

in improving health-service delivery are not well documented. In 2004, Clayton et al explored the potential for clinic committees as community structures that could be used to improve maternal child health programmes (66). They commented on the lack of a specific monitoring and evaluation framework for assessing the functionality of clinic committees (66). Their findings suggest that at most, the monitoring for these structures is limited to verifying the existence of meetings (66). The implications are that even if structures are in place, the absence of a clear monitoring and evaluation framework make it difficult to demonstrate their contribution to improving the health system.

CHAPTER 5: CONCLUSION AND RECOMENDATIONS

5.1. Introduction

This study used a combination of qualitative and quantitative methods to explore the functioning and effectiveness of district health governance structures from the perspective of the members of these structures in Gauteng Province. The study generated new knowledge on the existence of the DHC, their perceptions of their roles, functioning and effectiveness of these structures in light of the prescripts of the NHA.

DHCs have not been established in all the districts in Gauteng, and the mean scores on functioning and effectiveness suggest room for improvement. The study has also highlighted the factors that may enable effective governance and thus improve the performance of the DHS. In light of South Africa's move toward NHI, strengthening governance of the DHS is imperative. Under NHI reforms, the focus on health service management and governance within the DHS will be re-invigorated, with the establishment of PHC units at district and sub-district level, responsible for coordinating health services within the DHS (50). The findings of this study can be used to strengthen the existing good governance practices, and correct the weaknesses in governance. The key recommendations emanating from this study are described in the next section.

5.2. Recommendations

The proposed recommendations of this study are based on the study findings. They are presented in Table 12 and discussed below.

Table 12. Summary of recommendations

Recommendation	Responsible for implementation			
	Individual Member	**DHC**	**Provincial DoH**	**National DoH**
Develop of a national guidelines on DHS governance structures				X
Develop clear monitoring and evaluation criteria for DHS governance structures			X	X
Budget allocation to DHS governance structures			X	X
Ensure policy implementation		X	X	
Orientation and training of governance structure members		X		
Annual workshop of all governance structures	X	X		
Research			X	X

5.2.1. The development of a comprehensive set of national guidelines on DHS governance structures

The study has shown the enabling nature of the NHA in prescribing the structures, roles and functions of DHS governance structure. However, the study has demonstrated areas where there is insufficient clarity on the role of ordinary community members, how district level governance structures should interact with each other and with communities. In order for governance structures to function effectively, it is recommended that a set of national guidelines be developed. The

guidelines should focus on the importance of governance, and outline the principles of good governance. The target audience for these guidelines includes all members of governance structures. The purpose of these guidelines would be to:

I. Clarify the composition of the DHCs and what governance structures ought to do;
II. How they differ from district management teams;
III. How the different structures at district level should interact among themselves;
IV. How these structures should interact with communities.

The guidelines should also give guidance on meeting etiquette including but not limited to meeting preparedness and punctuality.

5.2.2. The development of clear monitoring and evaluation framework with criteria for DHS governance

Given the importance of the DHS and the governance thereof, the NDoH should develop a monitoring and evaluation framework with clear, but limited criteria and indicators for district governance in consultation with provincial and local government. This should allow for the monitoring of structures in terms of their existence, their goals, targets, progress and challenges. The application of this framework in all districts will allow for standardised reporting on an annual or quarterly basis. These reports should be made publically available and easily accessible to facilitate public engagement and accountability.

5.2.3. Budget allocation to DHS governance structures

The lack of financial resources is a constraint to governance. As such, it is recommended that the NDoH mandate all provinces to dedicate a line item in the health budget for the development and strengthening of DHS governance.

5.2.4. Ensure policy implementation

While it is accepted that the development of legislation and guidelines enables good governance, the existence of strategic policy frameworks in the absence of implementation is fruitless. Regardless of what new legislation or policies for governance might come to be, these need to be followed by support from national and provincial government to ensure that they are implemented at the local level. The MEC for health and local government, and MMCs for health in each district should ensure that governance structures are constituted and supported in their functions.

5.2.5. Orientation and training of governance structure members

It is essential that a comprehensive orientation and training programme for the members of governance structures be developed. The orientation and training programme should include but not be limited to the DHS and the PHC approach, the legislative and policy mandates for the DHS, the governance structures at district level and their envisioned roles and functions, and lastly the individual roles of members in the structures. Due to the ever changing nature of the health system and policy environment, this should be done annually and not just at commencement of employment or membership in a governance structure. Given the diverse backgrounds of those who form part of DHS and the governance structures, the orientation and training should be tailored to ensure that it is accessible, relevant, and usable by all who attend.

5.2.6. Annual workshop of all governance structures within the province

The findings of this study highlight significant differences in perceived functioning and effectiveness across the various districts. The initiation of annual workshops with all stakeholders would allow for the sharing of best practices. Districts are likely to perform well and poorly in different areas. The workshops could provide an opportunity to learn from each other. Taking a quality improvement and learning approach on governance practices could improve the effectiveness of the structures.

In the absence of legislation that provides for a single authority to deliver district health services, the workshops could also be used as a platform to strengthen inter-personal relationships and cooperative governance. The interaction and team-building nature of these workshops could in the interim be used to overcome the challenges associated with fragmentation and political differences within the DHS, which hamper effective DHS governance. The success of these workshops will depend on the willingness of politicians, managers to cooperate, as well as participate in a meaningful way.

