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A COMPARATIVE ANALYSIS OF FINANCIAL MANAGEMENT PRACTICES AT A DISTRICT LEVEL IN SOUTH AFRICA

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A Thesis submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in fulfilment of the requirements for the degree of Doctor of Philosophy.

Johannesburg, 2017

DECLARATION

I, Shakira Choonara declare that this Thesis Report is my own, unaided work. It is being submitted for the Degree of [Doctor of Philosophy] at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other University.



_____

(Signature of candidate)

30th_Tuesday_of_August_2017_in_Johannesburg_

To my loving parents, Cassim & Ayesha Choonara

To every patient who has suffered at the hands of the health system

I dedicate my life's work and this thesis to you

PRESENTATIONS ARISING FROM THESIS

1. **Oral presentation, "**Governance in the South African Health sector: an in-depth analysis of financial management processes at a district level". University of the Witwatersrand, Faculty of Health Sciences Research Day (South Africa), September 2014.
2. **Oral & poster presentation, "**Governance in the South African health sector: an in-depth analysis of financial management processes at a district level", Emerging Voices for Health Systems Research Pre-conference (South Africa), September 2014.
3. **Poster presentation, "**Governance in the South African health sector: an in-depth analysis of financial management processes at a district level", Third Global Symposium on Health Systems Research (South Africa), October 2014.
4. **Panellist,** "Defeating Ebola and building up resilient health systems for a better future", World Health Organization, European Development Days (Brussels), June 2015.
5. **Panel Discussion (organiser and panellist),** Universal Health Coverage and its Implementation Challenges – South African Research Chairs Initiative (SARChI),University of the Witwatersrand, School of Public Health Research Day (South Africa), August 2015.
6. **Poster Presentation,** "Building resilient-manager leaders in the health system: significance of informal on-the-job learning", Fourth Global Symposium on Health Systems Research (Canada), November 2016.

PUBLICATIONS FROM THIS THESIS

- Choonara S, Goudge J, Nxumalo N, Eyles J. 2017. Significance of informal (on-the-job) learning and leadership development in health systems: lessons from a district finance team in South Africa. BMJ Glob Health, 2(1): http://gh.bmj.com/content/2/1/e000138
- Choonara S, Goudge J, Nxumalo N, Eyles J. Identification of Bottlenecks in District Procurement Processes in South Africa. Manuscript submission (September 2017) to The International Journal of Health Planning and Management.

GRANTS & AWARDS

- Named 2017 Woman of the Year in Healthcare – Women of Stature Network, South Africa.
- Emerging Practitioner Award, Public Health Association of South Africa, 2017.
- Research Excellence Award for Female Next Generation Researchers South Africa, National Research Foundation, 2017.
- Awarded for dedication and achievement in research, Faculty of Health Sciences, Research Awards Celebration, University of the Witwatersrand, South Africa, 2016.
- Youth scholarship award to attend Women Deliver Conference, Copenhagen, 2016.
- Special Recognition Award for participation and selection for the European Development Days, Faculty of Health Sciences, University of the Witwatersrand, South Africa, 2015
- European Union (EU) Development Days Young Leader for Health, Belgium, 2015.
- Emerging Voice for Global Health, Cape Town, South Africa, 2014.
- National Research Foundation (NRF), South Africa, Freestanding Doctoral Scholarship 2014-2016.
- University of the Witwatersrand (South Africa), Postgraduate Merit Award (PMA) for tuition fees, 2014-2016.
- University of the Witwatersrand, School of Public Health (South Africa), SEED Funding Grant 2015.

ABSTRACT

Background:

Effective financial management is required across developed and developing countries which face the dilemma of curbing health expenditure yet ensuring the delivery of quality health services. The health system in South Africa (SA) is no exception, and is described as facing a number of challenges ranging from service delivery to budgetary issues. Prior literature indicates that decentralisation in the country has been marred with numerous financial management challenges associated with health districts e.g. insufficient control/ authority delegated to the districts and a lack of skilled staff. Much literature has documented difficulties related to decentralised financial management both in SA and globally, yet these challenges continue to persist. The primary aim of this study is to provide a comparative analysis of financial management realities between two districts in province x of SA.

It differs to previous studies, in that it has examined financial management through an organisational approach, drawing on a multitude of theoretical underpinnings including the sociocultural perspective, structures (rules, resources enacted through routines) and agency – actions of individuals (staff) going against and manoeuvring constraints. The organisational perspective extends to understanding hardware which refers to tangible aspects in the health system e.g. information technology (IT) or resources and software elements such as communication or interrelationships. The study draws out actual financial management routines linked to key processes (planning, resource allocation and budgeting and evaluation) as well as its associated challenges and successes at a district level. Finally, the thesis has set out to address gaps in decentralisation literature, by considering contextual influences such as history, politics and centralised bodies, particularly the Provincial Department of Health (PDoH).

Methods:

A qualitative research approach including a multiple case-study design was used. Primary data collection commenced in March 2014 and was completed in April 2015. A total of 58 participants were included in the study. Purposive sampling techniques were useful in identifying key participants involved in financial management at a district level. Key respondents at a sub-district and provincial level (PDoH) linked to district financial management, other support functions and external stakeholders from Non-Governmental

Organisations (NGOs) were included. An in-depth interview was carried out with each participant and follow-up interviews were done when necessary. This was followed by non-participant and participant observations being conducted in each study site, which allowed for data triangulation. Ethical approval was granted by the relevant university, provincial and district boards. Rigorous thematic content analysis was carried out.

Findings:

The study begins by describing and providing a brief overview of key financial processes carried out in each district, for example District Health Planning (DHP) or the District Health Expenditure Review (DHER). Essentially these were the everyday routinised tasks or realities examined. In both districts, namely Indawo and Isikhala, weaknesses included expenditure tracking difficulties or financial management challenges such as payment delays or difficulties linked to centralised processes carried out by PDoH. Despite similarities, there were notable differences in the way most of these processes were carried out. For example in Indawo, poor planning and budget motivation processes as well as a 'culture of compliance' to meet prescribed processes were reported. In Isikhala, there was better coordination, oversight and engagement of these tasks e.g. province considering the district's annual budget motivation to be one of the best. However, the findings reveal that even though prescribed financial tasks are carried out, effective financial management was still not achieved in both districts –difficulties with expenditure tracking. Procurement procedures require approval based on availability of financial resources; however requests were approved in both districts irrespective of budget availability.

The thesis then shifted a step further to understanding these realities, particularly why dysfunctional routines such as poor planning or compliance to tasks persist and where the mechanisms for improvement/ strengthening lie. Findings revealed why the two districts differ in relation to carrying out these tasks. Structuration theory developed by Giddens (1984) considers the relationship between structure and agency in society (defined above). This thesis further expanded structuration theory to the notion of a structuration nexus– consisting of four key components of financial management, namely; structure, agency, hardware and software.

The theory argues that in this case structure (rules and resources) similar to hardware are enacted through routine financial tasks necessary to shape human behaviour and organisational functioning. However, poorly coordinated routines were reported to exist and

constantly enforced in system, especially in the case of Indawo. Agency within the nexus refers to individual actors and their actions to either reinforce such practices or transform them i.e. question, change and implement effective financial management. Health system concepts which refer to resources or equipment, such as IT / hardware elements were found to affect routines from being effectively carried out in both districts. While software, particularly communication including teamwork, motivation and personal development, was found to propel agency to deal with constraints, find solutions and shift some of the dysfunctional financial practices reported in Isikhala. Findings further revealed strategies for nurturing software, particularly informal learning through strategies such as delegation in Isikhala finance unit.

However, while weaknesses and successes were noted in districts, they were inherently linked to the centralised level. Provincial participants provided insight into the rationale for centralisation of some financial functions. One of the primary reasons cited was the lack of district capacity and high levels of over expenditure in the province x making centralisation of some functions a perceived necessity. Although benefits of centralisation and expected gains were not realised as the central level itself was reported to have several weaknesses such as a loss of institutional memory (loss of skills in post-apartheid SA) or poor communication between units (software). Agency and system change at both levels were further compounded by political factors, post-apartheid restructuring and trade unionism which also affected routinised finance practices in both districts – poorly performing staff not being held accountable of political influences over vendor selection which increased financial costs.

Conclusion and Recommendations:

The country's National Health Insurance (NHI) policy re-emphasises the importance of decentralisation and effective financial management. However, the NHI policy offers few recommendations or details around actually strengthening this core district function. This thesis offers a comprehensive account of district financial management and strategies for its improvement particularly linked to its adopted organisational perspectives and nurturing software factors (teamwork, communication, better relationships). The study moves beyond describing challenges associated with key financial routines, to offering a novel understanding in the SA context around why these practices exist and what are the factors necessary to transform practices which do not render effective financial management.

Findings reveal that the four crucial elements of the structuration nexus (hardware, software, structure and agency) are particularly important in shaping financial management. It further argues and shows that these elements, if present, can contribute to organisational functioning within the health system, yet these elements are not necessarily considered during policy processes. Findings from the Isikhala finance unit points to specific practical strategies to nurture software in organisations - informal learning and delegation strategies linked to staff motivation and development. Lastly, financial management offered a lens to understanding decentralisation processes, specifically cognisant of its interlinkages and interdependent to functioning centralised levels and the complexities associated with contextual factors (history/ apartheid). Racial redress through key policies and legislation are undoubtedly important in addressing SA's past injustices, however has further complicated the decentralisation process, compounded by the role of politics and trade unionism which also need consideration. In essence, this thesis has shown what elements are necessary and need to be nurtured not just for financial management but for health systems functioning.

Key words: Decentralisation, District Financial Management, South Africa

ACKNOWLEDGEMENTS

One of the participants in this thesis described having a 'work father', I acknowledge that it is too early to give away results of the study but there are simply no words to adequately describe the role Professor John Eyles has played in my life. John, I have learnt so much from you as a leader and pioneer in our field and truly appreciate the mentorship and opportunities you constantly provide to all young researchers in your programme, most of all I enjoyed our many meetings and the constant laughs that we've shared. Thank you to Professor Goudge and Dr Nxumalo. A special thank you to Dr Prudence Ditlopo and Dr Bronwyn Harris, the two 'unofficial' mentors/ supervisors and Greer Van Zyl for all the fantastic media write-ups throughout the PhD journey.

To my dearest friend Kafayat Oboirien, I am certain that had I not met you, the PhD journey would not have been as fulfilling. We started this journey together and you have been my strength and backbone! I would also like to thank Pascalia Munyewende for her constant support, encouragement and being a phenomenal support structure during the PhD. A heartfelt thanks is extended to Faith Mambulu, Hlologelo Malatji, Ejemai Eboreime, Rachel Ceasar, Himani Pandya, Shehnaz Munshi, Teurai Rwafa, Nyasha Madzudzo and Siphiwe Thwala for all support along the way. I also could not have done this without either of you and all the staff and students based at the Centre for Health Policy, especially the admin team Ann and Nigel and colleagues from the broader CHP project, including Dr Andrea Egan, Professor Lucy Gilson, Dr Sassy Molyneux, Dr Benjamin Tsofa, Dr Edwine Barasa, Dr Veloshnee Govender, Mary Nyakuri, Rebecca Wolfe, Sephy Valuks, Elna Kattoor, Masuma Mamdani and rest of the team.

Constant words of encouragement greatly aided the PhD journey, from Professor Karen Hoffman's kind words in the elevator, Dr Latifat Ibisomi, Sasha Frade-Bekker and Professor Shan Naidoo's mentorship and guidance. Professor Clifford Odimegwu undoubtedly deserves recognition for the role he has played throughout my research career. I am also thankful for the constant encouragement and assistance offered by Angeline Zwane, Paul Bohloko, Jude Igumbor and all other staff at the School of Public Health. Being diagnosed with a medical illness was the most challenging and difficult obstacle I had to face mid-way through the PhD, I could not have completed this PhD without the advice and support of the Wits Disability Unit and colleagues Tish White and Andrew Sam.

Being selected for the European Development Days in 2015 has been life-changing as I had the opportunity to network and collaborate with other prominent young leaders. Marion Osieyo, Birwe Hambo and James Thuch Madhier each of you have been instrumental in the achievement of this degree. A special thank you to the coordinators of the Young Leaders programme, Claire Veale and Daniele Brunetto, you have touched our lives in so many ways and truly aided us with public speaking, networking and achieving our dreams/ aspirations, your constant support and mentorship is invaluable. To the Ahmed Kathrada Foundation staff, I've learnt so much through the youth leadership programme, the constant encouragement and support over the past few years has made all the difference, special mention to Neeshan Balton, Shaheda Seedat, Delani Majola, Busisiwe Nkosi, Nhlanhla Lucky Nkosi, Irfaan Mangera, Nadia Hoosen, Irfaan Mangera, Courtney Morgan, Lebohang Makhabela, Zarina Motala, Zaakirah Vadi and the many inspiring youth in the programme. My deepest gratitude goes to the stalwarts associated with the foundation, a heart-breaking moment was that Ahmed Kathrada (Uncle Kathy) was not late at the time of writing this, the late Shirish Nanabhai and others - it is essentially due to your sacrifices that we are able to educate ourselves as young South Africans. I would like to also thank Kristof Decoster and the Emerging Voices programme for providing critical oversight over blogs and assisting with refining my writing skills, this greatly aided with the write-up of this thesis! To the Junior Public Health Association (JuPHASA) and Public Health Association of South Africa (PHASA) Gauteng team, thank you for the continuous support! This PhD would also not be possible without the numerous participants especially at a district level who always availed themselves for interviews and observations. The Southern African AIDS Trust team, youth across the continent and in particular, Vicci Tallis and Jonathan Gunthorp who have played a pivotal role in mentorship and the completion of this PhD, a huge thank you!

On a personal level, I start by thanking you dad, throughout my life and on a daily basis you would always ask about my day, difficulties and plans to address these challenges. I always have the most stimulating discussions with you and I recently learnt of the importance of having a thinking partner (PS thanks to Alison du Toit). Dad thank you for being a life-long thinking-partner, best-friend and an outstanding support base, our daily conversations about healthcare, politics and world issues have shaped me to be a critical thinker, in fact it is only after I speak to you that I am able to put down my thoughts and write or inspired to create change and action. I am forever grateful for the role you play in my life.

Mum, you never had the opportunities I enjoy today, I am greatly indebted to you for the sacrifices you have made, the values and morals you have instilled which have gone a long way. Thanks for always cooking the most heart-warming meals, just being there for me and playing such a significant role throughout my life. My dear sisters, my life would be incomplete without both of you, thank you for always supporting me along the way. I know for a fact that I could never have completed this journey without you, you are without a doubt second mums, best friends and the people who always cheer me on, I am deeply appreciative of the constant support and love! To my elder brother I thank you for bringing laughter to life, you really brightened dark, cold days of the PhD. To my little brother who is always doing all the 'little' things for me, you lightened the load of the PhD and contributed substantially to it. To my little nieces and nephews (Zara and Yaseera, Yusuf), it means the world that you look up to me as a role model! Thank you to extended family and friends for the ongoing support; Ebrahim Cassimjee, Agnieszka Ignatowicz, Carmen Christian, Laura Roussouw, Vanessa Carter, Charlotte Du Plesis, Faheema Mahomed, Nasreen Jessani, Kgotso Kwathlai, Khosilee Tshabalala, Victoria Elias, Persie Mamidza, Lukhona Mnguni, Masixole Dlomo, Raeesa Ghoor, Ronald Ssenfuka Clerk, Maryam Seedat, Dr Rafique Ismail, Julia Mambolo, Sasha Frade Bekker and Sarah Jane Mitchell.

Lastly, but most importantly, to my husband and dearly beloved (Mohammed Hoosain), you are my advisor, confidante, best friend and life-long partner, you have given up many of your dreams and aspirations to put this PhD first. You have been on this remarkable journey from the very beginning and every single step of the way! I truly appreciate it and could possibly never thank you enough. I am forever grateful for the sacrifices you have made to support me financially and emotionally and your complete understanding during busy periods! I love you very much, this is our PhD, and in fact I confer an honorary doctorate linked to this PhD for you. I definitely could not have achieved this much without your support and unconditional love, you are my love and life.

Table of Contents

DECLARATION 1

PRESENTATIONS ARISING FROM THESIS 3

PUBLICATIONS FROM THIS THESIS 4

GRANTS & AWARDS 5

ABSTRACT 6

ACKNOWLEDGEMENTS 10

LIST OF FIGURES 17

LIST OF TABLES 17

NOMENCLATURE 19

KEY DEFINITIONS 23

STUDENT ROLE - CHP BROADER PROJECT 26

CHAPTER 1: INTRODUCTION 28

1.1 Chapter Overview 28

1.2 Background 28

1.2.1 Decentralisation of health services 28

1.2.2 Structures & reforms- the SA health system 30

1.2.3 Financial management – an essential component of the decentralisation process 34

1.3 Study Aim & Objective(s) 36

1.3.1 Overall aim 36

1.3.2 Objective (s) 36

1.4 Justification 37

1.5 Structure of thesis 38

CHAPTER 2: LITERATURE REVIEW 40

2.1 Introduction 40

2.1.1 Methods guiding the literature search 40

2.2 Centralisation, Decentralisation Debate - Importance of Complementarity & Coordination 42

2.2.1 Considering a broader context for understanding decentralisation 47

2.3 Organisational Underpinnings & Perspectives of Decentralisation 48

2.3.1 Machine perspective – public sector organisations and financial management 49

2.3.2 Organisational and historical features – decentralised financial management 54

2.3.3 Socio-cultural perspectives of health systems 61

2.4 Structuration Theory – Essentiality of Hardware and Software 62

2.5 Study Conceptual Framework 69

2.6 Summary 71
CHAPTER 3: METHODS 72
3.1 Introduction 72
3.2 Multiple Case Study Design 72
3.3 Study Site(s) 72
3.3.1 Indawo district municipality 74
3.3.2 Isikhala district municipality 75
3.4 Study Population & Sampling 75
Table 3.2: Brief description of study participants 77
3.5 Data Collection 78
3.5.1 Indawo district 80
3.5.1.1 In-depth interviews 80
3.5.1.2 Non– participant and participant observations 81
3.5.2 Isikhala district 82
3.5.2.1 In-depth interviews 82
3.5.2.2 Non– participant and participant observations 83
3.5.3 Observations with external stakeholders (NGOs) 84
3.6 Data Management and Analysis 85
3.6.1 Credibility & confirmability of data 86
3.7 Research Ethics 87
3.7.1 Ethical clearance 87
3.7.2 Informed consent 87
3.7.3 Ensuring confidentiality and anonymity 88
CHAPTER 4: CONSIDERING A BROADER CONTEXT FOR DISTRICT FINANCIAL MANAGEMENT 92
4.1 Introduction 92
4.2 Overview – Shifts between Centralisation & Decentralisation 92
4.2.1 The case for centralised finance functions 94
4.2.2 Centralised finance functions & associated difficulties 96
4.2.3 Rationale for centralised procurement functions 97
4.2.4 Difficulties with the hardware - centralised IT 98
4.3 Provincial Level Weaknesses 101
4.3.1 Legacy of apartheid & influence on PDoH functioning 101
4.3.2 PDoH & politicisation 104
4.3.3 Internal challenges 105

4.4 Conclusion 106
CHAPTER 5: OVERVIEW OF DISTRICT FINANCIAL MANAGEMENT 107
5.1 Introduction 107
5.2 Synopsis: District Finance Function 107
5.3 District Organograms- Finance Staff Roles and Responsibilities 110
5.3.1 Indawo district 113
5.3.2 Isikhala district 116
5.3.3 Comparison of finance structures in districts 118
5.4 District Procurement Function 118
5.5 Conclusion 119
CHAPTER 6: DECENTRALISED FINANCIAL MANAGEMENT – INDAWO HEALTH DISTRICT 121
6.1 Introduction 121
6.2. District Financial Management 121
6.2.1 Financial management process 1 – poor coordination of planning processes 121
6.2.2 Financial management process 2 – resource allocation & budgeting dilemmas 123
6.2.3 Financial management process 3 & 4– oversight & evaluation 125
6.3 Weak Centralised and Decentralised Institutions 129
6.3.1 Hardware factors & financial management - internet connectivity/ equipment 129
6.3.2 Difficulties of procuring 133
6.3.2.1 District procurement process – Foot Stands 134
6.4 Manoeuvring Constraints & Displaying Agency 140
6.4.1 Debilitating factors – Constraining Structural Environment 140
6.4.1.1 Broader political & unionised context 140
6.4.1.2 The role of NGOs 141
6.4.1.3 Software components of financial management- difficult relationships & demotivation 141
6.4.2 Problem-Based Coping, Transforming Routines & Predispositions to Agency 143
6.4.2.1 Supportive relationships 143
6.4.2.2 Displays of agency 145
6.5 Conclusion 147
7.1 Introduction 148
7.2 District Financial Management: Routines and Practices 148
7.2.1 Financial management process 1- engaging with planning 148
7.2.2 Financial management process 2- navigating resource allocation & budgeting processes 149

7.2.3 Financial management process 3 & 4- oversight & evaluation 151
7.3 Hardware affecting Finance - Unreliable Internet Connectivity 153
7.4 Failing Procurement Processes 154
7.5 Constraining & Enabling Factors- Displays of Agency 159
7.5.1 What constrains agency? 160
7.5.1.1 Considering the provincial & political context 160
7.5.1.2 Strained relationships & de-motivated staff 160
7.5.2 Significance of nurturing software in the system 161
7.5.2.1 Role of informal learning 161
7.5.2.2 Supportive relationships 163
7.5.3 A solution-driven environment & displays of agency 165
7.6 Conclusion 168
CHAPTER 8: COMPARATIVE ANALYSIS - DISTRICT FINANCIAL MANAGEMENT 170
8.1 Introduction 170
8.2 Comparison between Districts- Structuration Nexus of Financial Management 174
8.2.1 System changes – external influences on formal structures 175
8.2.2. Ineffective financial routines – importance of agency and transformational practices 176
8.2.2.1 Indawo district 176
8.2.2.2 Isikhala district 181
8.3 Chapter summary 183
CHAPTER 9: DISCUSSION 185
9.1 Introduction 185
9.2 Duality of Structure –Why does 1+2=6? 186
9.3 Two Sides of the Same Coin – Centralisation Decentralisation Debate 190
9.3.1 Implications of study findings - managing resources under the NHI 196
9.4 Limitations 199
9.5 Conclusion 202
CHAPTER 10: CONCLUSION 203
10.1 Introduction 203
10.2 Study Conclusion 203
10.3 Contribution of the Study 207
10.4 Recommendations 209
REFERENCES 211
APPENDICES 221

APPENDIX A: LIST OF KEY DOCUMENTS REVIEWED 221
APPENDIX B: STRUCTURE OF THE SOUTH AFRICAN HEALTH SYSTEM 222
APPENDIX C: ANNUAL PLANNING, MONITORING AND BUDGETING CYCLE 223
APPENDIX D: YEARLY PLANNING PROCESS MAP 224
APPENDIX E: INTERVIEW SCHEDULES- DISTRICT & SUB-DISTRICT 225
APPENDIX F: INTERVIEW SCHEDULES - EXTERNAL STAKEHOLDERS 235
APPENDIX G: OBSERVATION CHECKLIST 239
APPENDIX H: INFORMATION SHEETS AND CONSENT FORM 241
APPENDIX I: CONSENT FORM 268
APPENDIX J: ETHICAL APPROVAL LETTERS 269
APPENDIX K: PLAGIARISM DECLARATION 275

LIST OF FIGURES

Figure 2.1 Identifying and selecting relevant literature 24
Figure 2.2: Mapping decentralisation processes: context, influences and outcomes 30
Figure 2.3: Conceptual framework- analysis of decentralised financial management 51
Figure 3.1: Map of SA provinces 55
Figure 4.1: Financial management roles and responsibilities of provincial actors 75
Figure 4.2 Centralised IT Connectivity 82
Figure 5.1 Figure 5.1: Overview of key finance processes & documents 91
Figure 5.2: Basic organogram or structure of districts in PDoH province 92
Figure 5.3: Indawo District Finance Team 94
Figure 5.4: Isikhala district & Isifundo sub-district finance 97
Figure 6.1: Procurement Process Flow (Indawo) 118
Figure 7.1: Procurement Process Flow (Isikhala) 138