5.3. Areas for further research

This study on governance of district health systems was based on perceptions of key informants within districts. It would add value to have more studies that assess governance using more objective, quantitative assessment methods. This would eliminate the potential bias associated with self-reported measures of functioning and effectiveness. It is recommended that a nation-wide study be commissioned that focuses on what structures are in place, how they are functioning, and if they are effective Furthermore, to fill the gap in knowledge on the impact of community participation, this study should assess the effect of community participation on policy and decision making. The study could serve as a baseline for the country, and could assist in ensuring the appropriate measures for governance are put in place to facilitate the successful implementation of the NHI.

5.4. Conclusion

The findings of this study highlight several governance gaps, including the absence of DHCs in key metropolitan districts, as well as varying levels of functioning and

effectiveness. Furthermore, the study identified gaps in accountability and inconsistent relationship between communities, individuals and governance structures. While some strength and enablers such as the existence of legislation to guide structures and a shared vision for DHS were also identified and can be leveraged against, the gaps and challenges need to be addressed to ensure the successful implementation of DHSs.

REFERENCES

1. World Health Organization. Everybodies Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action. Geneva: World Health Organization; 2007.
2. Saltman R, Bankauskaite V, Vrangbaek K. Decentralization in Health Care. Glasgow: World Health Organization; 2007.
3. Brinkerhoff D, Bossert T. Health governance: principle-agent linkages and health system strengthening. Health Policy and Planning. 2014 Sep;29(6):685–93.
4. United Nations. Transforming our world: the 2030 Agenda for Sustainable Development. New York: United Nations; 2015.
5. World Bank Group. World Development Report: Governance and the Law. Washington DC; 2017.
6. National Planning Commision. National Development Plan: Vision 2030. Pretoria: National Planning Commision; 2011.
7. Department of Health. National Health Insurance Policy: Towards universal health coverage. Pretoria: National Department of Health (NDoH); 2017.
8. Republic of South Africa. Constitution of the Republic of South Africa, Act 108 of 1996. 1996.
9. Republic of South Africa. National Health Act of 2003. Government Gazette No 469;2004.
10. Department of Health. White Paper for the Transformation of the Health System in South Africa. Government Gazette No. 17910: National Department of Health; 1997.
11. Hall W, Ford-Ngomane T, Barron P. Health act and the district health system. South African Health Review 2005. Durban: health Systems Trust; 2005.
12. Rispel LC, Moorman J, Munyewende P. Primary health care as the foundation of the South African health system: myth or reality? In: Meyiwa T, Nkondo M, Chitiga-Mabugu M, Sithole M, Nyamnjoh F, editors. State of the Nation South Africa 2014- South Africa 1994-2014: A twenty-year review. Cape Town: HSRC Press; 2014. p. 378-94.
13. Naledi T, Barron P, Schneider H. Primary Health Care in SA since 1994 and Implications of the New Vision for PHC re-engineering. In: Padarath A, English R, editors. South African Health Review 2011. Durban: Health Systems Trust; 2011.
14. Rispel L. Analysing the progress and fault lines of health sector transformation in South Africa. In: Padarath A, King J, Mackie E, Casciola J, editors. South African Health Review 2016. Durban: Health Systems Trust; 2016.
15. Makuta I, O'Hare B. Quality of governance, public spending on health and health status in Sub Saharan Africa: a panel data regression analysis. BMC Public Health. 2015;15(932).
16. Rispel L, Moorman J. Health policy reforms and policy implementation in South Africa: A paradox? In: Daniel J, Naidoo P, Pillay D, Southall R, editors. New South African Review 3: The second phase-tragedy or farce? Johannesburg: Wits University Press; 2013. p. 239-60.
17. The Presidency SA. Twenty year review South Africa, 1994-2014. Pretoria: Government Printing Works; 2014.
18. Van Rensburg HCJ. Health and health care in South Africa. Pretoria: Van Schaik; 2012.

19. Van Rensburg HCJ. South Africa's protracted struggle for equal distribution and equitable access – still not there. Human Resources for Health. 2014;12(26).

20. World Health Organization. The challenge of Implementation: District Health Systems for Primary Health Care, Part A. Geneva: World Health Organization; 1988.
21. World Health Organization. Health systems strengthening glossary 2017 [07-06-2017]. Available from: http://www.who.int/healthsystems/hss_glossary/en/index3.html
22. McCoy D, Engelbrecht B. Establishing the District Health System. South African Health Review 1999. Durban: Health Systems Trust; 1999.
23. Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata,USSR,6-12 September 1978; 1978.
24. World Health Organization. Health system decentralization: Concepts, issues and country experience. Geneva: World Health Organization; 1990.
25. Padarath A, Friedman I. The status of clinic committees in primary level public sector facilities in South Africa. Durban: Health Systems Trust; 2008.
26. Siddiqi S, Masud T, Nishtar S, Jama M. Framework for assessing governance of the health system in developing countries: Gateway to good governance. Health Policy 2009;90(1):13-25.
27. Pyone T, Smith HL, van den Broek N. Frameworks to assess health systems governance: a systematic review. Health Policy and Planning. 2017;32(5):710-22.
28. Serapioni M, Duxbury N. Citizens' participation in the Italian health-care system: the experience of the Mixed Advisory Committees. Health Expectations. 2012;17.
29. Cleary S, Molyneux S, Gilson L. Resources, attitudes and culture: an understanding of the factors that influence the functioning of accountability mechanisms in primary health care settings. BMC Health Services Research. 2013;13(320).
30. Martinez M, Kohler J. Civil society participation in health system: the case of Brazil's Health Councils. Globalization and health. 2016;12(64).
31. Gilson L, Barasa E, Lehmann U. Everyday resilience in district health systems: emerging insights from the front lines in Kenya and South Africas. BMJ Glob Health. 2017;2(2).
32. Meier B, London L. Implementing community participation through legislative reform: A study of the policy framework for community participation in the Western Cape province of South Africa. BMC International Health and Human Rights. 2012;12(15).
33. World Health Organization. Health Systems Governance for Universal Health Coverage: Action Plan. Geneva: World Health Organization; 2014.
34. United Nations. Transforming our world: the 2030 Agenda for Sustainable Development. New York: United Nations; 2015.
35. World Health Organization. Draft thirteenth general programme of work, 2019–2023. Report by the Director-General. World Health Assembly Seventy-first World Health Assembly, 71/4, Provisional agenda item 11.1. Geneva: World Health Organization; 2018.
36. Hort K, Jayasuriya R, Dayal P. The link between UHC reforms and health system governance: lessons from Asia. Journal of Health Organization and Management. 2017;31(3):270-85.
37. Herrera CA, Lewin S, Paulsen E, Ciapponi A, Opiyo N, Pantoja T, et al. Governance arrangements for health systems in low-income countries: an overview

of systematic reviews. Cochrane Database of Systematic Reviews. 2017(9):Art. No.: CD011085.

38. Byleveld S, Haynes R, R. B. District management study. A review of structures, competencies and training interventions to strengthen district management in the national health system of South Africa. Durban: Health Systems Trust; 2008.
39. Masilela T, Molefakgotla P, Visser R. Voices of district managers. Durban; 2001.
40. Padarath A, Barron P, editors. South African Health Review 2017. Durban: Health Systems Trust; 2017.
41. Mid-year population estimates 2018 [press release]; 2018 [cited 2019 Jan 03]
42. Gauteng City-Region Observatory. The Gauteng City Region 2019 [cited 2019 Mar 01] Available from: www.gcro.ac.za.
43. Sambo LG, Chatora RR, Goosen E. Tools for Assessing the Operationality of District Health Systems. Brazzaville: World Health Organization Regional office for Africa; 2003.
44. Paul A. Harris, Robert Taylor, Robert Thielke, Jonathon Payne, Nathaniel Gonzalez, Conde JG. Research electronic data capture (REDCap) – A metadata-driven methodology and workflow process for providing translational research informatics support. J Biomed Inform. 2009;42(2):377-81.
45. StataCorp. Stata statistical software. Release 13 College Station, TX: StataCorp LP. 2013.
46. Mutale W, Tembo M, Balabanova D, Spicer N. Measuring governance at health facility level: Developing and validating a simple governance tool in Zambia BMC International Health and Human Rights. 2013;13(34).
47. Choi B, Pak A. Understanding and minimizing epidemiological bias in public health research. Canadian Journal of Public Health. 2005;96(4).
48. Althubaiti A. Information bias in health research: definition, pitfalls, and adjustment methods. Journal of Multidisciplinary Healthcare. 2016;9.
49. Sackett D. Bias in analytic research. J Chron Dis. 1979;32.
50. Department of Health. National Health Insurance Bill. Government Gazette No 42598. 2018.
51. McCollum R, Limato R, Otiso L, Theobald S, Taegtmeyer M. Health systems governance following devolution: comparing experiences of decentralisation in Kenya and Indonesia. BMJ Glob Health. 2018;3.
52. United Nations. World Economic and Social survey 201415: Learning fron national policies supporting MDG implementation. United Nations; 2016.
53. Brauns M, Stanton A. Good governance and the implementation of National Health Insurance in the Public Sector: A case of South Africa. Journal of Governance and Regulation. 2015;4(4).
54. Brauns M, Wallis M. Policy Implementation And the Promotion of Service Delivery within the Public Sector in South Africa. The International Journal of Business & Economics. 2014;13(2).
55. Gray A, Vawda Y. Health legislation and policy In: Padarath A, Rispel LC, editors. South African Health Review 2018. Durban: Health Systems Trust; 2018.
56. Hankla CR. Decentralization, Governance, and the Structure of the Local Political Institutions: Lessons for reform? Political Science Faculty Publications: Georgia State University; 2010.

57. Reddy PS. The politics of service delivery in South Africa: the local government sphere in context. The Journal for Transdisciplinary Research in South Africa. 2016;12(1).
58. Mahlangu P, Vearey J, Thomas L, Goudge J. Implementing a multi-sectoral responce to HIV: a case study of AIDS councils in the Mpumalanga Province, South Africa. Global Health Actions. 2017;10(1).
59. Georgellis Y, Lange T, Tabvuma V. Orientation Training and Job Satisfaction: A Sector and Gender Analysis. Journal of Human Resource Management. 2015;80(2):464-73.
60. Oboirien K, Eyles J, McIntyre D, Goudge J. South African Health Review 2014/15: Understanding roles, enablers and challenges of District Clinical Specialist teams in strengthening primary health care in South Africa. In: Trust HS, editor. Durban: South African Health Review; 2015.
61. Mulutsi EN. Implementation of the mental health care act in psychiatric hospitals. WIReDSpace: University of the Witswatersrand; 2017.
62. Van Rensburg HCJ, Pelser AJ. The transformation of the South African health system. In: Van Rensburg HCJ, editor. Health and health care in South Africa. Pretoria: Van Schaik; 2004.
63. Department of Health. Guideline for functional intergration: A key stratergy toward full implementation of the District Health System. Pretoria: Department of Health; 2003.
64. Baez C, Barron P. Community voice and role in District Health Systems in East and Southern Africa: A literature review. EQUINET Discussion paper 39; 2006.
65. The Presidency: Republic of South Africa. Policy framework for the Goverment-wide Monitoring and Evaluation System. Pretoria; 2007.
66. Clayton J, Bruce B, Dutschanke M, Wiilkinson S. Maximising the potential of Clinic Committees as Community Structures to promote Maternal, Neonatal, and Child Health. The Black Sash Trust; 2014.