LIST OF TABLES

Table 2.1: Overview – perspectives of organisational life 31
Table 2.2: Excerpt from the literature- characteristics of bureaucracy by major authors 33
Table 2.3: DHS – leadership competencies (adapted) 47
Table 3.1: Indawo & Isikhala district socio-demographic indicators 56
Table 3.2: Brief description of study participants 59
Table 3.3 Details of Tools Utilised in the Study 61

Table 3.4: Summary - Linking study objectives, conceptual framework, methods and data collected 72

Table 5.1: Financial controllers roles and responsibilities 96

Table 5.2: Isikhala district & Isifundo sub-district (description of finance tasks/ roles) 99

Table 5.3: Comparison of finance organograms between districts 100

Table 8.1 Summary of study findings 153

NOMENCLATURE

AG	Auditor General
ANC	African National Congress
APU	Accredited Procurement Unit
BAC	Bid Adjudication Committee
BAS	Basic Accounting System
BBBEE	Broad Based Black Economic Empowerment
BEE	Black Economic Empowerment
CABRI	Collaborative Africa Budget Reform Initiative (CABRI)
CEO	Chief Executive Officer
CHP	Centre for Health Policy
CHW	Community Health Workers
COSATU	Congress of South African Trade Unions
DBSA	Development Bank of South Africa
DHER	District Health Expenditure Review
DHP	District Health Plan
DHMO	District Health Management Offices
DHS	District Health System
DID	Department of Infrastructure and Development

ECG	Electrocardiogram
EE	Employment Equity
GDP	Gross Domestic Product
GRV	Goods Received Voucher
HIS	Health Information System
HOD	Head of Department
HPSR	Health Policy and Systems Research
HR	Human Resources
HREC	Human Research Ethics Committee
HSM	Higher level Senior Manager
ICT	Information and Communication Technology
IDP	Integrated Development Plan
IST	Integrated Support Teams
IT	Information Technology
IYM	In-year Monitoring Report
LMIC	Low and Middle Income Country
LSM	Lower Level Senior Manager
MHS	Municipal Health Services
NCD	Non-Communicable Diseases

NDoH	National Department of Health
NDP	National Development Plan
NGOs	Non-Governmental Organisation
NHA	National Health Act
NHI	National Health Insurance
NHIF	National Health Insurance Fund
NPM	New Public Management
PARI	Public Affairs Research Institute
PAS	Provincial Administration System
PBN	Provincial X Broadband Network
PDF	Provincial X Department of Finance
PDoH	Provincial Department of Health
PERSAL	Personnel Salary System
PFMA	Public Finance Management Act
PHC	Primary Health Care
PHPC	Provincial X Health Processing Centre
PMDS	Performance Management and System Development
PO	Purchase Order
PROCFINHR	Procurement Finance and Human Resources

PSSC	Provincial X Shared Service Centre
RDP	Reconstruction & Development Programme
SA	South Africa
SAP	System Application and Products
SARS	South African Revenue Services
TB	Tuberculosis
UHC	Universal Health Coverage
USB	Universal Serial Bus

KEY DEFINITIONS

- **Accruals:** refers to an expense or revenue in a period for which no payment has taken place by the end of a specific accounting period e.g. suppliers not paid after 30 days[1].
- **Agency:** a micro-level phenomena (individual actions), considered to be a resource within the system, contributing to system functioning and change e.g. to take action despite constraints [2].
- **BAS:** the Basic Accounting System (BAS) is a cash-based online system which allows for accounting payments including debtors, reconciliations, reporting, maintenance of code files, budget capturing and enables authorisation of payments [3].
- **Budget bi-laterals**: each institution e.g. districts or hospitals are invited to PDoH on an annual basis to either shift funds, motivate for increased budget allocations in certain areas and or additional or new budget allocations.
- **Conditional Grant:** these are funds which are allocated by the national government to provinces, but the provinces must spend them according to conditions set down by the national government. Conditional grants are designed around a single programme that the national government recognises requires a significant amount of money and is of national importance e.g. HIV/ AIDS. Conditional grants are only meant to supplement funding for a programme by the province. It is not the total amount that a province spends on that programme i.e. equitable share allocations [4].
- **Decentralisation:** includes the transfer of fiscal, administrative or political authority from the ministry of health to lower levels of government[5].
- **Decision-space:** the process of decentralisation refers to the transfer of responsibility of functions such as planning, management and financing from central government to peripheral levels [5].
- **Duality of structure:** Structuration theory argues that established routines are put in place and either reinforced or transformed by actors. Routines may influence how different agents operate on a daily basis but may also be the outcome of actions if agents attempt to transform/ merely reinforce these routines [6].
- **Evaluation:** this involves reflecting on financial management processes, objectives achieved and laying the foundation for the next planning cycle [7].

- **Financial management:** consists of four distinct processes which occur in a cyclical manner. Processes include, financial planning, resource allocation and budgeting, oversight and evaluation [7].
- **Hardware:** refers to elements such as rules, legislations, policies, skills, infrastructure, technology and funding levels of a health system [8, 9].
- **Health system:** refers to multiple organisations, as well as the actors and support systems which contribute to service delivery [8].
- **Journalising:** refers to financial reporting that corrects errors (misallocation) made previously in the accounting period and to ensure that the budget is balanced [10].
- **Leadership:** involves creating a vision, communicating the vision, inspiring, motivating and aligning people and the organisation to achieve this vision [11].
- **Management:** involves coordinating technical processes such as planning, budgeting, organising and staffing, whereas leading is about enabling those within and outside the system to face challenges and achieve results in complex conditions [11].
- **Non-participant observation**: refers to minimal participation of the researcher in actual processes and researchers tend to maintain a distanced stance from these processes [12].
- **Oversight:** this deals with expenditure management, in particular the reporting, auditing and control systems which are put in place, to ensure that plans or activities are implemented correctly [7].
- **Participant observation:** a form of ethnography where the researcher participates in daily processes and activities [12].
- **Personnel and Salary Administration System (PERSAL):** a central system used for the administration of the public service payroll in the SA government. PERSAL offers personnel administration, holds information in a database of employees, and offers standard and ad hoc reporting[3].
- **Planning:** a cycle which attempts to determine what the current situation is, setting goals, considering different alternatives to achieve these goals and deciding which alternative is best [7].
- **Reconciliations:** an accounting process used to compare two sets of records to ensure the figures are in agreement and are accurate. Reconciliation is the key process used to determine whether the money leaving an account matches the amount spent, ensuring the two values are balanced at the end of the recording period [13].

- **Resource allocation / Budgeting:** Process of deciding the amount of financial resources to be spent on different areas or priorities [18].
- **Software:** Includes components such as knowledge, processes of decision-making, relationships, communication, practices, values and norms [8, 9].
- **Structuration nexus:** Relationship and influence between four interconnected elements of financial management (and broader organisational functioning) – hardware, software, structure and agency.
- **Structure:** considered to be social structures (rules and resources), enacted through and organisations' daily routines e.g. financial processes[2].
- **Virements (budget-shifting):** annually, Provincial Department of Health- PDoH allows for district staff to provide recommendations, motivate and shift un-spent funds in certain areas of the budget. There are strict restrictions around what can be shifted as per the adjusted budget allocated by the provincial office (budget-bi-lateral). There are specific conditions around budget shifting, districts are only allowed to allocate the lowest amount within each economic classification (Compensation of Employees, Goods and Services) and may not shift between classifications.

STUDENT ROLE - CHP BROADER PROJECT

This doctoral study was nested within a broader multi-country project at the Centre for Health Policy (CHP), University of the Witwatersrand, which was conducted in one study-site (district) in province x of SA. Within the governance project at CHP, the doctoral study specifically focused on financial management. The doctoral study however went beyond the CHP project and focused on a second site in province x which served as a comparator site (further details are provided in Chapter 3- methods).

The project adopted an action-learning approach and was divided into two phases. Phase one involved the collection of data through in-depth interviews and observations and phase two included researchers and study participants working together to identify key challenges and finding solutions. The researcher contributed to the project through some of the listed activities;

Phase 1:

- Assisted with final drafting interview questions for the protocol and ethical approval (University of the Witwatersrand).
- Conducting all financial management, procurement and information technology (IT) related interviews (approximately 18 interviews spanning the district and provincial level). Conducted remaining 9 interviews, e.g. (HR or health programmes) together with supervisor.
- Conducting financial management related observations (participant and non-participant).
- Transcribing interviews, analysing data and assisting with publications/ write-ups.
- Operational activities-organising meetings and preparing presentations.

Phase 2:

- Attending reflective meetings- researchers and study participants jointly identify challenges and brainstorm solutions.
- Assisting with write-ups, e.g. policy briefs, diagrams for journal article publication.

Being nested within the study provided various opportunities and benefits including:

- Liaising and comparing results with doctoral students in other project settings e.g. Kenya.

- Through attending the consortiums annual meetings, interacted with several senior staff, discussed doctoral studies on broader global platforms and networked amongst consortia staff.

The CHP project provided an excellent platform whereby, the doctoral research was shaped, interrogated and provided several avenues for ongoing support and advice from senior researchers as well as opportunities for capacity development, particularly research training. Moreover, the researcher was able to draw on other interviews outside the realm of financial management (broader project) to gain a richer understanding of the study site.

CHAPTER 1: INTRODUCTION

1.1 Chapter Overview

The introductory chapter of this thesis aims to outline contextual realities and shows the importance of the topic under consideration – decentralised financial management. Section 1.2 is divided into three key sections, firstly discussing the importance of decentralisation as a major health systems reform which has been adopted internationally and in South Africa (SA), followed by specific insight into the study setting and the establishment of the District Health System (DHS) linked to the country's history and political sphere. The chapter then focusses on the difficulties associated with district financial management (why there have been few improvements) and highlights the need to shift focus and consider micro-level organisational perspectives i.e. practices, interactions and relationships – social elements of financial management (section 1.2.3). The study objectives and rationale are also outlined. Finally, the structure for the monograph is briefly discussed.

1.2 Background

1.2.1 Decentralisation of health services

Globally, decentralisation has been adopted by a number of countries across both the developed and developing world and is viewed as a pivotal developmental reform aimed at achieving efficiency and effectiveness with associated benefits of improved public management, increased responsiveness to local needs and local accountability [14, 5]. Decentralisation is largely defined as the transfer of power or authority around tasks such as planning, management and decision-making from national governments to lower levels of the state [14, 15]. The literature classifies decentralisation into four categories, namely; deconcentration, devolution, delegation and privatisation [16].

It is important to note that a specific context or jurisdiction may have more than one form/ type of decentralisation. Deconcentration, which is one of the most common forms of decentralisation, involves transferring administrative rather than political authority usually on a spatial/ geographical basis, however it is considered to be the least extensive form of decentralisation [17]. Delegation involves transferring managerial responsibilities for certain functions to agencies outside of central government and privatisation points to the transfer of government functions to private-for-profit or not-for-profit enterprises. Devolution aims to strengthen lower levels (sub-national levels) of government and establish political

independence e.g. local authorities which are then relatively independent and have the ability to raise revenue or carry out expenditure [14, 15].

In the health sector, the adoption of the Alma Ata Declaration in 1978 heightened focus around achieving primary health care (PHC) this was followed by several governments committing to PHC reforms, particularly through the decentralisation of health services[18]. A number of countries in sub-Saharan Africa (Ghana, Nigeria, Kenya, Uganda and SA) have implemented decentralisation reforms in their respective health sectors and in line with global commitments. Existing studies indicate that the benefits of decentralisation are not guaranteed and dependent on country-context and experiences.

Moreover, there is little evidence documenting the actual impact and benefits of such reforms [5, 19]. However, there have been some studies spanning numerous topics across various low-and-middle-income (LMICs) contexts which attempt to provide insights into health sector decentralisation experiences. For example, Bossert and Beauvais (2002) provided a comparative analysis of decision-space (choice allowed under decentralisation over tasks such as resource allocation or human resources –HR) in developing countries such as Ghana and the Philippines. There has also been literature focussing on decentralisation outcomes in Brazil and financial management in Uganda [20].

Nonetheless, most authors note limitations and challenges in measuring the outcomes of decentralisation and providing findings/ recommendations and comparisons between country contexts being even more difficult due to fragmented data and stark differences between countries in terms of history and politics [5, 21]. Other issues raised in the literature that attempts to document and indicate the impact of decentralisation is that dominant discourse focuses on macro-level structures and issues of health sector reform e.g. infrastructure, technology and economics of the health system instead of crucial human and social elements i.e. an organisational approach [9]. Thus, there appears to be a lack of literature focusing on decentralisation which particularly attempts to understand everyday organisational realities, including aspects such as interpersonal relationships, communication and motivation. In all fairness, decentralisation is considered to be a highly complex process reliant on context, diversity and institutional arrangements [21]. Given that it has been adopted globally and there are challenges in documenting experiences, it is important to continue examining such experiences cognisant of context, institutional arrangements, and focusing on implementation (organisational realities) to address such gaps in the literature.

1.2.2 Structures & reforms- the SA health system

Establishment & importance of the DHS

The policy of apartheid (racial segregation) resulted in deeply entrenched inequality, poverty and access to services such as education and healthcare premised on racial classification with non-whites receiving inadequate and poor quality services. Prior to 1994, the SA health system was divided along racial lines, fostering inequities and stark differences in health care and resources provided between whites and non-whites [22]. The SA health system is characterised by high expenditure on healthcare (8% of gross domestic product – GDP), with the private sector contributing to over half of the GDP and servicing only 13% of the population. Additionally the country is also grappling with the rapid escalation and dual burden of HIV and tuberculosis (TB), as well as the rise of non– communicable diseases (NCDs) [23]. Post 1994, significant health restructuring was required in the country, with previously racially divided administrations needing to be incorporated into one national health system [23]. Shifts towards decentralisation and implementation of the DHS was cited as early as the 1990s in the African National Congress (ANC) health plan – the ANC is the majority and ruling party since the 1994 democratic elections in the country. This was followed by major policy development, e.g. the Reconstruction and Development Plan (RDP), a social and economic policy framework implemented by the SA government after 1994 [24, 25]. The commitment to decentralisation was an attempt by the SA government to develop an efficient and equitable health system, with the DHS being a primary vehicle for PHC [26]. The process of decentralisation and PHC is also considered to be an attempt to re-make/ re-establish the state under the new democracy i.e. to address the racial injustices of the apartheid regime in every sector of society including in healthcare [27].

Box 1.1 Structure of the SA health System

The health system is divided into and modelled along three tiers similar to its federal system; national, provincial and local (municipality and district) level.

Two types of decentralisation processes began as early as 1994 namely; deconcentration and devolution [28]. In SA, the establishment of the provincial and district health offices was an example of deconcentration, while devolution involved shifting the responsibility for service delivery to sub-national levels of government including the province and local governments (municipalities)[29]. As early as 1995, discussions and debate already centred on the roles

and responsibilities of the different levels of the health system i.e. national, provincial, local (districts or municipalities) [24]. Subsequent to this, there was the introduction of PHC nationwide in April 1996, with key legislation following such as the 1997 White Paper (close to being signed into law) on the transformation of the health sector (decentralisation and a unified national health system instead of being racially divided as in the past)[30].

Another crucial development in the early years of decentralisation included the National Health Bill 2001, which provided some guidelines around how SA should be demarcated into health districts, and pushing forward a legal framework advocating for a DHS [31]. The National Health Bill was meant to remove uncertainty around roles, functions and powers which had been persisting in the three spheres of government around the DHS since 1994[31]. However, the anticipated passing of the National Health Bill did not materialise during 2002 and resulted in a legislative vacuum and a lack of clear guidance/outline for the establishment of the DHS [32]. In 2003, the National Health Act (NHA), number 61 of 2003, was proclaimed by the president on 19 April 2005, most developments in establishing the DHS came then into effect [31]. The NHA, 61 of 2003 detailed different functions of each tier of the health system under decentralisation- the SA health system was to be divided into and modelled along three tiers similar to its federal system; national, provincial and local (municipality and district) level.

The National Department of Health (NDoH) provides policy and strategic direction in the health sector and the provincial level is responsible for ensuring implementation of polices in various districts/ coordination of district activities [34]. Although it is important to note that demarcation of different levels and structures of the SA health system has not been as clear-cut even after the enactment of the NHA. As mentioned and given the legislative and policy vacuum prior to the NHA, provinces developed their own legislations, policies and structures. Provinces differed in whether districts (Gauteng province) or metropolitan (Western Cape Province) structures where put in place. The issue was further compounded by the fact that the local level of the health system was comprised of districts and municipalities (local government) structures which previously used revenue generated to fund and coordinate PHC activities[32]. However, under the NHA provinces would now be responsible for PHC functions (provincialisation), with little clarity around municipal health services (MHS) and its purpose in relation to districts [32]. The unclear division of activities and roles between different levels, especially between the district under provinces and municipalities has serious implications. For instance, there were moratoria placed on employment of staff in both

spheres of government (district/ municipality) and staff reported being demotivated by frequent changes and a lack of clarity of roles (overlap of functions) or authority especially with regards to local governments[33]. Nonetheless, these shifts saw increasing authority given to the provinces to allocate resources and provide oversight of districts which would be established.

As mentioned, politically there has been long-standing (over 20 years) commitment towards the development of districts for PHC and SA is currently reforming its health system with UHC through developing the NHI [25].The National Health Insurance –NHI scheme is the country's present reform aimed at achieving universal health coverage (UHC) which further places emphasis on PHC and strengthening of lower levels of the health system such as the DHS [22]. The recently launched NHI policy emphasises the role of the district through the provision of PHC services. The White Paper explicitly states that strengthening PHC services is dependent on improved management at facility and district levels, the contracting of health services is also meant to take place through an established Contracting Unit for PHC (CUP) in health districts [35]. Districts under the NHI will be responsible for management and coordination for management and coordination of PHC services which will be provided by a range of public and private providers. 11 NHI pilot sites were selected across the country to test the roll-out of NHI and the process for contracting doctors from the private sector has already begun, although responsibilities have already shifted from the provincial to national levels of the health system and now managed by two external organisations [36]. Within the DHS, District Health Management Offices (DHMOs) is a structure to which management, planning and coordination of non-personal health services provision will be delegated and must take into account the separation of purchasing and provider functions of health services [35]. Although the NHI policy while attributing increased delegation and authority to districts fails to clearly articulate such roles and is not cognisant of present financial management failures. Furthermore, these considerations need to be aligned to existing legislation (NHA), the DHS is considered -

> "This level of the health care system should be responsible for the *overall management and control* of its health budget, and the *provision and/or purchase* of a full range of comprehensive PHC services within its area of jurisdiction. Effective referral networks and systems will be ensured through co-operation with the other health districts. All services will be rendered in collaboration with other governmental, non-governmental and private structures"- [27].

Within the SA health system the district level as discussed represents the decentralisation of health services and is considered to be the cornerstone of several important public health considerations, namely the Alma Ata vision of achieving PHC and important in forging the way for its present reform - NHI. The country's overarching vision for 2030, the National Development Plan (NDP) is also cognisant of the importance of NHI in achieving SA's development vision of 2030 [37]. The NHI is further solidified by the release of the White Paper in late 2015 (possibility of becoming law). The NHI is meant to address the country's high inequities in healthcare and places emphasis on both PHC and district development.

Despite key legislative processes, implementation and establishment of the DHS to deal with the burden of disease facing the country there have been persistent challenges. DHS implementation is quite complex and there are continued difficulties around clarity and coordination between the different tiers of the health system which needs to be addressed [7].Chapter four will provide further contextual detail of the process of decentralisation e.g. relationships between centralisation and decentralisation of core functions in relation to the thesis topic – financial management. It has been over two decades since commitments have been made regarding the establishment of the DHS, yet challenges at a district level include – capacity weaknesses, high levels of bureaucracy to access resources, hierarchical and rigid bureaucratic culture, and reluctance on the part of provincial government and health departments to decentralise authority to lower levels[33]. These challenges point towards an urgent need to address these challenges and strengthen the DHS, its core components including financial management and especially in respect to achieving PHC and UHC.

Parallel processes of transformation – decentralisation & SA history

Under the apartheid system public institutions were centralised, authoritarian and coupled with unjust racial fragmentation which resulted in a complex and inefficient structure of state services which extended to the health system [38]. It is important to note that steps towards transformation and implementation of health reform such as decentralisation have been in parallel to SA establishing a new democracy (since 1994). A shift towards decentralisation was seen as more than just a structure or form of organisation but shifting away from a centralised authoritarian apartheid regime to community involvement with a strong bottom-up approach to planning policy development and management [38]. Commitments to the development of health districts are considered to be increasingly important in SA to be closest to the people and so that people can become part of health services, thus catering for

diverse and previously disadvantaged populations (non-whites) in SA. Despite there being substantial commitments to the establishment and increasingly important role allotted to health districts in SA and attention paid to their development, districts have begun to be neglected given the lack of capacity. Furthermore, there has been some debate around the role of the districts and their importance which this thesis further interrogates.

Broader policies adopted and affecting the DHS in particular, included the Employment Equity (EE) Act, 55 of 1998 which provides for measures in the workplace to ensure elimination of discrimination and promotion of affirmative action (promotion/ recruitment) of previously disadvantaged groups [39]. The Broad Black Economic Empowerment Act, 53 of 2003 was aimed at promoting black empowerment through the state awarding contracts to companies owned by previously disadvantaged populations [39]. A key instrument meant to reform of the health sector in light of financial management, was the Public Finance Management Act (PFMA), number 1 of 1999 which put in place standards for transparent and sound financial management in all government structures [31]. These policies and key legislations other than having aims of ensuring redress (apartheid discriminatory policies) are tied to the functioning of the health system including decentralised financial management (further expanded in chapter 4-5).

1.2.3 Financial management – an essential component of the decentralisation process

Box 1.2 Definition of financial management

Financial management - four distinct processes occurring in a cyclical manner - planning, resource allocation and budgeting, oversight and evaluation

[7].

Section 1.2.1 and 1.2.3 detail the importance of the decentralisation process and the establishment of the DHS in SA. The core aim of this thesis is to examine financial management which remains a core yet constrained function within the DHS in SA. Effective financial management is required across developed and developing countries which face the dilemma of curbing health expenditure and simultaneously trying to ensure the delivery of quality health services [40]. Challenges, especially around decentralised financial management (district level) are evident in other low-and-middle-income country (LMIC) settings. In three West African countries, it was found that decentralisation was accompanied by poor financial administration [19]. Another study in Uganda, found that decentralisation resulted in the district having insufficient funds to fulfil its expected tasks [41]. In SA,

inadequate delegation of authority to management teams, defective budgeting processes, staffing issues, a lack of managerial skills and vacancies are reported difficulties of health sector decentralisation [42]. Literature cites poor budgeting processes and particularly financial management as one of the most critical challenges facing the health system in SA, particularly among lower levels such as hospitals [43].

In 2009, Integrated Support Teams (ISTs) commissioned by the Minister of Health, undertook a rapid review of the health system in SA [44]. The national report indicated that financial information systems were inadequate, strategic planning processes between all three levels of government (national, local, provincial) were not aligned and that there was a need for improved budgeting processes [44]. The Provincial Department of Health (PDoH)[1] for example faced an alarming trend of over-expenditure in the period 2005-2009[45]. Budgeting and financial management processes were found to be sub-optimal in the province, there was also a disjuncture between policy formulation, planning, budgeting and implementation [45]. Management teams across various districts in SA reported having limited authority to make and implement decisions, moreover they struggled to implement national and provincial policy or programs as these were not accompanied by the necessary financial resources, i.e. unfunded mandates [42].

It is argued that the current design of the health care system in SA depends on the success or failure of the DHS [42]. The NHI policy document, highlights the importance of strengthening financial management and it is also clear from the literature that the financial management component of the DHS is strained and requires urgent strengthening. As indicated and discussed there has been substantial research in other LMICs including SA which documents over and under expenditure, and difficulties associated with each of the four financial processes e.g. planning or resource allocation. The field of health policy and systems research seeks to understand and improve how different actors interact in policy and implementation processes. The field attributes a central role to people/actors within the system as either providers, managers, decision-makers in the system and whose values, norms, cultures and identities represent a key facet of every health system [48]. Health systems are considered to be constructed and brought alive by social actors through the meaning they attach to (their interpretations of) their experiences [49]. Alluded to earlier,

[1] PDoH refers to the province in SA in which district financial management was examined/ compared, the reference has been anonymised fort ethical reasons (also refer to chapter 3 – further details reasons for anonymising the province).

reforms require significant changes in organisations, particularly the relationships and individual behaviour (social actors), with arguments in the field that health sector reform should pay more attention to the micro – level, everyday organisational realities of health systems [9].