Appendix 1

UNIVERSITY OF THE WITWATERSRAND JOHANNESBURG

R14/49 Dr K Tshabalala

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
CLEARANCE CERTIFICATE NO. M171071

NAME: (Principal Investigator)	Dr K Tshabalala
DEPARTMENT:	School of Public Health Medical School
PROJECT TITLE:	The functioning and perceived effectiveness of district health system governance structures in Gauteng Province
DATE CONSIDERED:	27/10/2017
DECISION:	Approved conditionally
CONDITIONS:	Formal approval to conduct the study must be obtained from the Provincial and District authorities and copied to the HREC (Med) prior to commencement
SUPERVISOR:	Professor L Rispel and Dr M Kawonga
APPROVED BY:	Professor PE Cleaton-Jones, Chairperson, HREC (Medical)
DATE OF APPROVAL:	15/12/2017

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary on 3rd floor, Phillip V Tobias Building, Parktown, University of the Witwatersrand, Johannesburg.
I/We fully understand the conditions under which I am/we are authorised to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated from the research protocol as approved, I/we undertake to resubmit to the Committee. **I agree to submit a yearly progress report**. The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. in this case, the study was initially reviewed in **October** and will therefore be due in the month of **October** each year. Unreported changes to the application may invalidate the clearance given by the HREC (Medical).

Principal Investigator Signature

Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

Appendix 2A

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Joburg
a world class African city

JOHANNESBURG HEALTH DISTRICT

Faculty Of Health Sciences
Research Ethics Committee,
University of The Witwatersrand
Johannesburg, South Africa
drkhanyisile@gmail.com

Enquiries: Dr EM Ohaju
Tel: 011 694 3888 Cell: 076 8831659
Email: Elizabeth.Ohaju@gauteng.gov.za
Hillbrow CHC: Administration Building
Cr Smith Str. & Klein Street
Private Bag X21, Johannesburg
South Africa, 2017

DRC Ref: 2017-12-005

NHRD Ref no: GP_201712_007

Dear: Dr Khanyisile Tshabalala

Re: ***THE FUNCTIONING AND PERCEIVED EFFECTIVENESS OF DISTRICT HEALTH SYSTEM GOVERNANCE STRUCTURES IN GAUTENG PROVINCE***

Your application dated **2017/12/06** refers.

The District Research Committee has reviewed your application. This letter serves as an in-principle approval to access the Districts Health facilities (mentioned below) for the above project subject to following conditions:

- The facility to be visited: **CITY OF JOHANNESBURG METROPOLITAN MUNICIPALITY OFFICES**
- This facility will be visited from **06/02/2018 to 06/02/2019**
- The research can only commence after you submit an ethics clearance certificate from a recognized institution.
- You will report to the Facility Manager before initiating the study.

Region	Regional Health Manager	Contact No.	Cell phone
CoJ	Mr Shikwambane	011 407 6524	082 261 4397

- Participants' rights and confidentiality will be maintained all the time.
- No resources (Financial, material and human resources) from the above facilities will be used for the study. Neither the District nor the facility will incur any additional cost for this study.
- The study will comply with **Publicly Financed Research and Development Act, 2008 (Act 51 of 2008) and its related Regulations**.
- You will submit a copy (electronic and hard copy) of your final report. In addition, you will submit a six-monthly progress report to the District Research Committee.

- Your supervisor and University of the Witwatersrand will ensure that these reports are being submitted timeously to the District Research Committee.
- The District must be acknowledged in all the reports/publications generated from the research and a copy of these reports/publications must be submitted to the District Research Committee.

We reserve our right to withdraw our approval, if you breach any of the conditions mentioned above.

Please feel free to contact us, if you have any further queries. On behalf of the District Research Committee, we would like to thank you for choosing our District to conduct such an important study.

Regards,

Dr EM Ohaju
Chairperson: District Research Committee
Johannesburg Health District
Date 8/02/2018

Mrs M. Morewane
Chief Director
Johannesburg Health District
Date: 09/02/2018

Appendix 2B

City of Ekurhuleni

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

EKURHULENI RESEARCH CLEARANCE CERTIFICATE

Research Project Title: The functioning and perceived effectiveness of District Health System Governance structures in Gauteng Province.

NHRD No: GP_201712_007

Research Project Number: 14/12/2017-06

Name of Researcher(s): Dr Khanyisile Tshabalala

Division/Institution/Company: University of Witwatersrand

DECISION TAKEN BY THE EKURHULENI HEALTH DISTRICT RESEARCH COMMITTEE (EHDRC)

- *THIS DOCUMENT CERTIFIES THAT THE ABOVE RESEARCH PROJECT HAS BEEN FULLY APPROVED BY THE EHDRC. THE RESEARCHER(S) MAY THEREFORE COMMENCE WITH THE INTENDED RESEARCH PROJECT.*
- *NOTE THAT THE RESEARCHER WILL BE EXPECTED TO PRESENT THE RESEARCH FINDINGS OF THE PROPOSED RESEARCH PROJECT AT THE ANNUAL EKURHULENI RESEARCH CONFERENCE.*
- *THE RESEARCH COMMITTEE WISHES THE RESEARCHER(S) THE BEST OF SUCCESS.*

DR. J. SEPUYA

DEPUTY CHAIRPERSON: EKURHULENI METROPOLITAN MUNICIPALITY

Dated: 14/12/2017

Dr. R. Kellerman

CHAIRPERSON: GAUTENG DEPARTMENT OF HEALTH (EKURHULENI REGION)

Dated: 14/12/2017

Appendix 2C

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

OFFICE OF THE DIRECTOR SEDIBENG DHS

Enq: Mpho Ngubane
016 950 6255
016 950 6210
E-mail: Mpho.Ngubane@gauteng.gov.za

TO : **DR. K. TSHABALALA**
WITS UNIVERSITY

FROM : **MS. S. HLAHANE**
DIRECTOR SEDIBENG DHS

DATE : **07 DECEMBER 2017**

SUBJECT : **PERMISSION TO CONDUCT RESEARCH – THE FUNCTIONING AND PERCEIVED EFFECTIVENESS OF DISTRICT HEALTH SYSTEM GOVERNANCES STRUCTURES IN GAUTENG.**

Please be informed that permission has been granted for you to carry out the abovementioned research at Sedibeng facilities. It is noted that you have already obtained Provincial Ethics Committee as well as the University of the Witwatersrand Ethics Clearance.

Kindly note that a copy of the report on the findings (especially) that concerns Sedibeng District must be submitted to the Director's office at the completion of the study.

This permission is also subject to the conditions stated in the protocol and any change in design and methodology must be communicated to the District Director.

We wish you success in your research endeavours.

Kind Regards

MS. S. HLAHANE
DIRECTOR SEDIBENG DHS
DATE: 07/12/2017

RESEARCH PROPOSAL DETAILS: GP_201712_007

Sedibeng DHS, Cnr Frikkie Meyer & Pasteur BLVD, Private Bag X 023 Vanderbijlpark

Appendix 2D

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

ENQUIRIES:
Office of the CEO
Dr JC Ganda
T | 018 788 1702
M | 073 2372437
E | Jatin.Ganda@gauteng.gov.za

7th of December 2017

To: Whom It May Concern

Re: GP_201712_007 - Dr Khanyisile Tshabalala

The above noted protocol has been reviewed and approved. The research may be undertaken at Carletonville Hospital. Carletonville Hospital pledges to provide the required support in terms of access as well as guidance should it be required.

Sincerely yours

Dr JC Ganda
CEO, Carletonville Hospital.

Appendix 2E

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Enquiries: Dr. Lufuno Razwiedani
Tel: +27 12 451 9036
E-mail: lufuno.razwiedani@gauteng.gov.za

TSHWANE RESEARCH COMMITTEE: CLEARANCE CERTIFICATE

MEETING: 10/2017
PROJECT NUMBER: 07/2018
NHRD REFERENCE NUMBER: GP _201712_007

TOPIC: THE FUNCTIONING AND PERCEIVED EFFECTIVENESS OF DISTRICT HEALTH SYSTEM GOVERNANCE STRUCTURES IN GAUTENG PROVINCE

Name of the Researcher:	Dr. Khanyisile Tshabalala
Supervisor:	Professor Laetitia Rispel Dr Mary Kawonga
Facility:	Tshwane District Offices
Name of the Department:	University of the Witwatersrand

NB: THIS OFFICE REQUEST A FULL REPORT ON THE OUTCOME OF THE RESEARCH DONE AND

NOTE THAT RESUBMISSION OF THE PROTOCOL BY RESEARCHER(S) IS REQUIRED IF THERE IS DEPARTURE FROM THE PROTOCOL PROCEDURES AS APPROVED BY THE COMMITTEE.

DECISION OF THE COMMITTEE: APPROVED

.....
Dr. Robert Oyedipe
Acting Chairperson: Tshwane Research Committee
Date: 29/01/2018

.....
Mr. Pitsi Mothomone
Chief Director: Tshwane District Health
Date: 2018.01.29

Appendix 3

THE FUNCTIONING AND PERCEIVED EFFECTIVENESS OF DISTRICT HEALTH SYSTEM GOVERNANCE STRUCTURES IN GAUTENG PROVINCE
INFORMATION SHEET FOR STUDY PARTICIPANTS

Hello. My name is..... I am a master's student from the School of Public Health at the University of the Witwatersrand. I am conducting research on the governance of the district health system in Gauteng as part of my master's degree.

Why am I doing the study?
There is little information on the functioning and effectiveness of the district health system governance structures in South Africa. I am doing the study to begin to address the gap. The aim of this survey is to obtain information on the perceptions of members of the various district health system governance structures on their involvement and participation in these structures, decision-making, functioning of these structures, and perceptions of achievements and challenges. The information obtained could be used to inform or advocate for health system improvements.

What am I asking you to do?
I invite you to complete a brief questionnaire which will take you about 15-20 minutes to complete. The questionnaire is electronic and will be filled in directly onto an electronic program called REDCAP, using a hand-held device (a tablet). Alternatively, I could help you to complete the questionnaire.
Your participation is voluntary and you may withdraw from the study at any time without having to give a reason for withdrawal. This is not a test, so there is no right or wrong answer. It is your opinions and experiences that are important. You may refuse to answer any questions that you don't feel comfortable answering.

How do I know that the information I give you will not get out to others?
The information that you give in the questionnaire will be kept confidential. All questionnaires will be assigned a code. The answers given will be analysed and reported as group data.

Did I get permission to do the study?
Permission to carry out this study was obtained from the University of the Witwatersrand, Human Research Ethics Committee as well as from the relevant health authorities.

Are there any benefits and risks of participation?
Participation in this study is voluntary and there will be no direct benefits to anyone who complete the survey. Similarly there will be no negative consequences for individuals who do not want to complete the questionnaire. You will not be compensated for taking part in the study. You have the right not to answer any questions that make you feel uncomfortable or that you do not want to answer.