To understand actual practices, and human organisational behaviour organisational and institutional theory are fundamental – i.e. a social-cultural perspective [9]. While this thesis does consider the four distinct processes of financial management (planning, budgeting and resource allocation, oversight and evaluation) its key components, associated documents and challenges. The thesis differs to previous literature in that it is geared towards providing in-depth insight into the everyday reality of financial management. It attempts to provide a thorough understanding of district level realities (micro – level analysis) using a socio-cultural organisational lens to understand human elements of financial management i.e. software (detailed further in chapter 2). The approach attempts to understand important components such as interaction between individuals (communication), relationships and motivation which have been overlooked and is argued to inherently shape system components such as financial management.

1.3 Study Aim & Objective(s)

1.3.1 Overall aim

To understand the micro-level practices of everyday financial management in two health districts in province X, SA specifically focussing on strengths, weaknesses and mechanisms for its improvement.

1.3.2 Objective (s)

1. To examine the four cyclical financial management processes (planning, budgeting and resource allocation, oversight and evaluation) in each district.
2. To describe and compare organisational realities of the districts' financial management units, their financial processes cognisant of hardware[2] and software[3] factors.
3. To provide a comprehensive analysis of decentralised financial management linked to other units at the district level - procurement, human resources (HR),

[2] Hardware: elements such as rules, legislations, policies, skills, infrastructure, technology and funding levels of a health system.

[3] Software: knowledge, processes of decision-making, relationships, communication, practices, values and norms.

information technology (IT) and in relation to broader contextual influences i.e. provincial, political and historical.

4. To provide policy recommendations to strengthen decentralised financial management under SA's health sector reform policy (National Health Insurance – NHI).

1.4 Justification

Given that decentralisation continues to be the path of health sector reform across many developed and developing countries including SA and considering the shortfalls highlighted in the literature, it is important to continue documenting experiences, successes and failures. An effectively functioning DHS is cited as being critical to the success of health sector reforms and is considered to be the cornerstone of the SA health sector. However, literature in LMICs including SA draws attention to challenges such as financial management. More so, financial management is a pivotal dimension and crucial to DHS functioning and important policy documents in SA (NHI white paper) calls for its urgent and necessary strengthening [22]. Financial management is critical to manage resources in the district with far-reaching impacts on other support functions e.g. procurement but also on ensuring there are sufficient resources available for service delivery.

While prior literature has focussed and provided insight into financial management, reports and papers have primarily focussed on more of its processes e.g. poor coordination of planning or difficulty accessing resources (section 1.2.3)[44]. Thus there has been a focus on financial management in LMIC settings yet there has been little improvement of this crucial function within the DHS. Perhaps the answer lies in the fact that there has been minimal literature focussing on decentralised financial management in light of contextual influences e.g. historical and political factors or that organisational approaches have not been explored or interrogated (social factors such as relationships, staff motivation and values) [50, 14]. This thesis has attempted to understand what are the micro-level practices of every-day financial management, what are its successes and weaknesses but more importantly what are the mechanisms for its improvement.

This study addresses these gaps in the literature by offering a comprehensive analysis of every-day financial management within the DHS, cognisant of technical factors (resources, policies, legislations) but moves beyond to providing insight into organisational functioning. The organisational approach in particular has proved valuable in understanding social

elements of financial management e.g. individual actors who carry out financial management, their motivations, interactions and relationships (further detailed in section 2.4.3 and 2.5). While the field of health policy and systems research has made significant strides one of its weaknesses is that few studies are orientated towards theoretical development [49]. This doctoral research further couples the use of different theories spanning both sociological and health systems fields to provide further depth and understanding of the organisational realities and micro-practices and human elements of financial management (different theoretical lenses detailed in chapter 2). Secondly, it has contributed to public administration field and decentralisation literature in considering DHS financial management challenges within a broader context (province, politics – objective 3). Finally and later detailed in chapter 9 and 10, specific mechanisms for strengthening financial management at a district level with broader lessons for the district and other levels of the health systems are offered. These lessons are drawn from the theories employed and study findings.

1.5 Structure of thesis

This monograph attempts to provide an in-depth comparative analysis of financial management realities and specific processes and practices at a district level. Chapter 1 has set out the rationale for study and three study objectives (section 1.3). Chapter 2 details existing literature on the topic and places financial management within a broader centralisation, decentralisation debate, cognisant of political and contextual issues. The study adopts an organisational approach of which two dominant theoretical perspectives are discussed, namely; the machine and socio-cultural perspective (table 2.2). While the machine perspective offers useful elements, it fails to examine individual actors, their interaction (relationships) and their actions which shape financial management. These social elements are considered within the socio-cultural perspective which framed the study conceptual framework including data collection and analysis. The socio-cultural perspective is interrogated and further discussed to engage with structuration theory from sociology.

Thereafter the methods (chapter 3) provides insight into the type of study design used, each study site and methodological related issues such as ethical considerations and data analysis. Chapters 4-8 present the findings of the study. Each chapter is structured around addressing or answering each of the study objectives. For example, chapter 4 is concerned with providing a comprehensive analysis of financial management in relation to the province (PDoH) and chapter 4 provides an overview of the four financial management processes

within each district (objective 1). Chapters 6 and 7 provide an in-depth analysis of financial management processes and practices in the Indawo district and Isikhala district respectively (objective 2). While chapter 8 attempts to provide an interpretive analysis of the study findings between districts (comparative analysis) coupled with the theoretical perspectives employed in the thesis.

Lastly, chapter 9 is specifically geared towards an interrogation of the study findings in relation to study objectives and the literature outlined in chapter 2, limitations of the study are also discussed as well as the significance and contribution of this study to the broader field of health policy and systems research. Finally conclusions (Chapter 10) are drawn and both policy and practical recommendations are offered to guide the strengthening of district financial management.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter begins by providing an overview of the search strategy employed in reviewing and updating the literature. The chapter then moves towards providing a thorough discussion of several theoretical lenses and existing literature essential in shaping the objectives, data collection and analysis of the doctoral study. The primary aim of this thesis is to provide a comprehensive analysis of decentralised financial management between two health districts in South Africa (SA). The chapter begins by arguing that decentralisation cannot be examined without cognisance and an understanding of roles, responsibilities and coordination with higher levels of the health system in this thesis referred to as centralised levels e.g. the Provincial Department of Health (PDoH)[4]. Furthermore, literature is outlined showing the importance of considering contextual and political factors for decentralisation analysis which has played a significant role in shaping state institutions in SA. The study adopts organisational approaches to understanding everyday realities (micro-practices of financial management) two key perspectives are interrogated and its relevance hereby discussed – mechanistic perspective (bureaucracy), socio- cultural perspective, particularly structuration theory (human and social elements). Finally, the conceptual framework is presented in this chapter which brings together literature extending to low-and-middle-income countries (LMICs), specific objectives of the thesis and the theoretical approaches employed.

2.1.1 Methods guiding the literature search

The overall aim and objectives of the study guided the literature searched and utilised to frame the study's conceptual framework and outline key gaps which the doctoral thesis sought to address. The search was continuously updated throughout the proposal, data collection and thesis write-up stages considering key areas covered in peer-reviewed journal articles e.g. centralisation, decentralisation, theories (sociological), health systems notions (hardware and software), district financial management, grey literature including policies (National Health Insurance, Public Finance Management Act- PFMA, Labour Act) from the SA government, publications from the Health Systems Trust (strengthening district financial

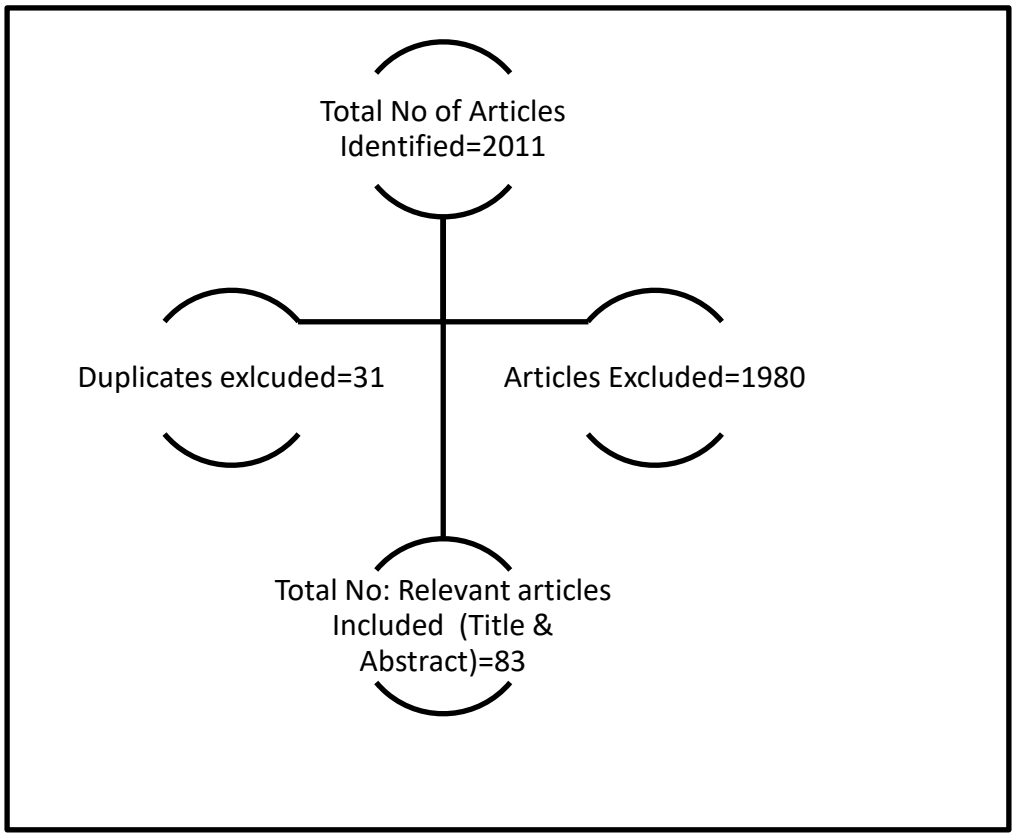
[4] South Africa is considered to be a quasi-federal state where provinces are considered to have considerable autonomy. Thus the provincial level can be recognised as having elements of both a centralised and decentralised level, in the context of this thesis it is understood as being the higher level i.e. higher than the district level and thus the functions it carries out may be decentralised in comparison to the national level but centralised in terms of the district level.

management) and the World Health Organization (WHO). Other areas of focus included leadership development, management, specific elements of financial management (planning, budgeting, resource allocation, oversight and evaluation), and public administration literature particularly considering a broader context for decentralisation. Specific journals or websites of institutions such as Health Policy and Planning, the South African Health Review, BioMed Central, American Journal of Sociology, the Collaborative Africa Budget Reform Initiative (CABRI) and Public Affairs Research Institute (PARI) were thoroughly engaged with to identify district financial management literature, public administration work and mapping the process of decentralisation in South Africa (SA). A more detailed search began tracking the articles searched, reviewed and included began in 2015 and updated on a six-monthly basis throughout the doctoral studies with the most recent update in July 2017.

A pilot literature search[5] was conducted between 1 February 2015 – 19 February 2015 to broadly map the literature on financial management (capacity, constraints and strategies for improvement) and to detect if any previous reviews were conducted on a similar topic. The Web of Science database was searched for published peer-reviewed journal articles. Grey literature included the platforms above (e.g. BioMed Central) and in some instances article reference lists pointed to additional literature. The full search was conducted and limited to the "healthcare sciences services" field in the Web of Science and the defined search period was between the years 2000 – 2015 and later updated to 2017. Duplicates were removed, and articles were screen based on title and abstract, and using the FM definition (planning, budgeting, resource allocation, monitoring and evaluation). Figure 2 .1 outlines the total number of articles, the total number of duplicates removed, relevant articles screened and if relevant included in the write-up.

[5] Key search terms yielding results; "decentralised financial management"; "financial management"; "financial management" strategies developing countries; "financial management" developing countries; "financial management" district level Africa; "financial management" local level Africa; "financial management" hospitals Africa; budget* district health; accounting* and budget strategy; "resource allocation" district; financial accountability district; "supply chain management" district; procurement district; strengthening district financial management, strengthen district health financial management.

Figure 2.1 Identifying and selecting relevant literature



[6]

Quality appraisals of articles were conducted using the Critical Appraisal Skills Programme (CASP) checklist for qualitative research (appendix B) [23]. In 2017, recent literature around strengthening financial management (WHO), articles on health policy and systems research (HPSR) – organisational strengthening and on the NHI policy reform in SA were searched and added to this chapter. Further literature searches involved updating the discussion chapter of the thesis and where necessary searching for literature pertaining to the methods (Chapter 3).

2.2 Centralisation, Decentralisation Debate - Importance of Complementarity & Coordination

As mentioned in chapter 1, decentralisation has been adopted as the main health sector reform in a number of countries (developed and developing) and is advocated to achieve

[6] **Inclusion Criteria;** low-and-middle-income settings, period years 2000 – 2015, public sector, district level/district health system/ local/meso & provincial levels, all study designs, topics included but not limited to - topics: financial management, planning, priority setting, budgeting, resource allocation, monitoring, oversight, accounting, auditing, costing, decision space, decision-making, authority, accountability, governance, capacity, financial information systems, procurement, supply chain management, internal controls, auditing, expenditure.
Exclusion Criteria; high income countries, articles prior to the year 2000 *(although if relevant e.g. mills or SAHR included)*, private health care facilities.

accountability, efficiency and responsiveness to local needs [5, 21]. There is some evidence in the literature which indicates that decentralisation has not yielded the intended benefits - for example two-thirds of people interviewed in two local authorities in Tanzania described its council (local) services as being 'bad', while another study found that close to 70 percent of interviewees in Ghana and 54 percent in the Ivory Coast stated that under decentralisation local authorities were not more responsive to their needs [19]. In other settings, such as the health sector in Brazil, one study reported decentralisation to be associated with increased bureaucracy, inefficiency, organisational fragmentation and political manipulation [18]. In SA, there is substantial complexity around the task of implementing decentralisation, it has also been a difficult to ensure the transformation of a fragmented and inefficient apartheid system into a unified national health system [30, 38].

Recent evidence indicates that developed nations also grapple with the decentralisation process and in some cases there have even been moves towards re-centralisation [51]. In Nordic regions, the process of decentralisation has been well-established since the 1970s; however, there have been recent moves towards re-centralisation of health services. For example in Norway, nineteen counties (districts) were replaced by five larger health regions run by boards appointed by the Minister of Health [51]. In Denmark, regional governments were reduced from fourteen to five and their powers were greatly reduced [51].

Turning specifically to decentralisation, international experiences indicate a number of challenges associated with financial management – e.g. a lack of skilled finance capacity in districts in Nigeria or district managers having to deal with the late disbursement of funds from the central ministry in Ghana [52, 53]. A Ugandan case-study points to the importance of considering both the centralisation and decentralisation phenomenon simultaneously. The study on decentralised financial management in Uganda noted the importance of having a well-functioning central level i.e. a national and provincial level which is also critical to decentralised units. The Ugandan study focussed on financial management of malaria control under a decentralised health structure, noting both centralisation and decentralisation weaknesses. District staff stated that resources were accompanied with instructions which specified how money should be spent. Other staff raised issues around accessing resources and districts facing long, tedious bureaucratic processes i.e. more than 25 steps between the district and central levels associated with the release of funds from central government [20]. The study effectively drew attention to a wider context in which centralisation factors should be considered; delays in remitting funds were due to the amount of paperwork and other

administrative procedures at the central level as well as other financial controls, such as donor funding requirements [20]. Central level authorities indicated that delays were also due to district factors e.g. a lack of skilled manpower at a district level - requests were either late or did not conform to guidelines.

Similarly, previous literature in SA points to both centralisation and decentralisation weaknesses of financial management. As early as 1995 in SA studies pointed to the importance of determining the functions which need to be carried out at both district and provincial levels [31]. However, structures and coordination between different levels of the health system remains complex in SA (discussed in section 1.2.2). In 1999, previous studies pointed to the fact that if the DHS is to be established successfully, the provincial and national Department of Health (DoH) will have to accept the diminished role [38]. The study further cited that the higher levels of the health system in SA are too involved with issues of implementation of operational level and that role clarification between different levels of the health system which are responsible for delays [38]. A previous study recorded that provincial managers for example also require approval from other actors e.g. Treasury which also contributes to financial management delays–

> "*You have to get 20 people to agree before you can do anything* and even when you have signing powers of R5 million, you have to go through endless processes to get a highlighter pen or a computer disc"-[54].

The literature indicates that, in LMICs including SA, decentralised financial management experiences are not well co-ordinated, there is a lack of clarity of roles and centralisation instead of supporting and propelling decentralisation has hindered it – ineffective centralisation over key finance functions e.g. accessing resources [42, 45]. It has been over 20 years, since the process of decentralisation has been implemented in the SA health system, yet it is clear that different levels of the health system remain weak and face challenges. This thesis focuses on decentralised financial management experiences and realities; however it is cognisant of the importance of complementarity and does not consider it in isolation from centralisation. Instead centralisation and decentralisation are viewed as two highly-interdependent processes –

> "Unfortunate, tendencies to discuss 'centralisation' and 'decentralisation' as if they were two, clearly defined, completely contrasting and therefore alternative states of

existence. This does not merely over-simplify issues but can actually hinder or distort both descriptive and prescriptive analysis"- [15].

Charles Perrow's (1977) writings around the bureaucratic paradox are in line with showing the importance of having well-functioning central and lower levels of an organisation. Perrow's 1977 writings further advocates for each level (central or lower levels) to have well clarified roles and well-coordinated activities (complementarity).

Box 2.1: Centralisation and decentralisation go hand-in-hand

A large organisation contracted a management consultant to identify areas of low-productivity. One of the consultant's focus areas was the management information services department; which is responsible for processing large amounts of information such as major divisions and sales, market trends and inventory control. The department had close to 20 employees which reported to one senior manager. The consultant found that the senior manager in the unit tried to exercise control over too many tasks, resulting in, information pile-ups or delays, neglecting tasks and the manager was described as the information bottle-neck.

The senior manager requested additional staff to deal with what he deemed a high workload. However, the consultant found that the manager handled too many routine matters, not enough authority was delegated and procedures should be revised in line with delegation to improve efficiency. The consultant recommended that two staff members should be promoted to mid-level manager positions and the department should be separated between these managers instead of recruiting new staff.

The two sub-managers coordinated functions and tasks between themselves, met regularly i.e. ensuring constant engagement/ communication between units. This reduced information flow that previously had to go to the manager i.e. they were able to deal with all routine matters the senior manager tried to handle alone, and as a result turnaround time for tasks was reduced and efficiency improved. The senior manager was able to tend to required tasks on time (and tend to tasks that he had previously neglected). These changes also allowed for more managerial time, the two sub-managers were able to improve staff morale, keep divisions happy and absenteeism also declined.

[55]

This example offers insight into the importance of considering day-to-day organisational tasks (routines). Box 2.1 shows that it is crucial to maintain centralised authority e.g. having a senior manager yet at the same time allowing for decentralisation of roles and tasks. What is important is that the right combination of tasks which are delegated should be achieved as well as coordination between the two levels (centralised and decentralised). It is thus important that the centralised authorities functions well and delegation takes place, the failure to delegate is described as 'eroding control' or inefficiency (e.g. senior manager initially tried to carry out too many tasks, resulting in either delaying or neglecting tasks and unable to manage the section effectively) which was evident. Most importantly, Perrot (1977) shows that delegating authority and decentralising has the possibility of working e.g. (mid-level managers) although there must be adequate coordination through engagement/ communication between levels, clarity of roles of actors and functions. These elements are considered in relation to providing a comprehensive analysis of financial management (which is objective 3 of this thesis).

2.2.1 Considering a broader context for understanding decentralisation

Other than complementarity there are multiple factors which shape the decentralisation process and should be considered when examining decentralisation or any of its core components such as financial management. Smoke (2015) offers a useful framework in public administration literature which details the importance of contextual factors (political, economic) and support mechanisms e.g. non-governmental organisations (NGOs/ aid agencies) which shape the decentralisation process. In SA for example; political interference in the health system often adds to further complexities to both provincial and district levels [54]]. Figure 2.2 draws attention to system development processes such as administrative control over financial resources, as well as other factors which feed into intermediate outcomes- improved managerial capacity and legal/ fiscal frameworks. Anticipated outcomes of the decentralisation process, includes improved service delivery, accountability, reduced poverty and stability (conflict reduction). The conceptual framework, figure 2.3 (objective 3) is specifically cognisant of factors detailed in figure 2.2 as it attempts to fully understand and compare decentralised financial management between two districts in SA.

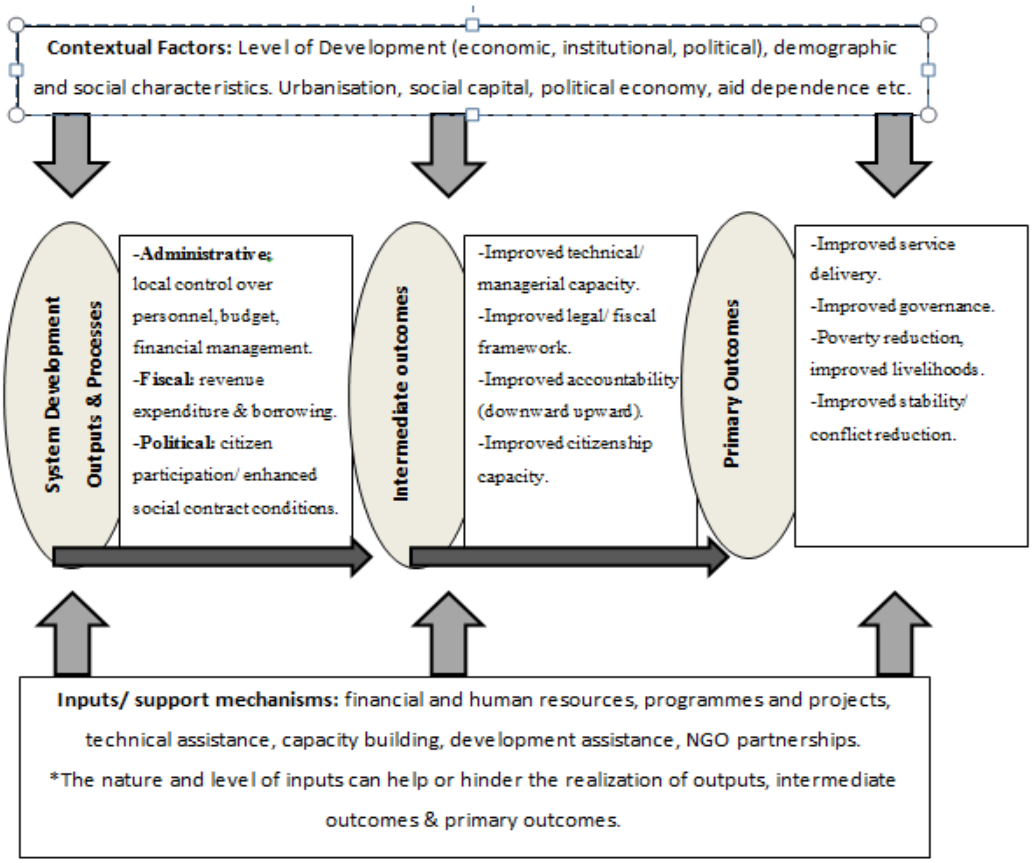


Figure 2.2: Mapping decentralisation processes: context, influences and outcomes [14]

2.3 Organisational Underpinnings & Perspectives of Decentralisation

Prior health systems literature on decentralisation affirms the need to utilise organisational perspectives which move beyond a macro-level analysis (components such as infrastructure, and economics of health systems) to organisational approaches focusing on its human and social dimensions [9]. In order to provide a comprehensive understanding of organisational reality, it would be important to understand both internal and external factors, including internal components such as individual actors, their relationships and motivations and as outlined centralised bodies, politics and history (section 2.2.1). Public sector organisations in SA are inherently shaped by its historical context and reform between different organisational models. The country transcended from an apartheid state to a democratic one i.e. from bureaucratic structures to New Public Management (NPM); privatisation and market-related principles. Public sector reform has taken place in parallel to decentralisation in SA, the two processes are inseparable and this thesis adopts the view that both processes (transformation outlined in section 1.2.2 and decentralisation) should be considered in any organisational analysis including that of district financial management. Health systems literature has

offered useful insight into the different perspectives of organisational life which are relevant to the field, namely the machine perspective and the social cultural perspective. A summary of these perspectives is provided in table 2.2, its relevance and adoption for the study is hereby discussed;

Table 2.1: Overview – perspectives of organisational life

Theoretical considerations	**Machine**	**Socio-cultural**
View of organisation	– Clearly define parts working efficiently together in routinized ways	– Reflective, responsive people forming complex social systems
View of human behaviour	– Compliant: humans simply comply with organisational change	– Social: human behaviour is influenced by social networks and relationships
Organisational form	– Hierarchy – Bureaucracy	– Social network – Community
Coordinating mechanisms	– Formal rules and procedures – Authority	– Norms – Values – Trust
Key organisational theorists	– Taylor (1911) – Weber (1947) – Fayol (1949)	–Roethlisberger & Dickson (1939) –McGregor (1960) –Golder (1954) –Merton (1957) –March and Simon (1958)

[9]

2.3.1 Machine perspective – public sector organisations and financial management

Health systems are considered to be complex institutions with a multiplicity of organisational forms, actors and interests [56]. This complexity is further heightened by the broader parallel processes and transformation of the state and its public sector institutions in SA (section 1.2.2). This has unduly affected organisational functioning including that of the district health system (DHS) and must be considered and understood in relation to decentralised financial management.