Whom do you contact if you want more information?

We will be happy to answer any question you have about this study. If you have any questions about your rights as a study participant, you may contact:

Human Research Ethics Committee (HREC) chair,

The University of the Witwatersrand,

Prof P Cleaton- Jones

Email:peter.cleaton-jones1@wits.ac.za

Tel (011) 717-2301

Administrative officer

Ms Z Ndlovu

Email zanele.ndlovu@wits.ac.za,

Tel 011 717-1234.

If you have questions about the research, you may also contact me or my supervisors:

Dr Khanyisile Tshabalala

School of Public Health

University of the Witwatersrand

Tel: (011) 717-2316

Email: Drkhanyisile@gmail.com

Professor Laetitia Rispel

School of Public Health

University of the Witwatersrand

Tel: (011) 717-2043

Laetitia.rispel@wits.ac.za

Dr Mary Kawonga

University of the Witwatersrand

Tel: (011) 717-2576

Email: Mary.Kawonga@wits.ac.za

Appendix 4

THE FUNCTIONING AND PERCEIVED EFFECTIVENESS OF DISTRICT HEALTH SYSTEM GOVERNANCE STRUCTURES IN GAUTENG PROVINCE

INFORMATION SHEET FOR KEY INFORMANT INTERVIEWS

Introduction and background

Hello. My name is..... I am a master's student from the School of Public Health at the University of the Witwatersrand. I am conducting research on the governance of the district health system in Gauteng.

I would like to request your participation as a key informant because you are the chair of the governance structure in this district or the manager or head of health services in the district.

The interview will last for about 30 minutes. If you agree to take part, I will ask you questions about the work that you do, the functioning of the governance structure, the challenges faced, your overall perceptions on governance in the district. The questions are not a test, so there are no right or wrong answers. It is your opinions and experiences that are important. My role as an interviewer is to listen and to understand your point of view, but not to pass judgment. You may refuse to answer any questions that you don't feel comfortable answering. You may also say that you don't know the answer to a question.You may also withdraw from the study at any stage and need not give reason for your withdrawal.

Confidentiality

The information that you give in the questionnaire will be kept confidential. None of the researchers who work in this research project are staff members of any health authority. Only members of the research team will know who has been interviewed. All interviewees will be assigned a code and these codes will be used on the transcribed interviews. These codes will only be known to members of the research team. We undertake that all information provided by you will be used only for the purpose of the study. Everything that you say when answering the questions will be treated as private and confidential. This means that apart from the person who asks you the questions, no one will know how you answered. Your name will not be revealed in any written data or report resulting from the study.

The answers given by participants will be combined and analysed to look for common themes and experiences. The combined information will be written up in the form of a report.

Consent

Permission to carry out this project was sought from the University of the Witwatersrand Research Ethics Committees. We will ask you to sign an informed consent form, both to participate in the study and to record the interview. If you are willing to give your consent and take part, the CHP will appreciate your participation and the information that you are willing to provide.

Benefits and risks of participation

Please note that participation in this study is voluntary and there will be no direct benefits to anyone who participates in the interviews. Similarly there will be no negative consequences for individuals who do not want to be interviewed. Also note that you will not be compensated for taking part in the study. During the interview, you have the right to decline to answer any questions that makes you feel uncomfortable, or to stop the interview at any time. However, we would really appreciate it if you do share your thoughts and feelings about the questions we will be asking you.

Recording the interview

We would like to request your permission to audiotape the interview because we cannot write down all your answers quickly enough and might miss some important things that you will say in response to some of the questions that you will be asked if we do not record them. It is essential for you to know that the tapes and notes will remain confidential and your identity will not be disclosed. The only thing we are interested in is your honest responses.

The tape will only be listened to by the researchers involved with the project. Tapes of interviews will be transcribed and transcripts of interviews will bear the code and not the name of the interviewee. The information will then be discussed by members of the research team and organized into a report. The tapes will be kept in a locked cupboard. As per national requirements, the tapes will be destroyed two years after the publication of the research findings.

Ethical Approval

Ethical approval for this study has been obtained from the University of the Witwatersrand Human Research Ethics Committee (HREC) Medical. We have also obtained the permission of the Gauteng Provincial Government and each of the Municipalities in the Province.

Questions

We will be happy to answer any question you have about this study. If you have any questions about your rights as a study participant, or questions or concerns about any aspect of the study, you may contact the chair of the HREC (Medical), Professor Peter Cleaton-Jones on (011) 717 1234. If you have questions about the research, you may also contact the me or my supervisors:

Dr Khanyisile Tshabalala

School of Public Health

University of the Witwatersrand

Tel: (011) 717-2316

Professor Laetitia Rispel

School of Public Health

University of the Witwatersrand

Tel: (011) 717-2043

Laetitia.rispel@wits.ac.za

Dr Mary Kawonga

University of the Witwatersrand

Tel: (011) 717-2576

Email: Mary.Kawonga@wits.ac.za

Email:
Drkhanyisile@gmail.com

Appendix 5A

THE FUNCTIONING AND PERCEIVED EFFECTIVENESS OF DISTRICT HEALTH SYSTEM GOVERNANCE STRUCTURES IN GAUTENG PROVINCE

CONSENT FORM FOR INTERVIEW

I have been given the information sheet on the research project entitled: ***The functioning and effectiveness of district health system governance structures in Gauteng province.*** I have read and understood the information provided on the Information Sheet and all my questions have been answered reasonably.

I understand that it is up to me whether or not I would like to participate in the interview and that there will be no penalties if I decide not to participate. I also understand that I do not have to answer any questions that I am uncomfortable with and that I can stop the interview at any time.

I understand that the researchers involved in this project will make every effort to ensure confidentiality and that my name will not be used in the study reports, and that comments that I make will not be reported back to anybody else. I consent voluntarily to participate in the interview for this study. I have been given telephone numbers that I may call if we have any questions or concerns about the research.

Participant's signature: _____ Date: _____

Interviewer's signature: _____ Date: _____

Appendix 5B

THE FUNCTIONING AND PERCEIVED EFFECTIVENESS OF DISTRICT HEALTH SYSTEM GOVERNANCE STRUCTURES IN GAUTENG PROVINCE

INFORMED CONSENT FOR AUDIOTAPE-RECORDING OF INTERVIEW

I have been given the information sheet on the project entitled:***The functioning and effectiveness of district health system governance structures in Gauteng province***

I have read and understood the Information Sheet and all my questions have been answered satisfactorily.

I understand that I can decide whether or not the interview should be tape-recorded and that there will be no consequences for me if I do not want the interview to be recorded.

I understand that information from the tapes will be transcribed and transcripts will be given a code and my name will not be mentioned. I understand that if the interview is tape-recorded, the tape will be destroyed two years after publication of the findings.

I understand that I can ask the person interviewing me to stop tape recording, and to stop the interview altogether, at any time.

I consent voluntarily for the researcher to record the interview.

Participant's signature: _____ Date: _____

Interviewer's signature: _____ Date: _____

Appendix 6

CONSULTATIONTO IDENTIFY DISTRICT GOVERNANCE STRUCTURES

District represented	1) Ekurhuleni District ☐ 2) Johannesburg District ☐ 3) Tshwane District ☐ 4) West Rand District ☐ 5) Sedibeng District ☐
Designation of person consulted	

Identifying governance structure(s) in the district			**Comment**
Q1. Does the district have a district health council?	Yes ☐	No ☐	
Q2. Does the district have a district health council technical committee?	Yes ☐	No ☐	
Q3. If answered no to Q1 &Q2, does the district have any other governance structure (s)?	Yes ☐	No ☐	
Q4 What is the name of the governance structure (s)?			
Q5. Can you provide us with contact details of the members of the governance structure(s) in the district	Yes ☐	No ☐	
Q6. If answered No to Q5, Who is the relevant person to contact regarding further information on the governance structures and details of the members of the governance structure(s)			

Appendix 7

THE FUNCTIONING AND PERCEIVED EFFECTIVENESS OF DISTRICT HEALTH SYSTEM GOVERNANCE STRUCTURES IN GAUTENG PROVINCE

QUESTIONNAIRE FOR MEMBERS OF GOVERNANCE STRUCTURE

For official use only

Name of Health District		
1. **Questionnaire number / Participant number**		☐☐☐☐
1. **Date of survey:**	**DD/MM/YY**	☐☐☐☐☐☐
2. **Health District ID**		☐☐☐
3. **Was the questionnaire completed?**	☐No 0 ☐Yes 1	☐
4. **Date checked:**	**DD/MM/YY**	☐☐☐☐☐☐

STATEMENT OF CONSENT

I have been given an information sheet and I understand the objectives of the study. I further understand that my responses will be kept confidential and that it is up me whether or not to complete this questionnaire. It has been explained to me that even if I choose not to complete this questionnaire, I should still return the questionnaire to the researchers and indicate **No** in the space below. My refusal to participate will in no way prejudice me**.**

I agree voluntarily to complete the questionnaire **(please tick):** ☐**Yes** ☐**No**

Signature/ Initial:..... Date:.....

IF YOU AGREE TO PARTICIPATE, PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS. TICK/ MARK OR CIRCLE THE BOX NEXT TO THE APPROPRIATE ANSWER.

SECTION 1: BACKGROUND CHARACTERISTICS

For official use only

☐☐	101	**How old are you?** *(in completed years)*	_____ years
☐	102	**What is your gender?**	☐Male……1 ☐ Female…….2
	103	**Which governance structure do you belong to?**	DHC ☐No.....0 ☐Yes...1 DHCTC☐No.....0 ☐Yes...1 Other: Specify_____
☐	104	**What is your portfolio on the governance structure?**	☐Chairperson ……1 ☐ Politician/Ordinary member…….2 ☐Ex officio member (manager or official)member…….3 ☐Other……...……...9 Please specify:_____
	105	**How long have you been a member of the governance structure? (in completed years)**	_____years
☐	106	**Are you resident in this district?**	☐No.....0 ☐Yes...1
☐	107	**Are you familiar with the provisions of the National Health Act on the district health system?**	☐ No.....0 ☐ Yes...1

SECTION 2: FUNCTIONING OF THE GOVERNANCE STRUCTURE

For official use only			
☐	**201**	Have you EVER attended a meeting of the [named] structure?	☐No... 0 **If no, do not proceed with questionnaire. Thank you for your time** ☐Yes...1
☐	**202**	In the past 3 months, have you attended a meeting of the [named] structure?	☐No... 0 ☐Yes...1
☐	**203**	Do you receive minutes of the meetings of the Council/Committee?	☐No... 0 ☐Yes...1
☐☐	**204**	Are you familiar with the roles and responsibilities of the Council/Committee?	☐No... 0 ☐Yes...1
☐☐	**205**	Does the Council/Committee structure have sub-committees?	☐No... 0 ☐Yes...1 ☐Unsure...2
☐☐	**206**	Do you serve on any sub-committees?	☐ No... 0 ☐ Yes...1