The previous administration in SA (apartheid government) was based on bureaucratic law, hierarchical, and characterised by racial oligarchy [57]. In fact, the apartheid government was considered to be a racial bureaucracy. Challenges of the past included a lack of representativeness in terms of the population of SA (race, gender and disability). There was a lack of popular legitimacy, lack of service delivery especially for blacks and centralised control and top-down management culture of public institutions [58]. It is thus important within the machine perspective of organisational functioning, to thoroughly examine the

notion of bureaucracy, its key theorist (Max Weber) its contribution to SA history and its role in defining present-day organisational structures in public institutions in the country.

Since the advent of the industrial revolution, organisations worldwide have modelled and incorporated elements of Weberian bureaucracy as a means of achieving efficiency. Weber's model of a rational organisation is premised on his notion of bureaucracy which thrives on six essential principles: namely the division of labour, hierarchical authority, extensive rules, separation of administration from ownership, promotion based on technical competency and impersonality [59, 60]. For Weber, an efficient organisation is a dehumanised rational model which succeeds in eliminating personal and emotional elements and is driven primarily by known rules and regulations - machine perspective [59, 61].

> "The fully developed bureaucratic apparatus compares with other organisations, exactly as does the machine with the non-mechanical modes of production. Precision, speed, unambiguity, continuity, unity, strict sub-ordination, reduction of friction and of material and personal costs, these are raised to the optimum points in the strictly bureaucratic organisation"- [61].

A review of literature pertaining to bureaucracy states that in reality it may be difficult to have all principles of Weber's ideal type organisation and instead bureaucracy should be viewed as a condition which exists along a continuum of low to high degree of bureaucracy [61]. Hall (1963) provides a useful overview of characteristics of the bureaucracy continuum in the literature;

Table 2.2: Excerpt from the literature- characteristics of bureaucracy by major authors

Dimensions of bureaucracy	Weber	Friedrich	Merton	Rudy	Heady	Parsons	Berger	Michel's	Dimock
Hierarchy of authority	*	*	*	*	*	*	*	*	*
Division of Labour	*	*	*	*	*	*		*	*
Technically competent participants	*	*	*	*		*	*		
Procedural devices for work situations	*	*	*		*		*		*
Rules governing behaviour of positional incumbents	*	*	*				*	*	*
Limited authority of office	*		*		*	*			
Differential awards by office	*			*					
Impersonality of personal contact		*							
Administration separate from ownership	*								
Emphasis on written communication	*								
Rational discipline	*								

* Cited by author [61]

Table 2.2 shows a mapping of bureaucracy literature and provides the rationale for why this thesis considers, outlines and expands Weberian principles which clearly shape bureaucracy understandings and literature especially with regards to well-functioning organisations. Table 2.2 specifically indicates that within the machine perspective of an organisation, Weber's theory of rational bureaucracy and its key principles which are cited and used by numerous authors (table 2.2 – Friedrich, Merton, Woody and Parsons) and must be considered and unpacked for research considering bureaucracy considerations. The literature mapped in the table further shows Weberian principles influencing the bureaucracy discourse. Based on this mapping of literature, six main characteristics (Weberian principles) were advocated when measuring the degree of bureaucracy [59, 61]. While Weberian principles of bureaucracy may yield efficiencies the literature alludes to the risks of over-bureaucratisation and inefficiency;

> "The virtues of bureaucracy are well known…if the bureaucratisation process is carried too far, if it is hastily pursued, and if it is misapplied, then the virtues turn into vices. Just where and when this occurs is a matter of speculation; however it is possible to discern the range when the functionality of bureaucratisation becomes dysfunctional... It has the possibility of resulting in inefficiency, then loss of productivity, and certainly dysfunctionality" – [60].

In order to move away from a machine bureaucracy (apartheids racial bureaucracy) and its perceived negative implications, the SA government as early as 1995 proposed to introduce decentralisation of managerial responsibilities. There was the introduction of new and more participative organisational structures, development of new organisational culture and learning organisations (a rule culture to one which is focused more on the achievement of meeting needs) [58]. From the late 1970s globally and in SA, the structure of Weberian public administration came under criticism, with the shift towards NPM [57]. An organisational model geared towards privatisation, restructuring of public services and introduction of private market disciplines with outcomes of good governance [57]. When the NPM was adopted in SA, it was associated with the attempts to re-invent the post-apartheid state, aligned to global thinking. There were suggestions that the SA state could continue to play a meaningful role in the economy and in society provided it moved away/aimed to transform from the bureaucratic model [57].

Since 1994, while there were attempts, legislation and commitment to transforming the public sector (section 1.2.2), however efficiency gains and actually moving away from the bureaucratic state was not achieved. While some gains have been made, for example increasing demographic/population representation in the public sector through employment Equity (EE), bureaucracy still exists, the state has not been able to move away from it, and is responsible for some inefficiencies including in the health sector. As Caiden (1985) stated, the dangers of over bureaucratisation is dysfunctionality – presently being seen, the health system in SA is characterised by some dysfunctional bureaucratic elements which continue to impact the system:

> While (managers) recognise the necessity of lines of authority and command… *hierarchies were obstacles in themselves*.… Respecting hierarchies also meant *time lags*, for work to be sent up and down the hierarchy. For example, parliamentary questions would be sent to the MEC's office, then to the Head of Department (HOD), then to the chain of the director and then to the deputy director who had to actually answer the question… *The relevant person would only have half an hour to do it* – [60].

Similarly previous research, found four main obstacles to DHS development, including hierarchical and rigid bureaucratic culture [33]. Some parts of the SA health system is subject to over bureaucratisation and its implications extend to financial management. Provincial and national managers in SA noted that bureaucratic procedures are one of the major factors hampering effectiveness (quote above). There was an understanding that procedures are required to prevent theft (misuse of public resources / corruption), however the cost of these procedures in terms of person hours spent was seen to be unnecessarily high – one manager described how a training programme had been delayed for months by the need to go through a tender board which had not sat for two months and they were unable to use available financial resources, others stated that-

> "Managerial challenges arise when, for example, all decisions flowing to the centre overburden the executives, resulting in slow and bureaucratic decision-making. Those at the central office will not be aware of local circumstances and will lack information about local conditions"- [62].

In SA and other country contexts a balance is yet to be achieved between Weberian bureaucracy and new approaches such as NPM, instead we see bureaucratic factors

continuing to hamper decentralisation. In fact, some literature states that the process of decentralisation is often obstructed by inappropriate or ill-defined organisational structures of the ministries of health and its associated bureaucracies with challenges such as clarity around rules, roles (hierarchy) and functions [63]. Only a few studies in LMIC contexts consider and provide a thorough analysis of the role of bureaucracy in health systems, yet it is clear that the two cannot be separated from everyday organisational realities. Internationally, previous studies in Nepal have found that formal hierarchies are not effective in solving local service delivery challenges and instead used to protect political and monetary interests of higher-level officials [64]. Other studies argue that organisations do not necessarily conform to Weber's rational bureaucracy, instead organisations especially government bureaucracies are influenced by external local cultures [65]. There are a few examples in existing SA literature which consider bureaucracy, the country's history and organisational elements of the health system (objective 3 of this thesis). Von Holdt's (2006 and 2010) writings consider the health system in relation to SA history and bureaucracy, specifically alluding to hierarchy and offer a useful analytic lens for understanding district financial management in a broader context. While there are a few other studies which examine financial management attempt to do this i.e. analyse bureaucracy and a broader historical context (discussed below- section 2.3.2) the studies do not go as far as Von Holdt's work which shapes significant considerations within this thesis.

2.3.2 Organisational and historical features – decentralised financial management

The primary argument of shifts towards transformation (section 1.2.2) was strictly about overhauling the bureaucratic system associated with the apartheid system [57]. The process of decentralisation, together with transformation of the public sector took place simultaneously, making Von Holdt's (2006 and 2010) writings relevant. It provides an analysis between the states trying to simultaneously address past racial injustices, while establishing a modern state specifically focussing on financial management [66]. Von Hold (2006) states that these two goals of the SA government are inherently opposed – he identified six features in the post-apartheid democracy found to affect decentralised state institutions such as hospitals, i.e. class formation, ambivalence towards skill, importance of face, hierarchy, ambivalence towards authority and budgetary rituals [66]. This thesis moves beyond the machine perspective to consider these factors influencing organisational functioning and in turn financial management (objective 3 – broader contextual understanding of financial management).

Feature 1: Class formation

Black class formation is critical to redress, legislation includes aspects such as filling posts by black professionals or leaving such posts vacant if there are no candidates of colour. In such cases, this supersedes Weber's principle of technical competency when there are suitably qualified white candidates. For example, another study in SA reported difficulties on national and provincial levels due to the transformation agenda prioritised over technical competencies in the system;

> The source of frustration mentioned by several interviews… Some of the colleagues or seniors were not competent and nothing was done about it... *Others spoke of colleagues who couldn't use a computer, handed in documents that had not been spell-checked and who didn't have the knowledge to do their job* – [54].

At a health systems conference focusing on decentralisation and reform hosted by the Development Bank of SA (DBSA), the difficulties between transformation, appointing skilled black staff, and the promotion of unskilled staff were noted;

> The lack of competent managers…*the filling of middle and senior management posts with insufficiently qualified or experienced people… Those individuals who do not have the necessary training and experience*… And ambition to succeed in the public service, their rise to the levels of seniority can be rapid with such staff staying only months in a post before applying for the next level of posts… This has the effect of leaving no skills transfer embedded in those that remain…and the number of senior level posts that remain vacant for long periods- [67].

However it is important to note, that given the country's history, transformation is necessary (black class formation – empowerment of previously disadvantaged races under apartheid). There has been some evidence that presently the SA government including health institutions engage in promoting employment/ entrepreneurship through tender processes for procurement amongst the black middle-class owned companies as a means of transformation/ black class formation. Such policies such as Employment Equity (EE) and Broad Based Black Economic Empowerment (BBBEE) discussed in section 1.2.2 usually takes precedence over cost-effectiveness/ efficiency i.e. normal procurement processes best buy and quality. Instead this shows that the health sector is grappling with SA's transformation agenda (empowering previously disadvantaged) and trying to procure items cost-effectively e.g.

economies of scale at the same time which may not necessarily be in tandem affecting financial management – budgets, expenditure, resource allocation.

Feature 2: Ambivalence towards skill

Under apartheid, power and race were intertwined e.g. whites wielded power and authority due to being more skilful and educated. As a result, there is an ambivalent feeling towards people who position themselves as being more skilful.

Feature 3: Importance of face

The notion of 'face' according to Von Hold (2006) refers to the SA state having to portray its achievements since the advent of democracy and particularly its reputation and gains in terms of its desired transformation goals (addressing injustices perpetuated by the apartheid system). This feature is important in SA state which attempts to show that it has provided a complete overhaul of the previous administration (apartheid bureaucratic, unjust and rule-bound system) to a transformed public sector [57]. As a result, the state is reluctant to admit to any challenges or addressing these issues.

Feature 4: Hierarchy

Hierarchy concentrates authority, provides direction and ensures coordination. It is meant to enforce accountability through clear lines of responsibility between upper and lower echelons of an organisation. Government acknowledges that despite several moves towards transformation, the public service is considered to still operate within an over centralised hierarchical and rule-bound system [58]. Hierarchy in particular points to the presence of bureaucratic elements which are hindering the health system and cannot be separated from the decentralisation debate in SA (section 2.3.1). Clarity around the roles and responsibilities of different levels of the health system still remain. Districts in SA, state that they have limited delegated authority especially over financial control and in accessing resources [42, 68]. Section 2.3 outlines difficulties – extremely long processes to access resources (even when available) at both provincial and hospital levels e.g. challenges to procure stationery in the health system. Alternate studies stated:

> We have financial autonomy and control, however the system does not enable us to actually benefit from the control – [54].
>
> Approval of appointments in budget is carried out at a provincial level, limiting the ability of managers to staff the institution… Politically, decision space and authority

> for CEOs of hospital is restricted due to hierarchical control and centralisation at the provincial level – [69].

Interestingly, hierarchy is associated with the machine perspective (Weber) which the SA state was attempting to overhaul. However, it is clear that hierarchy, particularly bureaucratisation continues to exist and may constrain rather than assist the functioning of the health system in SA. Another challenge is that hierarchy tends to enforce the command and control approach that reduces participation and opportunities for leadership, especially at lower levels. Excessive hierarchy in the literature is also described as being inefficient-

> "Excessive red-tape frustrates the hierarchical apex as much as it does clients of the organisation. It further distances those at the very top from what is really going on. They are already isolated enough if they do not remove themselves altogether by indulging in the grosser forms of elite behaviour. Having reached the top and being successful in their own eyes, they tend to self-indulge, to surround themselves with excessive privileges (the rewards of getting to the top) and act imperiously. The world they live in is so different from everybody else's. They are in danger of cutting themselves off even from their own organisation. *In short, the two worlds at the top and bottom of the hierarchy have little in common.* In their over-protected cocoon, the elite hear what they want to hear and they are told what it is supposed they want to be told. The picture they get of the organisation is what ought to be going on, not what is, going on. Calamity catches them by surprise; their shock is real, not posed. They really do not know"- [60].

Feature 5: Ambivalence towards authority

Authority in this context refers to discipline and accountability within an organisation which is not necessarily negative e.g. disciplinary processes for poorly performing staff. Performance management processes are meant to hold staff accountable, however in the SA context previous literature indicates that these processes are hindered by political and trade union influences leading to a breakdown of discipline i.e. contradicting disciplinary processes (ambivalence). The process of decentralisation is argued to be both a technical and political process, political influences are considered to add to further complexities to organisational health systems [54, 62]. Trade unionism was disallowed under the apartheid regime. Since 1994 there has been a rise of power and authority of the unions. More so, there has been a strong affiliation between the majority party in the country (ANC) and trade unions, further

heightening their power in state institutions including the health system. Together both politics and unions have influenced the functioning of the health system – influencing performance management processes, disciplinary processes/ breakdown of discipline and accountability in the system. Box 2.2 reveals the impact of union influence on the breakdown of authority in a specific hospital in SA;

Box 2.2 Examples depicting union influence & ambivalence towards authority in Chris Hani Baragwanath Hospital

"When the ANC took over, everything became relaxed; you could do anything in the new dispensation . . . *The lowest categories control the hospital. Since the unions were introduced the shop stewards have been running the hospital*, but they cannot even write their names! They get out of hand and it is difficult to handle. *Management is scared to discipline and control.* The shop stewards confront and victimise the nurses. We also belong to a union but we do our job. Everyone barks at us. We have no dignity; we are degraded. There is supposed to be democracy, but not in the manner of Baragwanath".

"There are *no disciplinary measures from top to bottom.* Who is to discipline whom, when? Someone comes on duty drunk but he will never be disciplined. Are we not supposed to be disciplined? Where is this discipline? A known habitual loafer is never disciplined. Someone steals a patient's clothes. They know exactly who is responsible, but there will be no disciplinary action. They call a meeting of everyone and give a lecture on how to conduct ourselves".

"Now we have corruption. Some do not work, others do. People are ungovernable. *They just disappear; there is no discipline*. They sign in for work and then go out, and at 3 p.m. they come back just to sign out. Their supervisors know and do nothing. Some of them do their washing and ironing on the premises ... Some of them are taxi owners and go to drive their taxis; others sell cassettes on the bridge"

[43].

The role of politics was also found to erode internal authority within hospital management. For example one study found that political/ trade union factors affected recruitment processes of staff and further weaknesses to governance structures meant to ensure accountability;

> Board members tend to forget the reason why they have been appointed … *Bringing politics into an institution not focusing on healthcare and the reason why they have been appointed.* The hospital board was dissolved because of issues of not knowing what governance is… There were some shortcomings before, especially in terms of

governance; the hospital board was really holding the institution to ransom. How do you put in a board member into the shortlisting of candidates for the hospital … *They want favours, they interfere too much and some even organise marches (protest) to hospital management* – [69].

Feature 6: Budget rituals

The sixth feature deals with financial management, already outlined (section 1.2.3) as a critical yet strained factor within health systems, including the district. It is argued that budgets continue to be drawn up by provincial levels and based on historical allocations, with minimal engagement from lower levels. Furthermore, financial systems are not linked to activities and it is impossible to engage meaningfully with financial information or for costs to be managed, severely impacting the organisations functioning and keeping track of its activities [66].

International literature for example also indicated similar difficulties at lower levels of the health system. For example, focussing on specific financial management processes, it was found that budget and planning processes at a hospital level in Kenya were poorly aligned, with inadequate role clarity of staff [70]. Similarly, inadequate financing levels, poorly designed financial financing arrangements and limited autonomy and decision space were found to negatively impact hospitals in Kenya [71]. Other specific literature showed that inability to collect data and the lack of funds to implement planned activities led to district teams questioning the usefulness of planning activities, which form part of the financial management cycle. Another factor found to influence planning included the perceived lack of decision-space Enablers and barriers to evidence based planning were found in the district health system in Uganda [72].Factors affecting budget rituals in Nepal included the fact that funds were only released later in the year, where at least half of the health budget was not received until the last four months of the year resulting in 20 percent underspending [73].

In line with the literature this thesis argues that it is clear financial management remains a major challenge under decentralised systems both globally and in SA. Organisational functioning of state institutions in SA, including financial management in health districts are affected by bureaucracy, transformation of the state (redress for apartheid policies) as well as the 6 key features (above) discussed. As argued by Von Holdt's (2010) and other supporting studies also outlined, the state has shifted away from the white-dominated, disciplined and

authoritative environment to being less authoritarian yet hierarchical with a breakdown of control and discipline, with levels, tasks and authority between different levels of the health system remaining unclear [38, 54]. Public sector institutions, including those in the health sector are evidently shaped by SA's historical context, its shifts in transformation of the public sector and continued bureaucracy. The machine perspective in particular offers insight into the role of bureaucracy and challenges linked to weaknesses in terms of district financial management e.g. difficulty accessing available resources. The machine perspective while relevant is based on the premise of theorists such as Max Weber who do not consider the human elements. Nonetheless, it is important in understanding SA's present-day bureaucracy and its elements in the health system. However, this thesis further considers the weaknesses of the machine perspective, in that it is not cognisant of social elements of the organisation particularly offering insights for objective 2 of the thesis (in-depth analysis of financial management realities).

2.3.3 Socio-cultural perspectives of health systems

Weber's work is centred on rules, regulations and the depersonalisation of relationships – principle of impersonality where individuals are rational beings and carry out tasks irrespective of emotions or personalities [74]. Weber's primary focus is on formal relations and structures within an organisation and while there is evidence of its contributions to effectively functioning organisations and it has little cognisance of informal structures which enable communication, norms of daily conduct, cohesiveness and individual choice/ independence[74]. In contrast to Weberian bureaucracy or as discussed (the machine perspective), structuration theory in line with the socio-cultural perspective places emphasis on the importance of actors as being reflective and responsive and their choices in shaping systems i.e. their actions (agency). It is argued that the human element particularly human values and behaviour is critical to ensuring effective functioning of health system components such as financial management [75]. This supports the debate that systems begin and ends with people, it is people who operate in various roles and contribute to changing or shaping a system [76]. As with any system, a health system is comprised of individuals, machines only aid with financial management, however it is individuals who carry out daily financial tasks. There is a dearth of information in this regard; particularly actors, their motivations, values and interaction at a district level and its influence on financial management which this thesis considers (objective 2- in-depth comparative analysis of financial management realties and practices).

2.4 Structuration Theory – Essentiality of Hardware and Software

Health policy and systems research is a relatively new field which is still in the process of evolving, as such there is recognition and an increasing focus and need to utilise theories especially from the social sciences [49, 77]. Central to the literature mapped in table 2.2 the socio-cultural perspective considers health systems to be social systems, points to specific social science theoretical contributions and recognises the importance of individuals and their roles within healthcare organisations [9]. Giddens is not explicitly listed in table 2.2 although his writings are aligned to the socio-cultural perspective and he offers a useful analysis of two different dimensions of the health system – structure and individual agency. Structuration theory states that agents and structures in social systems are inter-dependent phenomena, whereby the one shapes and continuously changes the other [6]. Agency refers to the micro-level (individual human actors) and structure is considered to be social structures (rules and resources) [2]. The theory argues that structure will not exist without the actions of individual agents, vice-versa and that each dimension constantly moulds and re-creates the other [6]. While there has been much contestation (a long-standing sociological debate) around the importance of structure over agency, this thesis considers both to be pivotal in shaping decentralised experiences of financial management.

Structures, particularly rules, policies and regulations are important in shaping society and could be linked or likened to Weber's notion of rational bureaucracy and its associated crucial formal structures. Chipkin (2012) highlights the importance of understanding public institutions in light of a broader structural context e.g. the state, its policies and goals. Section 2.3.2 further outlines Von Holdt's (2006 and 2010) writings on the SA state, its goals to deal with apartheid's injustices and policies of redress indicate the influence of broader structures such as the state on decentralised institutions – hospitals. The six elements outlined by Von Holdt (2006) draws attention to the influence of (structure) polices such as BBBEE and difficulties with hierarchy as well as financial management and its associated bureaucracy as well as social elements such as authority.

Although rules and resources do not exclusively refer to larger scale structures but also considers an organisations' daily routines which may be governed by both formal and informal rules [78]. Structuration theory argues that established routines are put in place and either reinforced or transformed by actors. These routines are deemed necessary for organisational functioning, culture and interaction; thus routines may influence how different

agents operate on a daily basis but may also be the outcome of actions if agents attempt to transform/ re-inforce them – duality of structure. This thesis considers the everyday routines of financial management, particularly focussing on tasks linked to the four cyclical processes[7] of financial management, how and why these routines were carried out including their functionality/ dysfunctionality. The concept of agency is associated with individual actions, which removes passivity of actions as considered by Weber, instead it sees individuals as actively appraising each situation, being reflective, knowledgeable and having the ability to act and as mentioned to either reinforce or change routines and situations [78, 79]. Agency is considered to be a resource within the system, contributing to system functioning and change, developed by an individual's personal experience and life-course, which to an extent influences their capacity and will to display it [79].

This points to agency not being a stand-alone phenomenon, influenced by structure but also by other components e.g. knowledge, skills and experience. While structuration theory considers elements such as power, agency could be further expanded as per the aforementioned. Thus the thesis attempts to draw on complementary notions of structure and agency linked to health systems notions of hardware and software, where the software dimension is particularly cognisant of knowledge and skills. Structuration theory and health systems notions of hardware and software are considered to be inherently interlinked with overlap for example similar to structure the hardware dimension of health systems includes rules, legislations, policies, skills, infrastructure, technology and funding levels of a health system [8]. Thus, while there are overlaps, the usage of the two theories addresses weaknesses and extends understandings of organisational elements i.e. hardware and software essentially offers an extension of elements to be considered within the structuration theory framework. It is essential to consider a complementary theory given that shortfalls of Giddens– there is no resolution and clarity offered between the dualism of structure and agency [80].

While the hardware dimension of financial management is undoubtedly important, software factors such as norms, values and relationships are equally so [8]. The lack of research on the value of software components is possibly one of the reasons responsible for the limited improvement of health reforms such as decentralisation [9]. Understanding actual daily practices, such as routines, communication and actual implementation together with hardware

[7] Financial management – planning, resource allocation and budgeting, oversight and evaluation.

components was found to improve health systems functioning at a sub-district level in the Western Cape province of SA [8]. Further health systems research suggests that organisational life, particularly routines are structured through documents and technology and also supported by collaborative work between people, their capability, identity and agency [81]. Routines are centred on what individuals will do and can do and is at the very centre of organisational life, although it is influenced by the hardware and structure e.g. level of available resources and technology but also by power, knowledge, skills and experience. For example, the software components – authority and power are argued to be separate but related concepts.

Under the decentralisation reform, one of the pivotal issues is to assess how much authority (decision-space) do agents at a district possess to carry out their tasks, including financial management tasks [5]. One study focusing on eight developing countries found that planning and costing was limited if district managers were not given sufficient power or authority to make decisions [82]. Earlier research conducted in Ghana, Uganda, Zambia and the Philippines indicated that all countries had moderate decision-space with regards to expenditure [5]. In essence, individuals at a district health level in these countries reported not having sufficient power or autonomy to financial management decisions. In the SA context, provincial health departments are reported have a high level of autonomy with regards to decision-making and resource allocation and thus influence districts financial functions [83]. It is clear that one of the main challenges at the district level is that there is no clear locus of power and that authority which has been decentralised is difficult to exercise due ill-defined roles between levels and presiding power/ authority [66]. Thus understanding power dynamics between the district and other levels of the health system is important in understanding coordination and authority linked to different financial functions and under decentralisation (centralisation, decentralisation debate outlined in section 2.2).

This study explores the impact of components related to structure and agency aligned to the socio-cultural perspective, how it further argues that the concepts are interlinked and shaped by hardware and software which are crucial components of a health system and influences district financial management. Prior research in Brazil emphasises the critical role played by informal aspects of management, and a wider political context in the implementation of policy and performance of the DHS [86]. Furthermore, to deal with the late disbursement of funds in Ghana, district managers reported using informal coping mechanisms (breaking formal rules) – borrowing resources internally, striking agreements with suppliers to purchase

goods on credit or preserving donor funding for when resources are needed [53]. This thesis argues that while agency is necessary to deal with decentralisation challenges it also aligns itself to the argument that capacity, interpersonal relationships (software) is equally important and actually shapes agency. For example, a prior study in Ghana points to the importance of attitudes, values, mind-sets, communication, staff motivation and relationships which are crucial to achieving and establishing effectively decentralised institutions [85]. This thesis essentially attempts to provide an in-depth understanding of financial management realities at a district level making use of the socio-cultural perspective and four particular elements structure, agency, hardware and software which shaped both data collection and analysis (objective 2, chapter 3-8).

This thesis further argues that displays of agency are premised on leadership. There is much contestation regarding definitions of leadership and management, although there is recognition in the literature that both management and leadership overlap in practice and that both are crucial to strengthening the DHS and to bring about the necessary change in service delivery and that both are crucial in an organisation [11, 86]. Management for example involves coordinating technical processes such as planning, budgeting, organising and staffing, whereas leading is about enabling those within and outside the system to face challenges and achieve results in complex conditions [11]. While these competencies are necessary in carrying our financial management practices, agency lies in the ability of individuals to operate in the face of constraints, find solutions and be innovative i.e. leadership. In contrast to management, leadership is broadly defined as creating a vision, communicating the vision, inspiring, motivating and aligning people and the organisation to achieve this vision [11]. Instances of agency within both districts will thus also be considered within a broader understanding on what facilitates leaders to act, but also what allows for and fosters leadership in these settings. Below are core competencies which the literature argues leaders should have;

Table 2.3: DHS – leadership competencies *(adapted)*

Competency	Description
1.People management & empowerment	Must be able to manage and encourage people, optimise their outputs and effectively manage relationships in order to achieve organisational goals.
2. Problem-solving & analysis	Must be able to systematically identify, analyse and resolve existing and anticipated problems in order to reach optimum solutions.
3.Programme & project management	Must be able to plan, manage, monitor and evaluate specific activities in order to deliver the desired outputs.

Competency	Description
4. Knowledge management	Must be able to promote the generation and sharing of new knowledge and learning in order to enhance the collective knowledge of an organisation.
5.Strategic capability & leadership	Must be able to provide a vision, set the direction for the organisation and inspire others in order to deliver on the organisational mandate.
6.Communication	Must be able to exchange information and ideas in a clear and concise manner appropriate for the audience in order to explain, persuade, convince and influence others to achieve the desired outcome.
7.Financial management	Must be able to compile and manage budgets, control cash flow, institute risk management and administer tender procurement processes in accordance with generally recognised financial practices in order to ensure achievement of strategic organisational objectives.
8. Change management	Must be able to initiate and support organisational transformation and change in order to implement new initiatives successfully and deliver on service delivery commitments.
9. Service delivery innovation	Must be able to explore and implement new ways of delivering services that contribute to the improvement of organisational processes to achieve organisational goals.
10. Client orientation & customer focus	Must be willing and able to deliver services effectively and efficiently in order to put the spirit of customer service into practice.
11. Honesty & integrity	Must be able to display and build the highest standards of ethical and moral conduct in order to promote confidence and trust in the public service.

[11]

The literature outlines two possible approaches to nurturing leadership competencies outlined in table 2.3. A review focusing on developing leadership and management capacities in low-and-middle-income-countries (LMICs) found that formal training (through university courses and workshops) is a common approach to leadership development [11]. Another alternative is work-place-based learning (informal learning). Within the informal approach of leadership development, workplace-based learning supports development of leadership skills, and allows actors to respond to changing circumstances in the workplace [87, 88]. This thesis considers such approaches to understand linkages between individuals who manoeuvre constraints/ find solutions and strengthen financial management in relation to both leadership skills and development.

The literature has shown that health system functioning including core components such as financial management would function more effectively in the presence of hardware, software, structure and agency (linked to leadership). Existing studies also point to other factors for consideration. For example, Cashin et al (2017) in a recent WHO publication discuss areas which should be given priority to ensure alignment between public financial management (PFM) and UHC – such as more coordination/ better communication between Ministries of

Finance and Health. They put forward the argument that a strong PFM system could lead to a higher and more predictable budget allocations, reduced fragmentation in revenue streams, timely budget execution and better accountability. However, they also argue that there are times when fiscal decentralisations can be at odds with policy objectives – pooling of health funds and particularly in countries where PFM systems continue to focus on line-item budgeting with little flexibility. It is argued that line-item budgets often lack flexibility to shift expenditure based on service deliver needs thus health care authorities should have enough autonomy to make decisions about allocating internal resources [73].

CABRI suggests that "value for money" as being key to achieving efficient spending. The "value for money" approach brings together the relationship between inputs, outcomes and outputs. In particular it is understood as the optimal use of resources to achieve the intended outcomes, which involves assessing whether the level of results achieved represent good value for money, against cost incurred [89].Rwanda's implementation of this program based budget structure as a strategy has led to an improvement in the orientation of its budget. It is based on the foundations of three key instruments, the annual budget (which identifies financial inputs required to achieve results), annual action plans (which identifies activities required to achieve results), performance contracts (to identify outputs and outcomes). These three instruments link financial inputs to specific outputs and outcomes which makes it more effective [89].

Another study shows how the aims of decentralisation i.e. increased accountability were achieved in Sierra Leone. Through civil society action, district health budget tracking scorecards were created to summarise findings on financial management in fourteen districts. The scorecards depicted progress on allocation and disbursement of funds at different levels in each district and how districts performed relative to others which resulted in citizens demanding accountability. The scorecards essentially allowed voters to hold leaders to account due to their evidence and knowledge of financial mismanagement of health districts [90]. This thesis, particularly objective four (policy recommendations) together with the study findings have engaged literature aimed at strengthening financial management.

Box 2.3: Summary key theoretical underpinnings (thesis)

Social science perspective - structuration theory

- Structure: considered to be social structures (rules and resources), enacted through and organisations' daily routines e.g. financial processes.
- Agency- a micro-level phenomena (individual actions), considered to be a resource within the system, contributing to system functioning and change e.g. to take action despite constraints.
- Duality of structure: structuration theory argues that established routines are put in place and either reinforced or transformed by actors. Routines may influence how different agents operate on a daily basis but may also be the outcome of actions if agents attempt to transform/ merely reinforce these routines.

Health policy & systems research *(complementary theory)*

- Hardware: similar and interlinked to structure refers to elements such as rules, legislations, policies, skills, infrastructure, technology and funding levels of a health system.
- Software: similar but an extension of agency includes components such as knowledge, processes of decision-making, relationships, communication, practices, values and norms.

Thesis contribution *(refer to figure 2.3, circle 1)*

- Structuration nexus: relationship and influence between four interconnected elements of financial management (and broader organisational functioning) – hardware, software, structure and agency.

2.5 Study Conceptual Framework

Figure 2.3: Conceptual framework- analysis of decentralised financial management

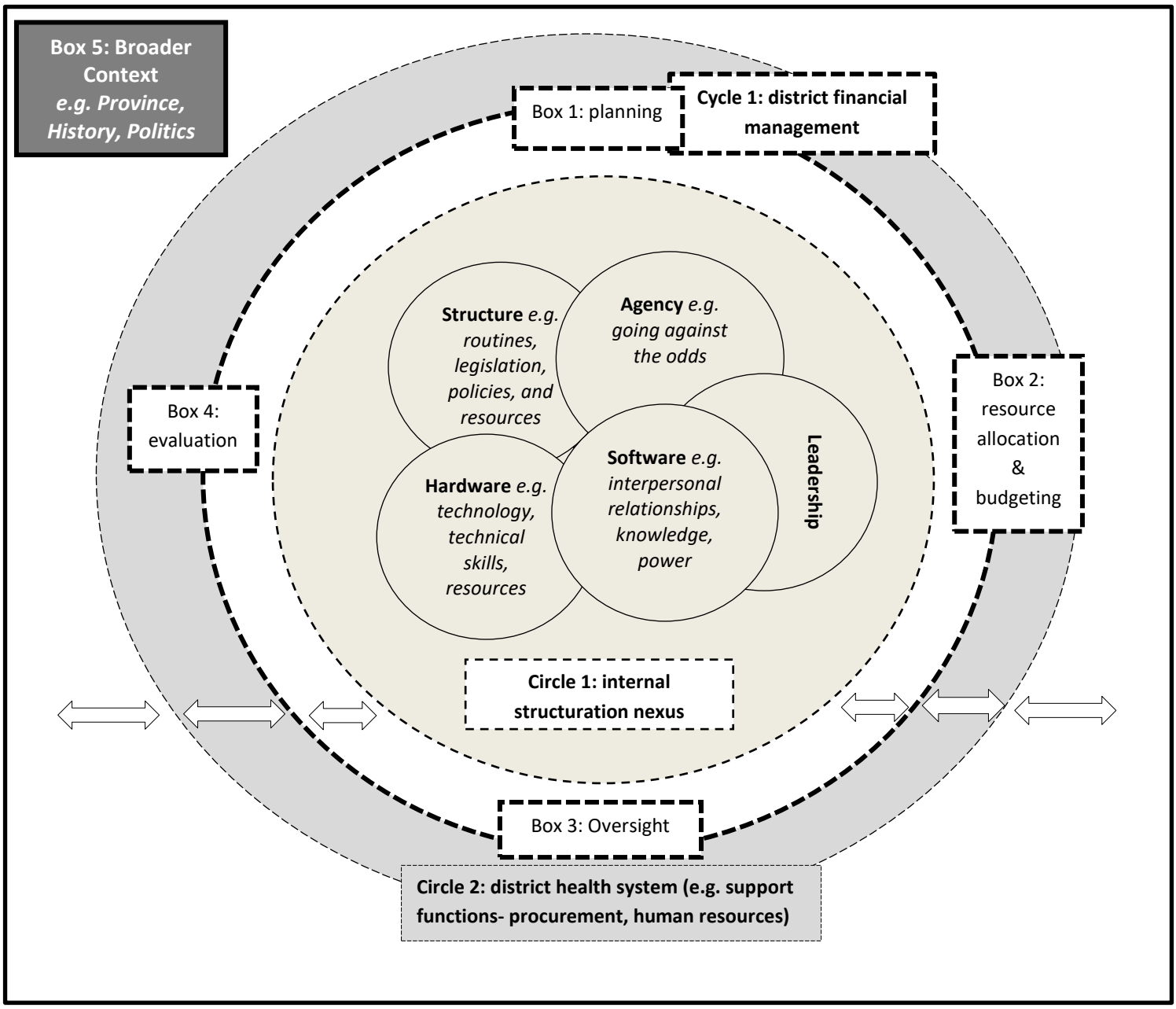


Figure 2.3 presents the conceptual framework developed and adapted for the purposes of guiding the research questions and data analysis for this thesis. The conceptual framework has drawn on financial management literature and theoretical perspectives (structuration theory, hardware, software and bureaucracy). Boxes are used for labelling purposes or specific processes and ease of reference when referring to the framework. Circular depictions refer to the district level while the outside square box of the conceptual framework denotes a

different levels of the health system, namely; the province. Cycle 1 is linked to objective 1 of this thesis; to examine the four cyclical financial management processes in each district. Box 1-4 depicts a cycle comprised of four processes, namely; planning, resource allocation and budgeting, oversight and evaluation.

This thesis considers the structuration nexus (circle 1) to be at the core of district financial management. The nexus brings together sociological and health systems notions which overlap e.g. hardware and structures both include resources. A weakness of structuration theory is that agency does not extend to understanding factors which propel it e.g. knowledge which is shown to be inherently interlinked to software. The study considers both agency and software to be linked to leadership. The conceptual framework adopts the main argument of the thesis that decentralised financial management is ultimately shaped and influenced by organisational factors outlined in circle 1 - structure and agency as well as hardware and software. The four elements were considered to be essential in relation to routines which are either reinforced or transformed through individual action (agency). Routines in this conceptual framework refer to every-day practices (formal and informal) specifically linked to each of the listed financial processes (cycle 1, box 1-4). Through understanding factors within the internal structuration nexus, everyday practices, routines and realities emerged and were shaped by these factors and thus answered the primary objective of this thesis (objective 2) - to provide an in-depth account of organisational realities of district financial management. It is however important to note that financial management does not take place in isolation to other units within the district and is linked to, interdependent and even influences the broader district e.g. other support functions (procurement, information technology (IT) and human resources – HR) as well service delivery. Circle 2 reflects the DHS which was cognisant of the broader district which was shaped by its financial management component and vice-versa.

As noted in the literature, any analysis of decentralisation or its components such as financial management cannot be separated from centralised (higher) levels and contextual factors such as history and politics. Section 1.2.2 shows the complexities of the SA health system linked to its unjust past (apartheid) and the present government's attempts at redress. In order to provide a comprehensive analysis of financial management, box 9 in particular points to the important role contextual factors played in shaping district financial management - provincial department of health, politics (union) and history. Figure 2.3 brings together the objectives and relevant theoretical frameworks employed to understand and provide insight and allow

for comparisons of financial management between two health districts in SA. Policy recommendations are based on the findings emerging from objective 1-3 in line with the conceptual framework elements outlined in figure 2.3.

2.6 Summary

This chapter provides a detailed discussion of the strengths and weakness of existing literature and theories in relation to financial management. The centralisation, decentralisation debate is revisited and shows the impact of having weak centralised and decentralised levels in LMIC contexts such as Uganda and SA. Perrow's theoretical contribution with regards to complementarity and coordination between the levels are considered. Section 2.3.1 in particular highlights the importance of considering contextual factors, such as politics and history which has shaped objective 3 of this thesis and how these factors influence financial management.

This thesis differs to existing studies in that it attempts to offer a comprehensive account of financial management not through a macro-level analysis but rather an organisational approach understanding everyday practices and complexities within and between districts. Sociological and health systems theories have been set out and its relevance discussed. The machine perspective alludes to SA's past organisational structures (apartheids' racial, bureaucratic and hierarchical system), in this light Weberian principles are discussed as well as Von Holdt's (2006 and 2010) writings of the democratic state attempting to move away from these principles and the challenges experienced at a hospital level in SA. Studies are outlined which show that elements of bureaucracy continue to define state institutions. However, one of the core weaknesses of the machine perspective is that it fails to consider human and social elements of financial management.

The socio-cultural perspective has been discussed at length and shapes the core of this study (objective 2 – in-depth analysis of financial management realities). Structuration theory offers a basis for understanding financial management routines and how they are enforced by structure and agency, however the chapter turns to health systems literature to argue that it is complemented and expanded to consider hardware and software elements i.e. the structuration nexus. The nexus has been outlined in the conceptual framework of the study which sets out the importance in adopting an organisational approach to examine decentralisation and its core components in the health system such as district financial management.

CHAPTER 3: METHODS

3.1 Introduction

This chapter outlines the rationale of the specific study design selected, sampling and data collection methods to meet the objectives of the thesis. It presents an overview of both districts in terms of socio-economic and health indicators, followed by data collection tools, and analysis. Ethical approval processes and specific ethical considerations are detailed. Lastly, a comprehensive summary linking objectives, methods and outcomes are outlined (table 3.3).

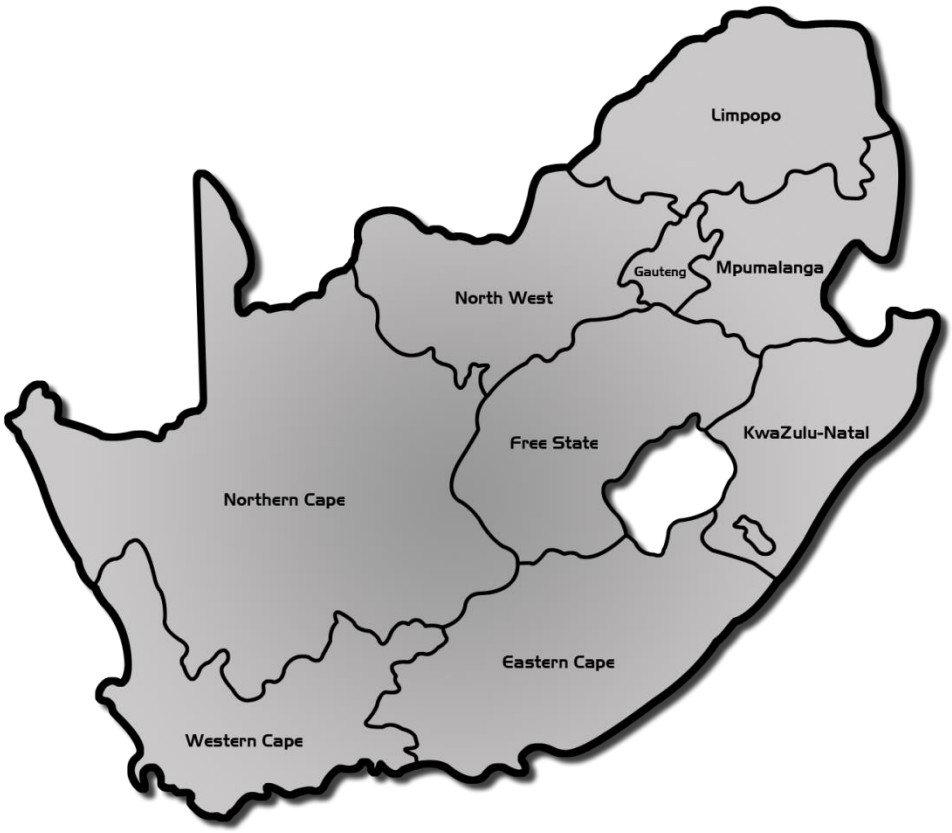
3.2 Multiple Case Study Design

The selection of qualitative or quantitative studies is guided by the type of research question which needs to be answered [91]. Qualitative research is intended to provide rich contextual understandings of the social world including social realities, practices and perspectives or views of what is being studied [92]. This thesis provides insight into the organisational realities of district financial management, so qualitative research was suitable as it allowed for an understanding and analysis of organisational elements such as relationships and other complex social phenomena [93]. A case study approach offers thorough and detailed descriptions of a specific site, with specific considerations of contextual influences [93]. Steps involved in case-study research include defining the case being studies and whether to study a single or multiple set of cases [94].A multiple case study design is advantageous in drawing similarities and differences both within and between cases [93, 95]. The cases selected for the study were the district health system and the specific unit/ sub-cases of analysis compared were the two district finance units.

3.3 Study Site(s)

South Africa (SA) is demarcated into nine provinces which are listed in Figure 3.1. Two districts in province x of SA was selected for the doctoral study (province name not revealed to meet ethical requirements and protect district and provincial participants).

Figure 3.1: Map of SA provinces [96]



The study took place in two health districts in the province, Indawo district and the Isikhala district - pseudonyms have been created to prevent identification of districts in order to protect participant's anonymity and confidentiality. This doctoral study is nested in a broader project at the Centre for Health Policy (CHP), with the Indawo district being purposefully selected for the study. Isikhala district was selected as an additional site for the doctoral study.

The two districts are comparable to each other as they are largely reliant on mining and agriculture with some sub-districts being semi-rural. These districts were purposefully selected as they are not National Health Insurance (NHI) pilot sites. The SA government is moving towards implementing its NHI scheme (discussed in section 1.2.2). The government has selected eleven pilot sites across the country to test the implementation of NHI. Since 2012, these pilot sites have been characterised by rapid changes and NHI interventions such as additional planning processes or managing funding for NHI through conditional grants which have been allocated by the National Department of Health (NDoH) [22]. Such interventions add further complexity to existing district health systems (DHS). While non-

pilot districts also face similar systemic constraints as NHI sites, they provide more stable contexts in which to conduct research - they have not yet been subject to major NHI interventions such as new planning processes, infrastructural changes, or having to manage additional conditional grants. Consequently, the Indawo and Isikhala health districts were purposefully selected to deal with constraints of carrying out research in a rapidly changing context and also because these sites are also considered to be relatively under-researched districts in province x.

Within these two districts, a sub-district in each site was selected to provide a detailed picture of financial functions and processes within the district. Through the broader CHP project discussions, the Impilo sub-district was purposefully included in the study - district management recommended conducting research in this specific sub-district which would be in line with the projects objectives. Similarly, once the study commenced in the Isikhala district, the district finance team suggested focussing on the Isifundo sub-district which is further away from the district offices (semi-rural and may yield interesting results and insights into additional challenges especially for sub-districts which are further away from the district office). Below are some key characteristics of each study site;

Table 3.1: Indawo & Isikhala district socio-demographic indicators

Indicators		Indawo	Isikhala
Demographic / Economic	Population	942 000	850 000
	% Unemployed	36.3	25.3
	% Formal Housing	85	70
Health	% Uninsured Population (use of public health services)	80	75
	No. district hospitals	3	2
	No. clinics	40	44

Sources [97-99]

3.3.1 Indawo district municipality

Indawo is one of the most populous districts in province x, with close to a million people residing in the district (table 3.1). The majority of the population (80 percent) reside in the selected sub-district (Impilo) [7]. Socio-demographic statistics indicate that 85% of the population have access to affordable housing, electricity and sanitation[10]. Economic

growth in the district is reliant on its agricultural and mining industries. The district currently has an unemployment rate of 36.3%.