	Statement	Strongly Disagree	Disagree	Disagree slightly	Neither disagree nor agree	Agree slightly	Agree	Strongly agree
a.	I receive the schedule of all the meetings for the entire year	1	2	3	4	5	6	7
b.	I like the agenda of every meeting as it is very clear	1	2	3	4	5	6	7
c.	I think the Council decisions that are taken are not transparent	1	2	3	4	5	6	7
d.	My Council/ Committee meetings always start on time	1	2	3	4	5	6	7
e.	I always receive the documents for the meetings very late	1	2	3	4	5	6	7
f.	We always take decisions at every meeting	1	2	3	4	5	6	7
g.	I do not receive the minutes of the Council meetings	1	2	3	4	5	6	7
h.	My Council does not follow-up on recommendations of previous meetings	1	2	3	4	5	6	7
i.	I know what my role is on the Council or its committees	1	2	3	4	5	6	7
j.	I received orientation on the district health system in South Africa	1	2	3	4	5	6	7
k.	At every meeting, I have all the facts to enable me to make a decision	1	2	3	4	5	6	7
l.	We as a Council/Committee regularly review data on district health system performance	1	2	3	4	5	6	7
m	The health outcomes for the district are discussed at our council/committee meetings	1	2	3	4	5	6	7
n.	I do not understand the discussions about district health services	1	2	3	4	5	6	7

o.	I participate actively in all the meetings	1	2	3	4	5	6	7
p.	My Council/committee has a relationship with the clinic committees	1	2	3	4	5	6	7
q.	I think that hospital boards are not important to the district health system	1	2	3	4	5	6	7

207 Listed below are questions on the functioning of the [named] structure Please indicate how strongly you would agree or disagree with each statement by circling the corresponding number.**PLEASE INDICATE A RESPONSE FOR EACH STATEMENT – DO NOT LEAVE ANY OUT.**

SECTION 3: PERCEPTIONS ON EFFECTIVENESS

301 Listed below are questions on the effectiveness of the [named] structure. Please indicate how strongly you would agree or disagree with each statement by circling the corresponding number. **PLEASE INDICATE A RESPONSE FOR EACH STATEMENT – DO NOT LEAVE ANY OUT.**

	Statement	**Strongly Disagree**	**Disagree**	**Disagree slightly**	**Neither disagree nor agree**	**Agree slightly**	**Agree**	**Strongly agree**
a.	I think that the Chairperson of the Council/Committee keeps us focused on district health system development	1	2	3	4	5	6	7
b.	We are not committed to cooperative governance	1	2	3	4	5	6	7
c.	We all participate in the development of a district health plan	1	2	3	4	5	6	7
d.	I do not know what the budget is for district health services	1	2	3	4	5	6	7
e.	My Council/Committee is accountability to communities	1	2	3	4	5	6	7

	Statement	Strongly Disagree	Disagree	Disagree slightly	Neither disagree nor agree	Agree slightly	Agree	Strongly agree
f.	My Council has a good working relationship with the MEC for Health	1	2	3	4	5	6	7
g.	My Council has developed criteria to monitor progress against our goals	1	2	3	4	5	6	7
h.	I think there is a lot of tension between the Council and executive management	1	2	3	4	5	6	7
i.	We always examine progress against agreed upon targets	1	2	3	4	5	6	7
j.	We do not ask questions about budget variances or deviation from targets	1	2	3	4	5	6	7

SECTION 4: Are there any comments that you wish you make about the district health system, or its governance?

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

Appendix 8

THE FUNCTIONING AND PERCEIVED EFFECTIVENESS OF DISTRICT HEALTH SYSTEM GOVERNANCE STRUCTURES IN GAUTENG PROVINCE

KEY INFORMANT INTERVIEW SCHEDULE

Governance structure:	**Date of interview:**
Position:	
Result codes 01 = Completed 02 = Respondent not available 03 = Respondent refused	04 = Partially completed 05 = Other

SECTION 1: CHAIR OF GOVERNANCE STRUCTURE ONLY	
1. Does the council/committee have guidelines or terms of reference on its functions and responsibilities?	☐No.....0 ☐Yes...1
2. Does the council/committee have sub-committees?	☐No.....0 ☐Yes...1
3. Have meetings been held in the last 12 months?	☐No.....0 ☐Yes...1
4. How often are the meetings held?	1 Weekly ☐ 2 Monthly ☐

	3 Quarterly ☐ 4 Annually ☐ 5 Ad hoc ☐ 6 Never ☐
5. Are minutes of the meeting taken?	☐No.....0 ☐Yes...1
6. Does the council/committee have indicators or criteria to measure its performance?	☐No.....0 ☐Yes...1

SECTION 2: INTERVIEW GUIDE

7: In your opinion, what are some for the achievements of the council/committee in the last 12 months? (Probe: reason for these achievements, what made them possible)?

8: What have been some of the challenges or barriers encountered by the council/committee in carrying out its functions in the last 12 months (probe: the reasons for these challenges?)

9: Are there any areas where this structure has not performed as planned/anticipated in the last 12 months? Which are these? In your opinion what are the reasons from the deviations from plans or targets

10: Could you comment on the relationships between?

- The Council and the Province
- Political members and officials
- The Council and residents in the municipality?

11: What are the mechanisms for collaboration/interaction between the Council/Committee and other departments (e.g. roads and works, water and sanitation, etc?)

12: How does the Council account to the community on the delivery of services in the district?

SECTION 3: RECOMMENDATIONS FROM COUNCIL CHAIR AND HEADS OF HEALTH

13: If you could advise the Minister of Health on district health systems in Gauteng, what recommendations would you make?

14 Do you have any further comments you wish to make?

THANK YOU