Influenza, pneumonia and tuberculosis are the leading causes of mortality in the district [100]. Progress has been made on the HIV/AIDS situation: the HIV prevalence rate has declined from 31.8% in 2008 to 28.9% in 2009[100]. Close to 76 percent of the population who are co-infected with tuberculosis (TB) and HIV are reported to be on antiretroviral therapy (ART)[9]. Approximately 80% of the total population is uninsured and the public health sector provides health services to these uninsured individuals [99]. There are three public hospitals in Indawo and close to 40 clinics with 21 located in Impilo. There are also four CHCs and Maternity Obstetric Units (MOUs) in Impilo. The other two are primarily serviced through a few clinics and mobile units. The introduction of ward-based primary health care outreach teams with community health workers (CHWs) as the core component has also improved accessibility of health services throughout the district [97].

3.3.2 Isikhala district municipality

Isikhala has a population of approximately 850 000 people (table 3.1) [98]. Most residents reside in urban areas of the district [12]. The mining industry is the foundation of economic growth and employment in the Isikhala. The unemployment rate is 25.3% in the Isikhala, with 70% of the population reported to reside in formal housing [101]. Seventy percent of the population is uninsured and are covered by public healthcare services [99]. Isikhala has two district hospitals, 44 clinics, eight of which are located in rural areas. Some rural parts of the district do not have clinics and are serviced by mobile clinics.

3.4 Study Population & Sampling

A particular focus of the study was the district level, although participants also came from sub-district and provincial health levels. In total, 27 participants in the Indawo district (4 from the sub-district), 21 participants in the Isikhala district (3 from the sub-district) and remaining participants (10) at the provincial level and Non-Governmental Organisations (NGOs) were included. These 58 participants were identified through purposive and snowballing sampling techniques. Purposive sampling refers to the deliberate selection of study participants in line with the study purpose, although one of the disadvantages is the possibility of selection bias which should be considered [1]. In this case, purposive sampling was used to identify those involved in financial management at districts. This also included district staff and financial assistants positioned through NGOs. Discussions with the Indawo district director and

Isikhala research/ ethics coordinator, who also serve as a medical practitioner in clinics, assisted with the identification of these key participants.

The study also adopted flexibility and included additional study participants through snowballing sampling to broaden perspectives of data collected. This type of sampling depends on a particular respondent referring the researcher to other possible participants who would be able to provide insight/ information on the given topic and form part of the study sample [95]. Snowballing sampling was used to further identify participants linked to district financial management. Senior staff members from other units linked to finance (human resources-HR, procurement, information technology-IT, health programs and primary health care - PHC**)** formed part of the sample. The sample extended to the Isikhala sub-district site (Isifundo) where there was some administrative/ finance capacity. At the time of the study, finance capacity in the Impilo sub-district (Indawo) was not yet established however key participants were included to understand how sub–district finance processes were managed.

Table 3.2: Brief description of study participants

Level	Description	No. of Participants
Provincial	Managers ▪ Finance ▪ HR ▪ IT ▪ Procurement	5
NGOs / External	Staff collaborating with districts ▪ Finance ▪ HR NGO Expert	5
Indawo district	Managers ▪ Head of district ▪ Finance ▪ HR ▪ PHC ▪ Health programmes ▪ Procurement ▪ IT Mid-level managers & junior staff ▪ Finance (assistant managers, controllers, clerks, interns, capturers) ▪ Procurement (assistant manager, supervisors, buyers, receivers)	23
❖ Impilo sub-district	Managers ▪ Sub-district (manager) ▪ Facility/ clinic manager ▪ Local area manager (municipality) ▪ HR	4
Isikhala district	Managers ▪ Head of district ▪ Finance ▪ HR ▪ PHC ▪ Procurement ▪ IT ▪ Health information systems (HIS) Mid-level managers & junior staff ▪ Finance (assistant managers, controllers, clerks, interns, capturers) ▪ Procurement (assistant manager, supervisors, buyers, receivers)	18
❖ Isifundo sub-district	Managers ▪ Sub-district (manager) ▪ Facility/ clinic manager ▪ Administrative officer	3

3.5 Data Collection

Two main techniques were utilised to collect data. Objective 1 and 2 of this thesis attempts to provide an overview of financial management processes, followed by organisational realities. This includes a comprehensive account of every-day routines, actions (agency) and how they are shaped by hardware and software factors (figure 2.3). In-depth interviews combined structure and flexibility and its importance is emphasised in the literature i.e. to gauge participant's points of view of the topic and personal accounts [102]. Interviews with key participants were useful in collecting data for objective 1 and 2. However, to ensure the validity of data collected and to confirm/ gain further insight into what participants reported or shared during interviews, it is often deemed useful to use complementary data collection tools, such as observations. Observational research has its roots in the anthropological discipline and specifically ethnography which has proven to be fundamental in conducting qualitative research [103]. In this study, understanding phenomena such as relationships/ interaction, routines and communication (figure 2.3, circle 1 –structuration nexus) was central and data collection methods had to move beyond interviews (objective 2). There are two main types of observational methods, namely participant and non-participant observation, which were both employed in the study to capture such nuances. Non-participant observation involves minimal participation of the researcher in actual processes and researchers tend to maintain a distanced stance from these processes [12]. With participant observation, the researcher immerses themselves in a social setting and participates in relevant activities [102]. Participant observation offers a thorough contextual understanding of physical, social and cultural aspects of participant's lives (including occupations), their relationships, and behaviours [104]. One of the noted disadvantages associated with observational research is that it is time-consuming [104]. In both districts it took approximately one month to shift from non-participant to participant observation – August 2015-September 2016 in Indawo and November 2015-December 2015 in Isikhala. Participant observation spanned a period of three months; September-November 2015 in Indawo and December 2015-February 2016 in Isikhala (further detailed in section 3.5.1).

Nonetheless, these techniques were valuable in providing a thorough account of everyday organisational realities, including insight into social relations shaping financial management e.g. relationships and staff motivation (structuration nexus). In both districts, data collection took place between April 2014 and January 2016. Interviews also extended to NGOs and the province (objective 3). In some cases follow-up interviews were carried out with relevant

participants to clarify information, gain further insight into specific issues discussed during interviews and to explore new areas which could not be covered during the first interview (June 2016 - August 2016). Observations further strengthened validity, complemented in-depth interviews and primarily involved job-shadowing individuals in the Indawo district and the entire finance team in Isikhala. Specific activities included, attending key meetings and being granted permission to access minutes and key financial documents. The doctoral researcher developed the tools for the in-depth interviews relating to financial management for the broader CHP project together with supervisors (refer to appendices E & F). The in-depth interview tools from the study were adapted and utilised in both districts. In line with the objectives of the doctoral study guidelines for the observation process were developed to capture both actors and processes (refer to appendix G). Tools were rigorously developed and revised based on internal approval processes e.g. faculty committee decisions and ethics committees.

Table 3.3 Details of Tools Utilised in the Study

Data Collection Method	**Topic**
District	
In-depth interview 1.A	Overall roles of individuals and meetings/ interaction)
In-depth interview 1.B	Background, skills, motivations and experiences - daily activities
Interview 2	Insight into financial management processes (planning, budgeting and resource allocation)
Interview 3	Insight into financial management processes (oversight and evaluation)
Interview 4.A	Performance management experiences-being managed
Interview 4.B	Performance management experiences-managing others
Other stakeholders (province and NGOs)	
Interview 1	Meetings and Interaction
Interview 2	Involvement and support, district financial management processes
District, province & NGOs	
Observation 1	Meetings
Observation 2	Job-shadowing

In-depth interviews listed in table 3.3 were all conducted in English. There were no requests for interviews to be conducted in another language and all participants were conversant in English. During observations a few staff conversed in their native languages, however the doctoral researcher understands basic isiZulu and was able to continue observations. If the researcher could not understand a specific process or conversation being observed or another language besides IsiZulu was used, the researcher double-checked with the finance managers (described as gate-keepers in section 5.3.1 and 5.3.2) in Indawo and Isikhala who were always willing to translate to English. Below are further details of the data collection methods and processes in each district.

3.5.1 Indawo district

3.5.1.1 In-depth interviews

Primary data was collected for the CHP project in the Indawo district with the researcher conducting the majority of finance related interviews. The study commenced with in-depth interviews being carried out with key participants in Indawo in April 2014 and continued up until data saturation was reached (December 2015), saturation occurring when new interviews provided similar data (no new information in relation to study objectives). The purpose of in-depth interviews is to understand participant's experiences, actions and perspectives of a particular subject/social world [92]. At suitable dates/times for respondents, one in-depth interview was carried out with each of the 27 participants in Indawo (this includes 4 interviews at the sub – district level). Some data has also been drawn from the second phase of data collection in the broader CHP project which provides more information around performance management and on study participants and its linkage to financial management[8]. Interviews are outlined in (appendix E & F). Conducting interviews allowed for an overview of financial management (objective 1 and figure 2.3, cycle 1), insight into the backgrounds and roles of participants, challenges, successes and interaction with others in terms of district financial management **(**objective 2 and 3). The researcher contacted each participant to set up an interview at a time/date suitable to them. Each interview lasted for approximately one hour and was conducted on a face-to-face basis in participants' offices or in available meeting rooms. In some cases there were challenges of conducting interviews in open plan offices and there was an instance where the participants an open plan office

[8] Another colleague on the CHP project conducted the performance management interviews, in some cases the doctoral researcher was part of the interview.
-However, the information collected is beyond the scope of this thesis only relevant raw data emanating from these interviews was used for this thesis and was analysed by doctoral researcher.

requested to be interviewed together. Conducting in-depth interviews was useful in allowing the researcher to make contact with participants and setup possible observations.

3.5.1.2 Non– participant and participant observations

Once a sufficient number of interviews had been carried out, the researcher together with supervisors discussed observations with the head of the district. Subsequent to this the researcher contacted the district's finance manager telephonically and via email to request permission to begin the observation phase of the doctoral research. It took approximately one month to obtain approval. The district's finance manager suggested that a starting point for the observations was to job shadow the assistant finance manager. The researcher made contact with the assistant manager and requested to attend finance related meetings as a starting point. The first stage of the observation process involved attending the 'PROCFINHR' meeting in August 2015 – this is a meeting which brings together procurement, finance and HR functions at a district level (on a monthly basis). At this stage the researcher made use of non-participant observations. This technique allowed the researcher to learn more about the reality of district financial management, it was useful in identifying meetings/individuals to observe and gaining the trust of participants (objective 2, figure 2.3, circle 1). Trust of participants was imperative, as a shortfall of observational research is that participants may change their behaviour once observed [95]. This is also termed Hawthorne effect in qualitative research – where participants operate and react differently when being observed [105]. The Hawthorne effect was addressed through extensive time being spent at the district and trust/ relationships being fostered which also allowed for the transition of participatory observations (discussed below). Observational research was centred on the daily happenings of the district and included job shadowing the assistant financial manager – who has his own office. Possible observations were set up together with the assistant manager on a weekly basis, and involved their meetings as well as the managers' daily tasks.

During the observation process, the assistant manager provided key documents essential to financial management such as the District Health Expenditure Review (DHER), policies and minutes of meetings. Job shadowing the assistant manager led to some observations of one or two other individuals being carried out and also following a paper trail to understand how certain financial processes/ functions actually happen at a district level. The paper trail (procurement process flow) involved looking at how items were procured from an end user, the role of finance in oversight of available budget, delivery of items and payment of

suppliers. Observation field notes were recorded in a notebook and typed at the end of each day. In essence the finance manager served as a key informant in the study facilitating access to resources, other participants which are not usually available to an 'outsider'- e.g. key meetings and documents [104].

The shift from non-participant to participant observation occurred relatively soon in the observation process. Trust and space for participation occurred when there were technological challenges in a district meeting. The researcher decided to assist with the technological challenges - this marked the beginning of participant observation stage in Indawo (September 2015-November 2015). The researcher continued to attend meetings, job-shadow the assistant manager and assist if and when requested. For example the assistant manager requested help to print documents for meetings, or to work together in populating the DHER. In cases where the district required some assistance, the researcher offered advice. In one case the researcher assisted those in Indawo to make contact with colleagues in the other thesis study site (Isikhala) in order to address an issue which had arisen in a meeting. The observational aspect of the doctoral research helped provide a deeper understanding of district financial management functions and it challenges as well as the people and their relationships as well as other software and hardware factors which shape this crucial function (objective 1 and 2, figure 2.3- cycle 1 and circle 1). Moreover, it built relationships between the researcher and participants, which provided the researcher with a first-hand account of the everyday financial management realities faced by those at the district.

3.5.2 Isikhala district

3.5.2.1 In-depth interviews

Once a substantial amount of information was collected in the Indawo site, in-depth interviews were carried out in Isikhala. The research/ ethics coordinator (described in section 3.4) in the district, provided contact details of the relevant finance managers - mid-level managers which are responsible for the finance section in Isikhala and who also requested to be interviewed together. Thereafter, these managers set up interviews with each of the individuals in the finance section for the researcher. Interviews lasted approximately 45 minutes to one hour and all finance staff were interviewed between March 2015 and April 2015. Other individuals involved in procurement, HR, health programs and those at the sub – district level (Isifundo) took place until March 2016. In-depth interviews were carried out with each of the 21 participants in Isikhala to meet objective 1-2 of the thesis- overview of

financial management and organisational realities i.e. relationships, communication and routines. However, noted differences in data collection was that the Indawo site yielded more information, as the doctoral study drew on other relevant interviews/ participants which was conducted through the CHP project (beyond the scope of the doctoral study yet included to provide a richer understanding of the site), whereas, Isikhala only served as the doctoral study site.

3.5.2.2 Non– participant and participant observations

Requests to conduct observations in Isikhala were met with some bureaucratic challenges, (approval to conduct observations was delayed). However, permission was granted to commence observations in November 2015, approximately three months later. The delay in conducting observations affected the data collection process, in Indawo it was possible to observe planning and oversight processes e.g. the District Health Plan (DHP) and DHER. However in Isikhala, these processes were already completed, analysis of these documents was carried out retrospectively and participants were probed on the processes and how they were conducted which may have yielded more positive outcomes being reported around these processes (also noted as a limitation of the thesis in section 9.4). Once permission was granted it was recommended that observations begin with the finance middle managers and the entire finance team. Finance managers listed all possible functions which should/ could be observed in the finance team. While observations were scheduled around specific functions, there was flexibility as the researcher was allowed to request additional observations such as attending meetings in 2016 and follow a paper trail between procurement and finance.

Non–participant observation was used at first, to job-shadow individuals in charge of specific functions and to gain an overview of financial management (objective 1 and figure 2.3, cycle 1). The finance team with the exception of the middle managers sit together in an open plan office space and in comparison to Indawo; it took more time for the researcher to gain participants' trust in a setting with multiple individuals. One of the difficulties of conducting observations/job shadowing in an open plan office is that it disturbed other staff members if only one person was being observed, though the researcher tried to minimise any disturbances to the natural setting. Observations took place around scheduled tasks and deadlines such as reconciliations, in-year monitoring reports, petty cash processes and budget motivations. It was however useful to observe the finance staff in a team setting and the benefits of being an open plan office – such as frequently communicating with each other and supporting each other/drawing on each other's knowledge (objective 2 and figure 2.3, circle

1). Moreover, observing several individuals allowed for a broader understanding of financial management functions/ activities across the finance unit instead of one managers activities as in Indawo (objective 1). Observations further provided insight into financial tasks (routines), interaction, communication and teamwork – the structuration nexus consisting of crucial hardware and software factors shaping financial management (figure 3, circle 1).

While observing the district's budget allocation processes, one of the finance middle managers requested that the researcher give input, ask questions and be part of the process - this fostered a shift to participant observation. However, there was less space for assistance and fewer requests for researcher assistance in Isikhala compared to Indawo. Both finance middle managers have separate offices and were also observed separately. Similar to Indawo, both middle managers (served as key participants in the observation process) were helpful in providing presentations and other key documents which they made use of. Job shadowing in Isikhala covered multiple individuals and not one individual as in the case of Indawo, and team meetings were observed e.g. internal finance meetings such as for work/ activity updates or to create presentations. The researcher met with the procurement officer in Isikhala to carry out a similar comparison. This was useful in identifying who is involved in specific processes, and what the timeframe for procuring and payment is (objective 3 – documenting interdependent and interlinked processes to district financial management).

3.5.3 Observations with external stakeholders (NGOs)

Non-participant observation was used to gain a basic understanding of external stakeholders in relation to district financial management processes, influences, coordination between different levels and power dynamics between different actors (objective 3 of the thesis). During an interview at provincial level, information emerged on district and provincial interaction. During one of the interviews, the researcher requested to observe the relevant meetings mentioned. Provincial level meetings with district/hospitals around the annual budget allocation processes were observed. Some meetings at a district level were conducted by NGOs; this enabled the researcher to observe the interaction and influence of NGOs in the district.

The objectives and data collection tools (in-depth interviews and observation questions refer to appendices E, F and G) guided the sorts of processes and individuals who should be observed. However, to an extent how/ who was observed was also subject to ethical permission and recommendations of high-level managers. Nonetheless, both participant and

non-participant observation provided a rich and deep understanding of financial management realities in both districts and their interactions with external stakeholders such as the province and NGOs.

3.6 Data Management and Analysis

Where permission was granted, in-depth interviews were tape-recorded. In some cases participants declined to be tape-recorded and field notes were taken during the interview. Interviews were transcribed and the researcher verified the typed up transcriptions (verbatim). Transcriptions were labelled and stored in a database created prior to commencing the interviews. This ensured that transcriptions could not be linked to study participants thereby ensuring confidentiality and anonymity. Each transcription was initially read and discussed by both the student and supervisors, followed by detailed and thorough line by line reading and summary notes being made in Microsoft Word (inductive analysis). Codes were then placed next to the relevant notes and information, with codes ranging within and outside of the conceptual framework (figure 2.3) e.g. communication, relationships, managerial skills financial processes, IT, successes, challenges. Similar codes were then grouped into possible themes and sub-themes i.e. relationships and communication into the software theme or resources and IT into hardware themes – thus thematic analysis was utilised. Thematic analysis was useful as it allowed for flexibility (both inductive and deductive techniques) but also that it allows for rigorous searching and identifying of codes and themes [106]. The data between districts was then compared and interpreted using the conceptual framework (figure 2.3). This allowed for further refinement/ review of the grouping of information into themes and sub – themes (deductive analysis). Codes and themes were thus reviewed in light of the conceptual framework, objectives and then finalised.

A summary document in Microsoft Word was then created of the main themes, sub – themes and quotations per interview and separated by district to guide the write-up of the study. The summary document also included themes drawn out from the typed up observation notes from each study site. Thematic analysis also offers benefits of comparing and contrasting similarities and differences of themes [95]. Commonalities and differences in terms of themes and sub – themes between districts were identified and analysed between the two districts, particularly focussing on the conceptual framework and objectives e.g. figure 2.3, cycle 1 (overview of financial management), circle 1 (structuration nexus) and circle 2, box 5 (broader district and national/ provincial context). Analysed data was also used to understand

the interactions (meetings), daily interactions/ relationships of actors and between different units, actor maps (organograms) – (chapter 5). The study's conceptual framework provided value in terms of deductive analysis and comparative analysis of themes between the two study sites.

Validity in qualitative studies can be confirmed by similar findings through multiple methods [95]. Triangulation was achieved through two means. Firstly, common themes/ sub-themes and ideas were validated by having multiple readers (student and supervisors) discussing and reading transcriptions. Observational research was used to supplement, confirm and further understand the dynamics of district financial management raised by participants during in-depth interviews. Field notes from non – participant and participant observations were typed up in Microsoft Word according to the date and specific tasks/meeting observed (section 3.5). Flow diagrams of financial processes were drawn up to summarise observation data and illustrate deadlines, processes and actors involved (chapter 5). Documents, presentations and policies provided during the observation process supplemented information around implementation of financial processes, actors/units involved, relationships, challenges and solutions to solve these issues. Observation data was compared to in-depth interviews and analysis was also guided by the conceptual framework, which allowed further triangulation. Again information was analysed and documented separately for each study site and then compared.

3.6.1 Credibility & confirmability of data

The literature describes various elements such as credibility, transferability, dependability and confirmability which are necessary to ensure the trustworthiness of qualitative research [107]. Strategies to ensure credibility and confirmability were employed in the thesis. Researchers are expected to take steps to ensure that the study measured what intended i.e. credibility and this can be through extended time or familiarity with the study site, opportunities for participants to refuse participation, peer-scrutiny and even feedback [107, 108]. Additionally qualitative researchers face the paradox of having to thoroughly understand a study context yet maintaining objectivity and ensuring credibility based on positionality within the system [109]. It is argued that reflectivity assists with addressing issues related to positionality [110]. Engagement with supervisors allowed for reflection and maintaining objectivity and being cognisant of power, relationships and influence on participants/ the system (positionality). The importance of triangulation and feedback is also an element of confirmability (researchers confirming that findings emerge from the data not

their own predispositions) [107]. While triangulation was important in confirming findings through multiple methods, it was also useful to continuously engage with supervisors and other colleagues in the broader CHP project around data collected and emergent themes – which allowed for constant reflexivity and further rigour i.e. peer scrutiny. Credibility was also shown when participants declined to be interviewed or observed and the researcher would adhere to these requests (section 3.6 and further discussed in 3.7.3). Secondly, when middle managers in Isikhala requested to be interviewed together, this was noted and mentioned (section 3.5.2.1). Finally, at the end of the data collection process, the researcher together with the supervisor fed back findings to the head of the district in Isikhala to discuss accuracy and the need to collect any further information. In Indawo, as part of the broader CHP project various feedback sessions were held with numerous district staff in line with the objectives of the project thus allowing for further discussion and confirmation of study findings.

Other writings on credibility also point to the importance of qualitative data collection including opportunities for intense exposure to phenomenon under study, to ensure multiple perspectives are collected, establish rapport with participants and fully understand contextual influences[3]. The use of observational techniques allowed for an in-depth and rich understanding of financial management (objective 1 and 2). The shortfalls of the data collection process have been discussed in section 3.5.2 – the researcher being unable to observe some key financial processes in Isikhala due to ethical delays, the difficulties of observing an entire team in Isikhala and observations being subject to higher level approval which is also listed as a limitation later in the thesis.

3.7 Research Ethics

3.7.1 Ethical clearance

Appendix J contains ethical approval granted by the relevant institutions. The provincial Department of Health (PDoH) and the Indawo health district provided ethical approval for the CHP project which was also used for this study. Prior to commencing the study ethical, approval was sought from University of the Witwatersrand Human Research Ethics Committee (HREC Medical) and the Isikhala district ethics committee.

3.7.2 Informed consent

At the beginning of each in-depth interview, information sheets and consent forms were administered to all participants to obtain written consent to participate in the study and be

tape-recorded (Appendix H & I). Information sheets outlined the purpose of the study, benefits and risks and participants ability to decline the interview or withdraw at any time. In some instances participants declined to be tape-recorded and written notes were taken during the interview. The researcher also heeded to participants requests to switch off the tape recorder at certain times during the interview and did not report on this data.

Observational research, including attending meetings and job-shadowing were useful in understanding the actual implementation of financial management in an everyday district setting. During the protocol development phase, HREC (medical) recommended that if any incidents occur, informed consent to report on it should be retrospectively granted by the participant. No such incidents occurred and the study tried to minimise risk to participants. Before commencing with observations, requests and permission to conduct observational research were discussed with relevant senior managers in both districts. Before job shadowing or attending meetings financial managers informed staff of intended observations either verbally or via e-mails and stated that observations were only for doctoral research purposes and would not have any negative implications for staff. When e-mails were sent requesting permission to conduct observations some participants indicated that they did not want to be observed and were free to opt for this. The researcher did not carry out the intended observations e.g. of meetings when participants raised concerned or declined through e-mail. During meetings, finance managers in both districts would introduce the research and stated that if there were any objections the researcher would leave the meeting (however this never happened). Job shadowing took place with the permission of participants and was centred round their availability. No meetings were tape-recorded and only field notes were taken during observations

3.7.3 Ensuring confidentiality and anonymity

Information collected was used for research purposes only. All information documented during any of these forms of data collection was kept confidential and no names were reported in any form with pseudonyms used to prevent identification of the province or specific districts in which the study was conducted (section 3.3). Participants were also guaranteed confidentiality and anonymity when informed consent was sought. Recorded information (written and tape recorded) has been kept in a secure place under lock and key for a period of five years (2015-2020) at CHP offices. Thereafter all information will be destroyed. No one, other than the main researchers (Shakira Choonara and supervisors, Professor John Eyles, Professor Jane Goudge and Dr Nonhlanhla Nxumalo) has seen or has

access to recorded material and the transcripts. Names of interviewees were kept separate from any written or typed documents including all documents used during data analysis. As already stated codes were created for each participant and in doing so removed any identifying information. In all associated publications, reports or in the thesis, no individuals were identified either by names, designations or personal information.

Table 3.4: Summary - Linking study objectives, conceptual framework, methods and data collected

Objective(s)	Data collection tool(s)	Data collected
1. To examine the four cyclical financial management processes (planning, budgeting and resource allocation, oversight and evaluation) in each district. (figure 2.3 – cycle 1)	-In-depth interviews -Observations (participant & non-participant)	• To provide insight into key routines (documents, processes and tasks) of finance staff in both districts in relation to the four listed processes of the financial management cycle (planning, resource allocation and budgeting, oversight and evaluation), results detailed in (*chapter 5).* • Analysis of how key processes were conducted in both districts as well as how they differed. • Creation of actor maps (organograms) to provide details around the structure of the finance team in each district, reporting structures, hierarchy and interaction. Actor maps were useful in comparing the two sites in terms, number of staff and key functions in each district and finance capacity in each district *(chapter 5).* • Additionally, details and an overview of provincial finance processes which remain centralised and why they remain centralised and its influencing district financial management were also mapped and examined i.e. payment of suppliers (*chapter 4).*
2. To carry out and compare organisational realities of the districts' financial management units, their financial processes cognisant of hardware[9] and software[10] factors. (figure 2.3, circle 1 – structuration nexus)	-In-depth interviews -Observations (participant & non-participant observations)	• Data collected allowed for an in-depth understanding of the internal structuration nexus affecting financial management in each district (refer to circle 1, figure 2.3). Factors are linked to hardware, software, structure and agency. Information around key financial processes from cycle 1 (objective 1) are further detailed for each study site – i.e. planning as well as software factors particularly documenting relationships, support and displays of agency/ how districts manoeuvred constraints *(chapter 7 and 8).* Comparisons between districts were carried out in light of specific themes documenting commonalities and differences around hardware and software processes *(chapter 8).*
3. To provide a comprehensive analysis of decentralised financial management linked to other units at the district level - procurement, human resources (HR), information	-In-depth interviews -Observations (participant & non-participant observations)s	• Information around other units, interlinkages, coordination and challenges associated with financial management is also presented *(chapter 6 and 7).*Comparisons between districts around procurement, IT and HR were also made in this regard *(chapter 8).* • Information collected placed decentralised financial management within a broader context and considered essential factors relevant to the SA context, including, history, politics and other levels of the health system (province). Broader influences at both the district level and

[9] Hardware: elements such as rules, legislations, policies, skills, infrastructure, technology and funding levels of a health system.

[10] Software: knowledge, processes of decision-making, relationships, communication, practices, values and norms.

Objective(s)	Data collection tool(s)	Data collected
technology (IT) and in relation to broader contextual influences i.e. provincial, political and historical. influences i.e. provincial, political and historical (figure 2.3, circle 2 & box 5)		provincial level were examined, to gauge influence on financial management. Information provided insight into types of challenges in each district and the province *(chapter 5-8).*
4. To provide policy recommendations to strengthen decentralised financial management under SA's health sector reform policy (National Health Insurance – NHI).	-Reviewing current literature and considering thesis findings.	• Thesis findings to inform possible recommendations to existing documents.

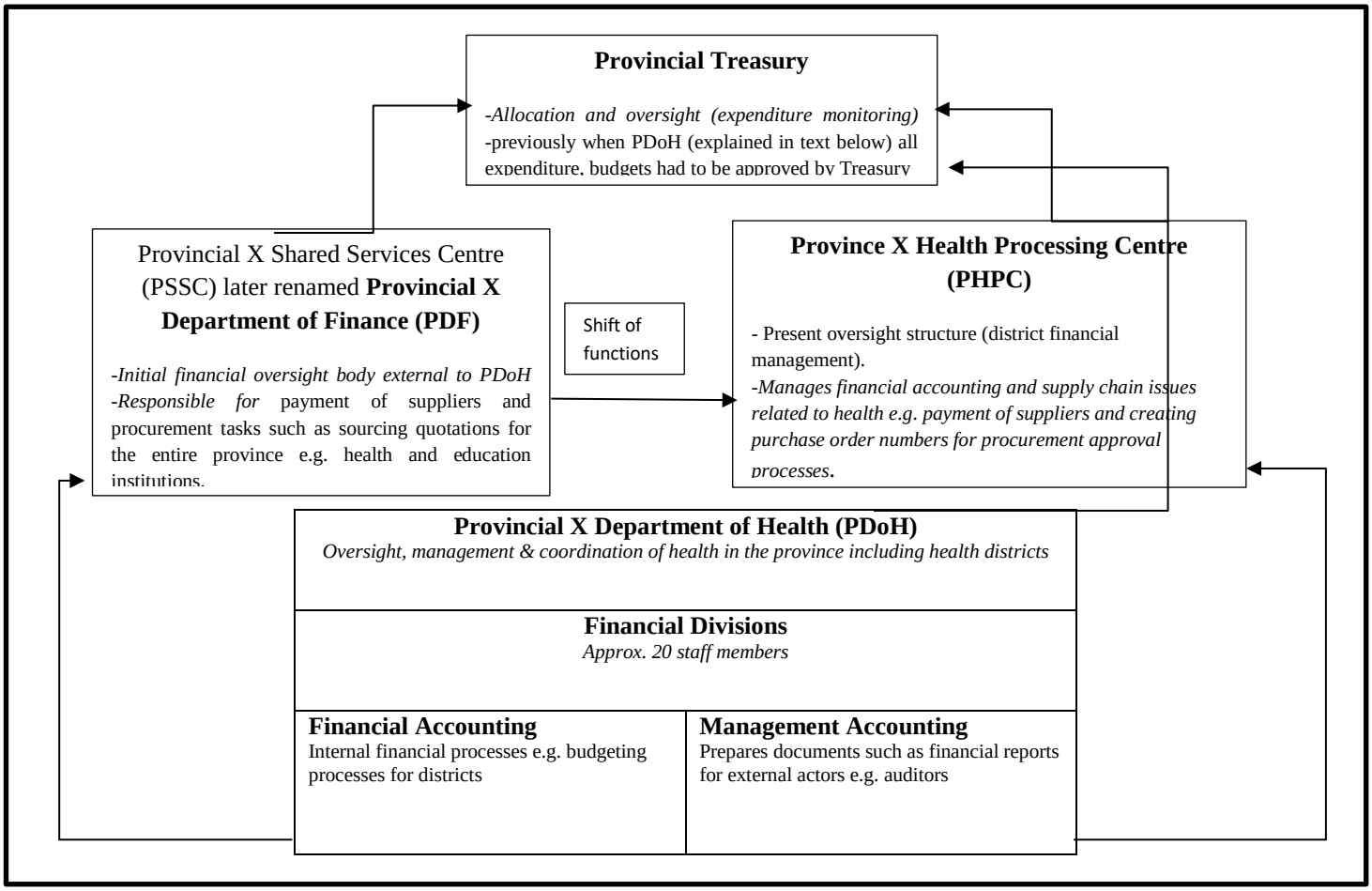
CHAPTER 4: CONSIDERING A BROADER CONTEXT FOR DISTRICT FINANCIAL MANAGEMENT

4.1 Introduction

While district financial management is the core focus of the thesis it does not take place in isolation and affected by other levels of the health system e.g. the province and other support functions such as procurement. This chapter explains the role and functions of the province in relation to district financial management i.e. it provides insight into the context in which districts operate. The chapter focusses on provincial financial management processes – resource allocation, oversight (monitoring expenditure) payment processes and utilisation of available financial resources which are part of financial management (procurement approval processes). Linked to financial management province's role in procurement and information technology (IT) which is closely linked to district financial management and will be expanded on in chapters 6-7. Proceeding chapters will particularly outline the lack of hardware (IT) and its implications on district financial management. Provincial level challenges especially in relation to organisational functioning are discussed, including apartheid legacies, the political environment and trade union influences which were found to impact district financial management (further expanded in chapter 6-7). The software component of the Provincial X Department of Health (PDoH) – relationships, interaction between units and communication - is also explored. Lastly, the implications of, and need for, centralisation coupled with such challenges are highlighted as they go hand-in-hand with decentralisation challenges detailed in chapter 6 and 7.

4.2 Overview – Shifts between Centralisation & Decentralisation

Figure 4.1: Financial management roles and responsibilities of provincial actors



The aim of this thesis is to understand the micro-level practices of everyday financial management in two health districts in province X, SA specifically focussing on strengths, weaknesses and mechanisms for its improvement. Although, some functions continue to be centralised (not necessarily at a national level but specifically at a provincial level) and were found to affect district finances. In 1994, the government proceeded with implementing decentralisation of health care and delegating certain procurement and finance functions to the district level.

However in 2000, a provincial-wide (political) decision was taken to establish the Provincial X Shared Services Centre (PSSC), later renamed Provincial X Department of Finance (PDF) - a centralised body; building on previous finance institutions at province and set up to achieve efficiency, minimise costs and achieve greater bargaining power. PDF functions included payment of suppliers and procurement tasks such as sourcing quotations for the entire province e.g. health and education institutions. Later, some functions such as sourcing quotations were decentralised to ensure a quicker turnaround time, however approval of

procurement of goods or services through purchase order (PO) numbers and payment of suppliers remain centralised. The primary reason for this is that PDoH in 2009 faced high levels of over-expenditure and non-payment of suppliers. PDoH was then placed under administration by provincial x Treasury - i.e. all expenditure, budgets had to be approved by Treasury.

PDoH is comprised of two finance sections and approximately 20 staff in each unit. The management accounting unit deals with internal financial processes e.g. budgeting whereas the financial accounting unit prepares documents such as financial reports for external actors. The management accounting unit in particular carries out budget allocation and budget-shifting processes which are some of the main process highlighted in this chapter and those that follow – e.g. the budget-bi-lateral process for districts which is coordinated by PDoH. Payment functions for the past three years or so moved away from the PDF to the PDoH and presently to the Province X Health Processing Centre (PHPC) which deals specifically with financial accounting and supply chain issues related to health e.g. -

- Payment of suppliers.
- Approval of procurement of goods or services through creation of purchase order numbers (PO).

4.2.1 The case for centralised finance functions

Some participants stated that centralisation, particularly the establishment of the PSSC as well as on-going centralisation, was largely political (decisions were made outside of the health sector by other political stakeholders linked for example to interests keeping their jobs while decentralisation was pursued);

> Province x is the only province that is centralising so much; they are doing the exact opposite of all other provinces… *I think that there are two reasons, one it is that the districts are not competent, the other is that its political people who are trying to protect their jobs* i.e. present the province as being important and much needed – NGO Staff 1.

However, several other participants provided a three-fold rationale for continued centralisation of certain finance functions. Even under decentralised healthcare structures, centralised bodies such as the PDoH have a critical role to play in overseeing certain processes to achieve efficiency, standardisation and to address professional skills-shortages. Provincial participants explained that certain functions such as payment of suppliers and

district financial management functions needed to be centralised due to inadequate capacity[11] at lower levels including the district level. For example, invoices for payments were not processed on time contributing to the province experiencing high levels of over-expenditure, cash-flow problems and non-payment of suppliers:

> *We have about 300 clinics and it would be impractical to have a finance officer in each of these clinics…* Another issue is that there aren't correct finance structures and capacity in districts to manage these tasks…Adding to this, there was a provincial instruction at the time which stated that administrative posts within PDoH should not be filled… Decentralisation of payments, for example, didn't work with the capacity we had and it wasn't because there was no money, instead you would find that paperwork wasn't processed on time, capacity was lacking and as a result suppliers weren't paid… This contributed to serious cash-flow problems for PDoH around 2012– Provincial Manager 1 (Interview 1).

> *PDoH was in great financial difficulty, billions of Rands were owed to suppliers, and one of the reasons for this is that there wasn't a centralised streamlined process.* Clinicians would have suppliers' invoices sitting on their shelves instead of processing them and no one is aware that the supplier has not been paid. We were then placed under administration (oversight and approval required from provincial Treasury). Treasury allocated around R4 billion to us, we had to ensure that payments happened centrally, although even R4 billion wasn't enough. There were some suppliers who hadn't been paid for years and even more invoices are coming through – Provincial Manager 1 (Interview 2).

PDoH is however, no longer under administration, indicating that centralisation of key functions were not necessarily negative and to an extent did address the provinces cash flow issue. Although there are still inefficiencies noted – e.g. even at a provincial level there are still delays around approval and payments as well as challenges linked to increased bureaucracy to track payments and expenditure.

[11] Respondents raised the lack of capacity as the primary reason for the need for centralised functions. Potter and Brough's 2004 capacity framework will be discussed in chapter 8 and 9 and refers to unpacking the type of capacity participants are referring to. For example, the framework argues that organisational capacity is reliant on a hierarchy of needs, namely; tools, skills, staff and infrastructure. The application of this framework to analysis of data in the thesis shows the lack of tools (equipment, technology), skills (technical financial skills and managerial) and authority transferred to the district (role of the districts in financial management).

4.2.2 Centralised finance functions & associated difficulties

Despite centralisation of payment functions to address the provinces cash flow problems, participants stated that it is still difficult to track the actual budget, payments and accruals at both the province and district:

> In my opinion, *there is no control; no one knows what is ordered, who is paid* and what contracts are in place – Provincial Manager 2.

> There are many issues around centralisation of finance functions, even at province staff try and balance the budget to avoid audit queries. Balancing the budget is to meet the needs of the Auditor General (AG) and it's because the media and public look at the AG report. *However, balancing the budget does not make any sense in terms of tracking expenditure, because numbers are changed on Basic Accounting System (BAS) so you can't see actual spending,* it's not useful. Then even the budget section at province, all they really do every year is add 10% to all budgets and they follow a manual process where they load the budget onto BAS and this takes up to two months, which result in the districts not getting their budget on time – NGO Staff 1.

District staff stated that suppliers submitted invoices directly to PHPC for payment; however the province does not effectively communicate which payments have been processed back to the district. Provincially, tracking payments was described as being difficult due to limited communication and clarity around tasks between PDoH procurement and finance units. Furthermore, there appeared to be fragmentation/ separation of functions between PDoH finance units (financial and management accounting) and PHPC:

> The problem is two-fold. The budget is essentially managed by province, it is now centralised. District systems will reflect that there are still funds available without recognising that payments are in process, you will find that institutions are even unaware of the commitments they have so they continue to order and later discover that they actually overspent. The districts do try to put together a list of suppliers who haven't been paid (accruals), however to me these accruals are meaningless figures as the data reflected on the systems may be unreliable/ not reflecting what is paid or not unless they follow up and province does not liaise with them over what has been paid or not. The other issue is that there is a disconnect between some sections at province, accrual templates are created by the financial accounting unit and the budget

> unit works with expenditure but these two units deal with separate issues of finance and don't come together - Provincial Manager 1.

It is clear that while centralisation was meant to address issues such as cash-flow challenges, finance functions are not being carried out optimally i.e. difficulty in tracking payments. Besides these reasons, communication between the province and district around tracking accruals was hampered by slow internet connectivity (centralised internet connectivity line).

4.2.3 Rationale for centralised procurement functions

Financial management is inherently linked to the procurement function (figure 2.3, circle 2); the procurement of both goods and services requires financial authorisation and budget availability (access to available resources and expenditure tracking). An overview of procurement processes at a provincial level is required at this stage of the monograph to fully understand district financial management. Participants explained that in the year 2000, with the establishment of the PSSC, functions such as selection of suppliers (vendors), and contracts with suppliers and approval of procurement was centralised. Primary reasons cited for this was to achieve efficiency through bargaining power which could be wielded through a centralised body such as PSSC:

> Often district or hospital submissions are incorrect, they don't have the capacity. Companies or suppliers need to comply with certain requirements e.g. tax clearance certificates. These certificates ensure the companies are in good standing by SA law; otherwise you might experience challenges when these companies are not compliant and they will be reported to the SA Revenue Services (SARS). Quite often you will find lower levels (district) select companies which don't have updated tax clearance certificates otherwise you note that the cheapest quotes aren't selected for the submission. *We as head office needed to centralise and needed to be the watchdog to ensure that these processes are carried out correctly* – Provincial Manager 4.

> Previously, each institution e.g. district would source its own quotations and enter into contracts with suppliers with limited negotiating power. *We centralised these functions to allow PDoH to achieve economies of scale through negotiating bulk orders instead of individually placed orders with suppliers*– Provincial Manager 4.

Post the PSSC, the PDF took over these functions and more recently and as mentioned PHPC was established within the PDoH continues to provide oversight of key procurement

functions e.g. approval of district procurement processes. However, some delays were still noted especially around sourcing quotations as a result, the function- sourcing of quotations - has been returned to the district level to allow for a quicker turn-around-time. However, participants stated that selection of suppliers and contracts remain centralised to ensure control and reduce corruption.

4.2.4 Difficulties with the hardware - centralised IT

Chapter 6 and 7 expand on IT challenges and its serious implications for conducting day-to-day financial management activities. Centralisation of IT is also listed by district participants as affecting IT connectivity and the procurement of IT equipment necessary for district and sub-district functioning. Reasons stated for continued centralisation over Information and Communication Technology (ICT) units, is that IT is not yet well-established at either the district level or the province. Staff stated that there is more capacity at a provincial level compared to districts and hence most functions remain centralised. Other participants argued that in some areas of IT, it is necessary to have centralised functions and it would not be feasible to decentralise-

> Regarding internet connectivity, *housing important functions for IT at a provincial level is important; otherwise you risk people lower down interfering with the main server* and that could create even more problems. Even my office at PDoH doesn't have access to these functions, it is housed at PDF to ensure that the main servers works– Provincial Manager 3.

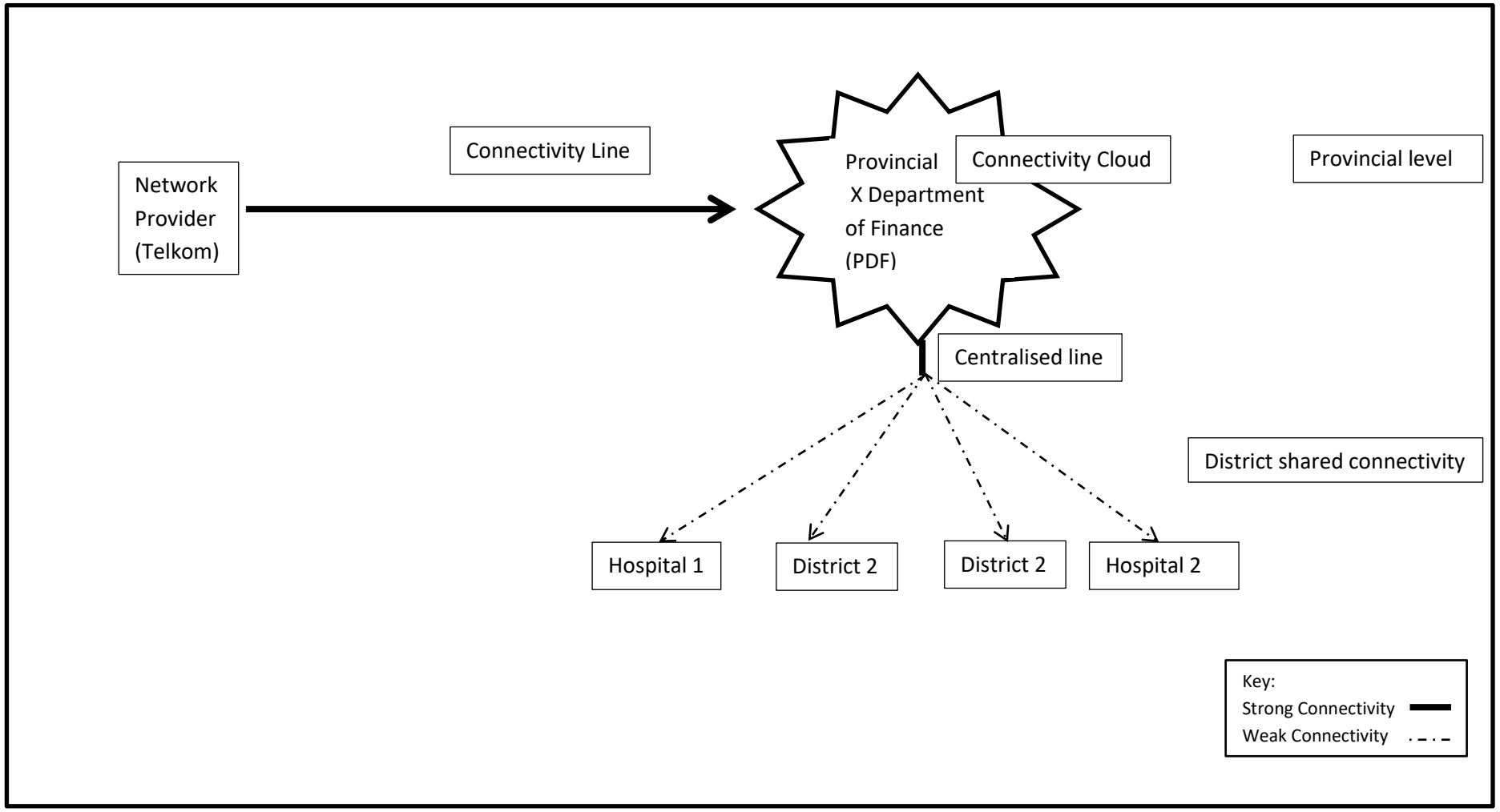
Moreover, staff said that ICT was under-resourced and that it is a neglected area in comparison to service delivery. In order to manage these limited resources, procurement functions over IT equipment and infrastructure plans were primarily centralised at PDoH. Lines of authority in this regard were blurred. In some districts IT equipment was purchased through district processes, while others were subject to provincial approval processes and plans and still do not have the necessary equipment or infrastructure. These issues will be outlined in detail in the proceeding chapters. However figure 4.2 is useful in providing a brief overview of the difficulties of continued centralisation in some regards. Participants alluded to political influences over IT processes (expanded in section 4.2.4). Moreover centralised procurement processes were described as being ill-defined around IT- districts would place IT related requests however provincial procurement is often aligned to other mandates/ instructions e.g. only R10 million allocated to purchase laptops irrespective of districts other

needs, but R10 million was not sufficient to cover all requests leaving some districts without any equipment and infrastructure:

> At many of our institutions IT connectivity or equipment is non-existent; you have staff that do not even have access to e-mails- Provincial Manager 1.

Thus it was not necessarily staff in PDoH which made decisions, instead they were outside of the health sector by other political stakeholders linked for example to interests in tenders yielding individual financial gain instead of meeting health sector needs. Political factors were cited as resulting in tender selection which escalated costs and left little budget for other areas of IT such as infrastructure improvements. Presently, there is a centralised internet connectivity line housed at PDF, which services all health districts and hospitals in the province. It is described as being ‘outdated and extremely slow’ and impeding district financial management.

Figure 4.2 Centralised IT Connectivity



4.3 Provincial Level Weaknesses

Objective 3 of this monograph is concerned with providing a comprehensive analysis of decentralised financial management i.e. coordination of tasks, functions and oversight by PDoH and its influences on district functioning. While some functions and processes have been transferred from PSSC and PDF back to PDoH and particularly PHPC in an effort to improve efficiency, ensure control and improve bargaining power, such benefits of centralisation have not yet been fully realised. This section discusses challenges affecting the centralised level (PDoH) and why these expected gains are yet to be achieved and in forthcoming chapters (5-8) shows influences on district financial management.

4.3.1 Legacy of apartheid & influence on PDoH functioning

Apartheid has had deep-rooted impacts on the SA health system. Most notably, some participants stated that it has resulted in a loss of institutional memory, a skilled white-workforce;

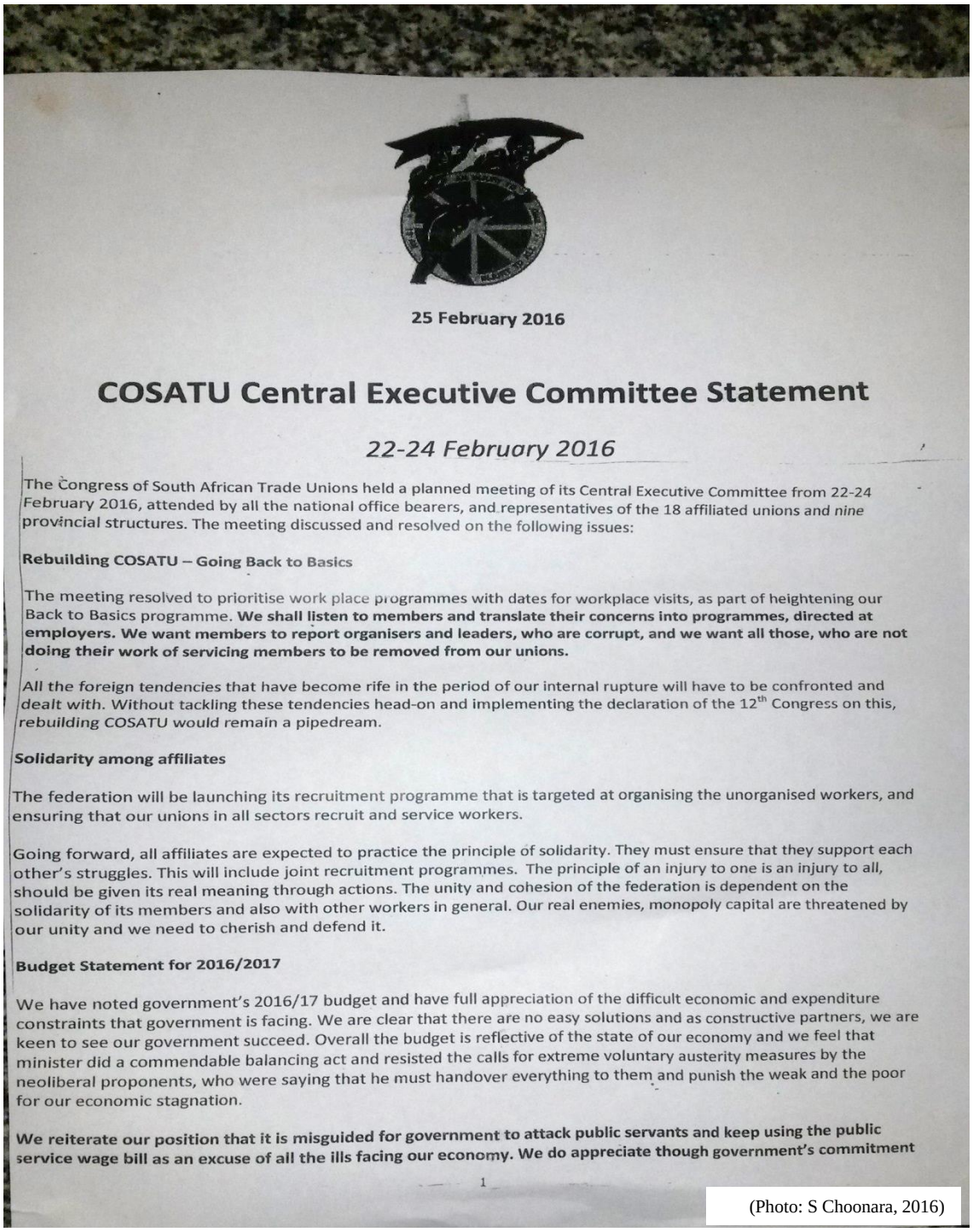
> I understand that post-1994 there had to be redress and there was a circular for whites to either stay on or have the option of applying for a package and leaving. I am one of the few white individuals who stayed behind, otherwise we saw all the skilled staff leave government and we never quite managed to address the skills-shortage – Provincial Manager 2.

The SA government in 1994 offered packages to skilled whites in an attempt to redress past injustices and implement policies such as Broad Based Black Economic Empowerment (BBBEE) which promotes employment of people of colour i.e. previously disadvantaged populations (section 1.1.2). Moreover, the government and in turn PDoH also promoted the use of BBBEE companies (suppliers). In fact, SA law (BBBEE- Act 2003) requires all companies to be BEE compliant. While redress is important and needed, there have been some challenges;

> I wouldn't say that things worked better under apartheid compared to now. Under the old regime there were more established suppliers, e.g. major corporations. Post 1994, *we took the decision to support BEE companies, which isn't a wrong decision but we must understand that the challenge is that they aren't obviously as well established white-owned companies.* Sometimes they don't have stock and some even source their products from established suppliers, so they act as a middle-man and this contributes to cost escalation as well – Provincial Manager 4.

During the apartheid regime, trade unionism among non-whites was banned; the rise of the anti-apartheid movement saw a rise in trade-unionism. Provincial participants explained that while trade unions are important they were described as negatively impacting transparency and accountability of staff at province:

> Trade unions are a major problem here, it is difficult to discipline anyone and there is no accountability here. For example, auditors keep requesting documents, no one replies to these e-mails sometimes for three months on end or people come in and leave the office when and if they feel like it and you can't discipline them. There was an instance where I tried to discipline my staff, the unions got involved and instead of staff being disciplined, they were protected, I was disciplined and transferred to another section – Provincial Manager 2.



25 February 2016

COSATU Central Executive Committee Statement

22-24 February 2016

The Congress of South African Trade Unions held a planned meeting of its Central Executive Committee from 22-24 February 2016, attended by all the national office bearers, and representatives of the 18 affiliated unions and *nine* provincial structures. The meeting discussed and resolved on the following issues:

Rebuilding COSATU – Going Back to Basics

The meeting resolved to prioritise work place programmes with dates for workplace visits, as part of heightening our Back to Basics programme. **We shall listen to members and translate their concerns into programmes, directed at employers. We want members to report organisers and leaders, who are corrupt, and we want all those, who are not doing their work of servicing members to be removed from our unions.**

All the foreign tendencies that have become rife in the period of our internal rupture will have to be confronted and dealt with. Without tackling these tendencies head-on and implementing the declaration of the 12th Congress on this, rebuilding COSATU would remain a pipedream.

Solidarity among affiliates

The federation will be launching its recruitment programme that is targeted at organising the unorganised workers, and ensuring that our unions in all sectors recruit and service workers.

Going forward, all affiliates are expected to practice the principle of solidarity. They must ensure that they support each other's struggles. This will include joint recruitment programmes. The principle of an injury to one is an injury to all, should be given its real meaning through actions. The unity and cohesion of the federation is dependent on the solidarity of its members and also with other workers in general. Our real enemies, monopoly capital are threatened by our unity and we need to cherish and defend it.

Budget Statement for 2016/2017

We have noted government's 2016/17 budget and have full appreciation of the difficult economic and expenditure constraints that government is facing. We are clear that there are no easy solutions and as constructive partners, we are keen to see our government succeed. Overall the budget is reflective of the state of our economy and we feel that minister did a commendable balancing act and resisted the calls for extreme voluntary austerity measures by the neoliberal proponents, who were saying that he must handover everything to them and punish the weak and the poor for our economic stagnation.

We reiterate our position that it is misguided for government to attack public servants and keep using the public service wage bill as an excuse of all the ills facing our economy. We do appreciate though government's commitment

1

(Photo: S Choonara, 2016)

Image 4.1: Regular trade union notices (PDoH offices)

A significant union role was noted at a provincial level. Image 1 depicts a notice by the Congress of South African Trade Unions (COSATU) which is one of the biggest confederations of trade unions in the country. It played a significant role in the achievement of democracy and exerts considerable influence in the country's political sphere as well (aligned to the majority party, the African National Congress- ANC). This can be noted in the budget section of the notice which states that they are constructive partners of the state. Often union meetings are held with provincial staff and notices are placed throughout PDoH premises. Several participants stated that unions tend to protect poorly performing workers, although it is important to note that this is coupled with contextual influences and policies such as BBBEE (later discussed in chapter 6 and 7).

However, trade unionism alone is not responsible for staff not being disciplined/ being held to account. In some units such as finance, senior management vacancies were also found to affect provincial functioning -

> To fill a vacancy at province is quite a cumbersome process, there are ways around it but very few actually do it. The human resource (HR) division needs to do the adverts, and then there are hundreds of applications from which you need to shortlist and then filling the actual post is another process that drags on. *In finance there is a Director Budget Management post that hasn't been filled for ten years. It's a combination of long HR processes but also that it is difficult to attract skilled staff to these posts*, they could make more money elsewhere for less stress- Provincial Manager 1.

It is thus clear that while post-apartheid re-structuring is underway, challenges associated with BBBEE and the rise of trade unionism post-apartheid are evident and found to affect provincial functioning, in turn affecting district financial management, procurement and IT.

4.3.2 PDoH & politicisation

> We are subject to politics, there is definitely is a lot of politics- Provincial Manager 1.

Several participants highlighted challenges linked to political factors. Two specific examples are outlined to illustrate the influence of political factors on resources and on recruitment/ procurement processes.

Example 1- unfunded mandates

> There are a lot of unfunded mandates; you will find that politicians make promises. We only have the resources which Treasury has allocated to us but have to find ways of implementing these promises - Provincial Manager 1.

Example 2- recruitment & procurement

> I would say that there are political pressures, not just on tender selection (procurement), but also on the issue of employment. *There is this tendency that people will refer candidates to you and you know that they are implying you need to hire them* – Provincial Manager 1.

Example 3: procurement

> Personally, I feel the approach has never been holistic. PDF is busy improving the connectivity through new infrastructure, which was a political decision and we weren't consulted or involved. Instead they are going to do all the sites then come back with budget constraints and we won't be able to purchase equipment, so we sit with dribs and drabs of IT components everywhere not fully equipped institutions- Provincial Manager 3.

Some participants mentioned that procurement/ selection of suppliers for IT equipment and infrastructure were influenced by some political actors (suppliers selected on the basis of their linkages to politicians) often with high costs which impacted the provinces IT budget. Other respondents explained that recent 5-10 year plans to improve internet infrastructure through the Provincial X Broadband Network (PBN) through faster fibre connectivity were underway, however such decisions were taken provincially and politically by GDF with minimal consultation and involvement of the health department, and also therefore the districts.

4.3.3 Internal challenges

Some participants argued that centralised functions especially at a provincial level were affected by weak communication, coordination (software issues) and integration between and within finance, procurement and IT units;

> There are major gaps around role clarification between finance and supply chain at province and there are difficulties which arise. If for instance, when the invoice is incorrect finance will argue that they do not check invoices but pay them and supply

chain will argue that they don't even work with invoices it's the finance section job- Provincial Manager 4.

Regarding the structure at province, there are two separate financial and management accounting unit. *The problem is that communication between the two sections is weak. Those in management accounting do not ever speak to those in the financial accounting unit.* For example, BAS is supposed to be an expenditure monitoring tool, but the management accounting section moves the budgets around or passes journals to balance budget over which doesn't reflect the true expenditure and they do this without telling the other unit (financial accounting) what the real expenditure was or about the processes they carried out – NGO Staff 1.

Currently even in the ICT directorate, there is a *total lack of transparency around decisions or plans and communication between different sections* – Provincial Manager 3.

Implications of having a poorly functioning provincial level, especially where the linkage of different sections is weak coupled with other external challenges (e.g. loss of institutional memory, power of trade unions) and political factors impact centralised functions such as finance and IT.

4.4 Conclusion

This chapter outlines the rationale of shifts towards re-centralisation over key functions such as finance and procurement. While centralisation is meant to be more effective and critical to addressing the shortfalls of decentralisation, it is evident that there are several provincial level challenges such as a political factors, vacancies and de-linkages (lack of communication) between units which hamper the success of centralisation. The chapter touched specifically on the implications of ineffective centralisation, particularly focussing on difficulty tracking expenditure and slow internet connectivity (hardware). This chapter sets the broader context in which both districts operate in and the following chapters unpack in greater detail how everyday financial management tasks in districts are affected and their response to such challenges.

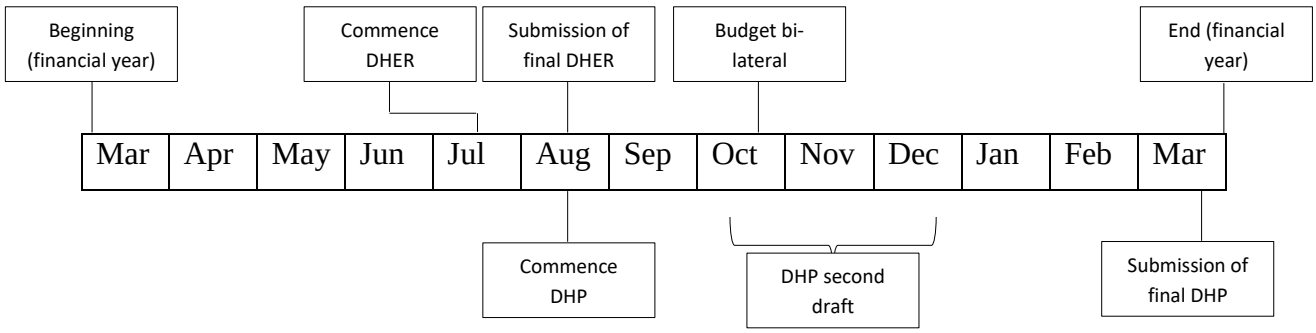
CHAPTER 5: OVERVIEW OF DISTRICT FINANCIAL MANAGEMENT

5.1 Introduction

Certain financial management tasks have been delegated to the district level; however some functions are carried out provincially by the Provincial X Department of Health (PDoH) and have been outlined in chapter 4. Before proceeding to specific results and an in-depth account of district level challenges and successes, this is chapter provides a brief overview of everyday finance processes – routines around planning, budgeting and resource allocation, oversight and evaluation. This is followed by district-specific information including, actor maps (organograms) with descriptions around designated roles and tasks for each study site, and some insight is provided into district procurement which is closely linked to financial management (figure 2.3, circle 2) and is discussed at length in chapters 6-7.

5.2 Synopsis: District Finance Function

The conceptual framework (figure 2.3) details the financial management cycle as comprising of four distinct processes. Below is a timeline of the key processes to be discussed;



Timeline - finance processes and deadlines at a district level in South Africa (SA)

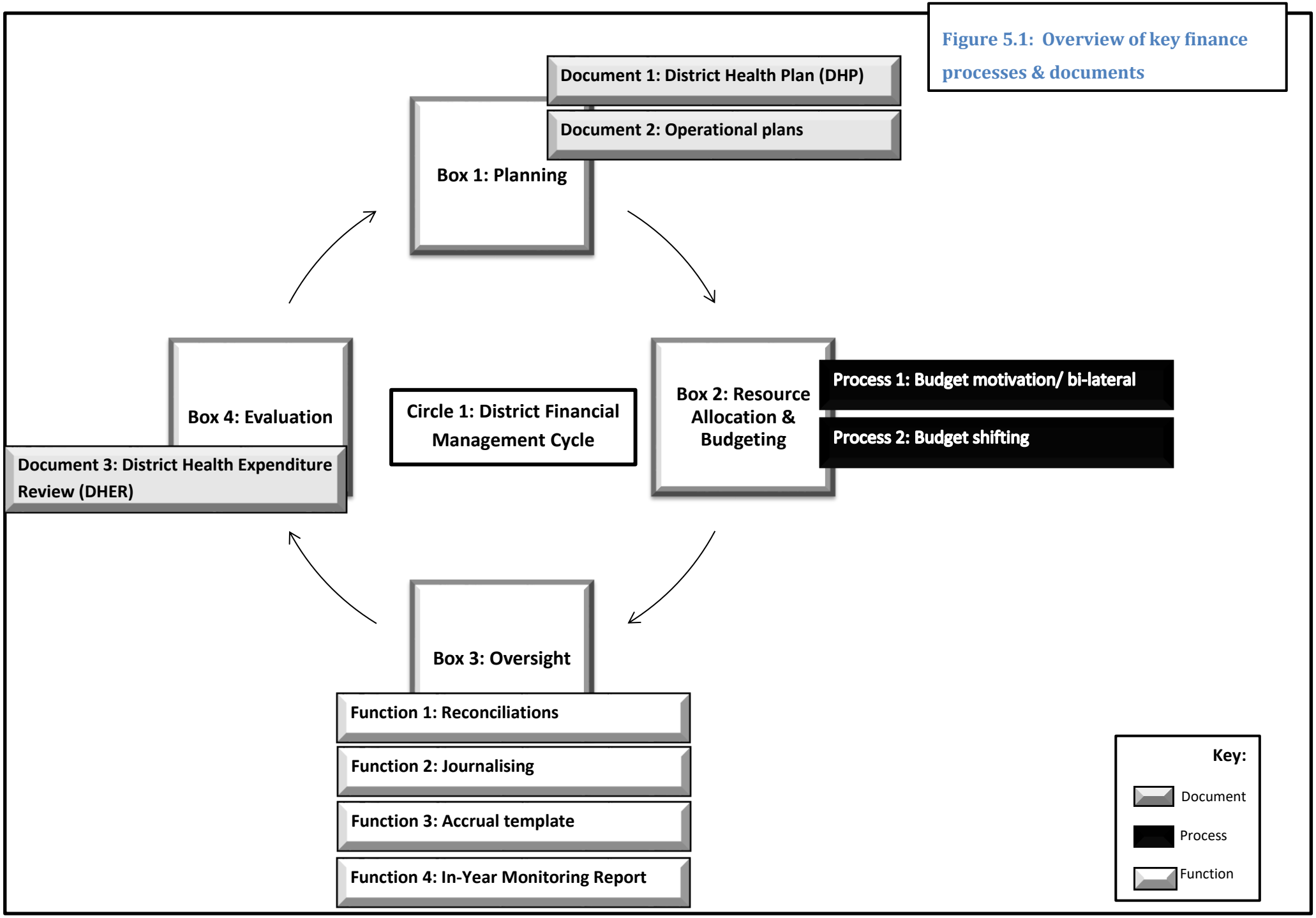
While, the timeline above and figure 5.1 do not provide a comprehensive list of all financial management processes they illustrate key activities which emerged, then discussed in subsequent chapters. The District Health Plan (DHP) is compiled by districts on an annual basis. The standardised template is meant to set the tone for decentralised planning and budgeting and aims to align district and provincial planning and budgetary processes. The district plans set out the strategic direction and areas for implementation for the forthcoming year and offers budgetary insight i.e. costing. The district financial year commences in March. According to provincial timelines, it is advised that the DHP process commences in

August/ September, with at least two drafts and a final DHP submitted before the end of the financial year (March).

Box 2, which refers to financial management, process 2 (resource allocation and budgeting), highlights the importance of budget bi-laterals and budget-shifting. Annually, the province provides room for motivation and negotiation for additional resources (October each year). Each district is able to put forward a presentation detailing its financial requirements and based on available resources. The province may allocate additional resources to meet these needs (budget bi-laterals). The district is also given some authority to make recommendations on unspent resources and its reallocation (budget-shifting), although it is limited to certain standard accounting standard practices in the public sector e.g. not being able to shift between economic classifications. Budget classifications refer to different categories/ classifications such as compensation of employees or capital goods/ assets. Districts are responsible for allocation of the budget to sub-districts and over the procurement of items below the R500 000 threshold (expanded in section 5.4). Budget allocation to the sub-districts are handled by the financial controller or junior level finance manager (figure 5.3 and figure 5.4) who are meant to consider sub-district needs for the year, available budget and the DHP.

The oversight process (box 3, figure 5.1) involves tracking expenditure, through accruals, reconciliations (between systems e.g. the Basic Accounting System –BAS- to see if payments are correct); through the standardised in-year-monitoring (IYM) report and journalising to correct instances where funds and payments are placed in the wrong accounts (misallocations). The oversight function pertains to the monitoring expenditure of programmatic activities (e.g. primary health care- PHC), finance activities of other unites e.g. human resources/ salaries and the budget approval for procurement functions. Actors depicted in figure 5.3 and 5.4 (further detailed in table 5.1 and 5.2) are involved in oversight processes pertaining to financial management in the overall district (including the sub-district). The District Health Expenditure Review (DHER) theoretically and practically is meant to be closely linked to the DHP and provides an overview of the district's finances in relation to its service delivery indicators e.g. access to health facilities in the district, ratio of medical professional to patients. The DHER is also a standardised template prescribed by higher levels of the health system (province, national), districts are required to compile and submit through to the province in August every year.

Figure 5.1: Overview of key finance processes & documents



5.3 District Organograms- Finance Staff Roles and Responsibilities

Figure 5.2: Basic organogram or structure of districts in PDoH province

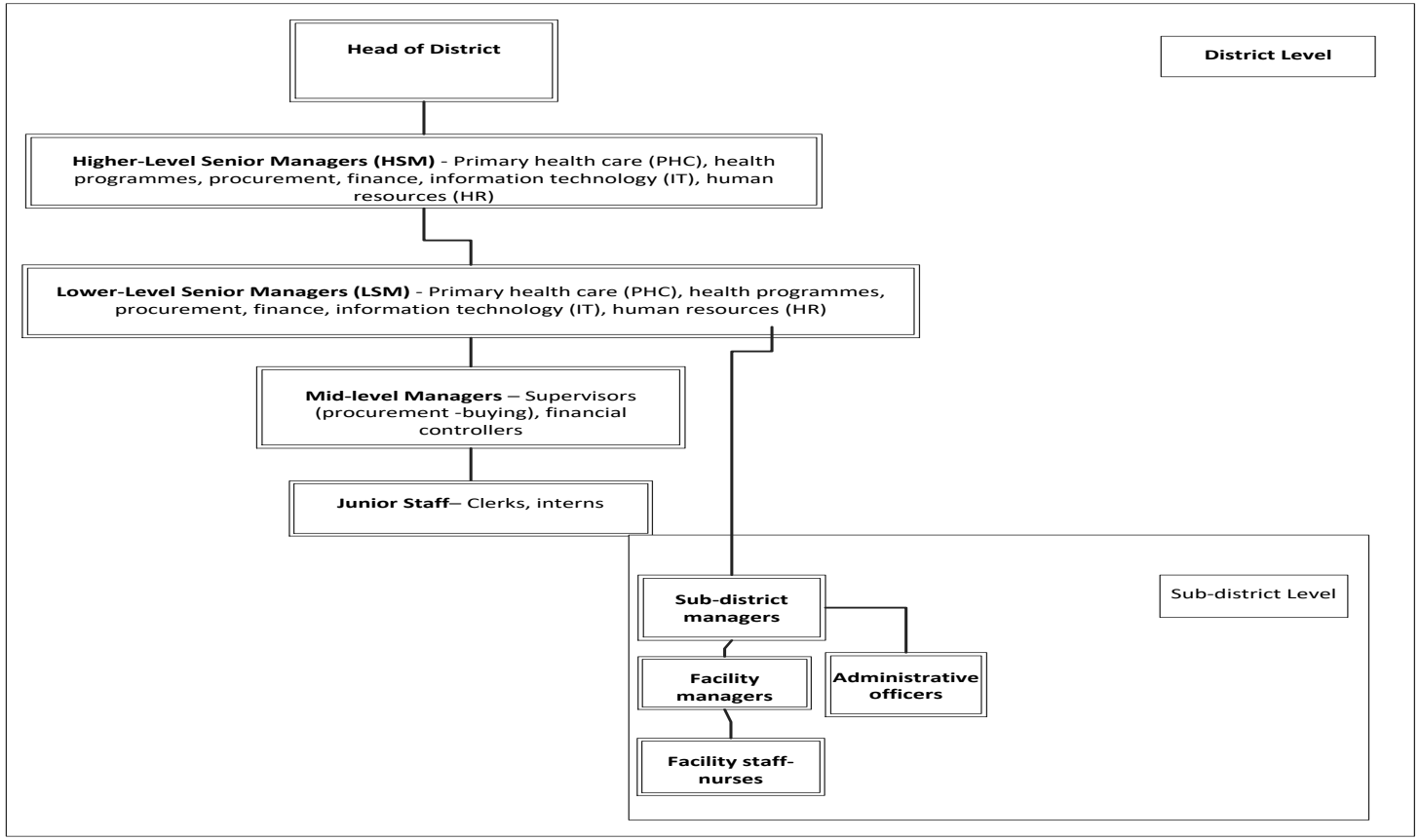
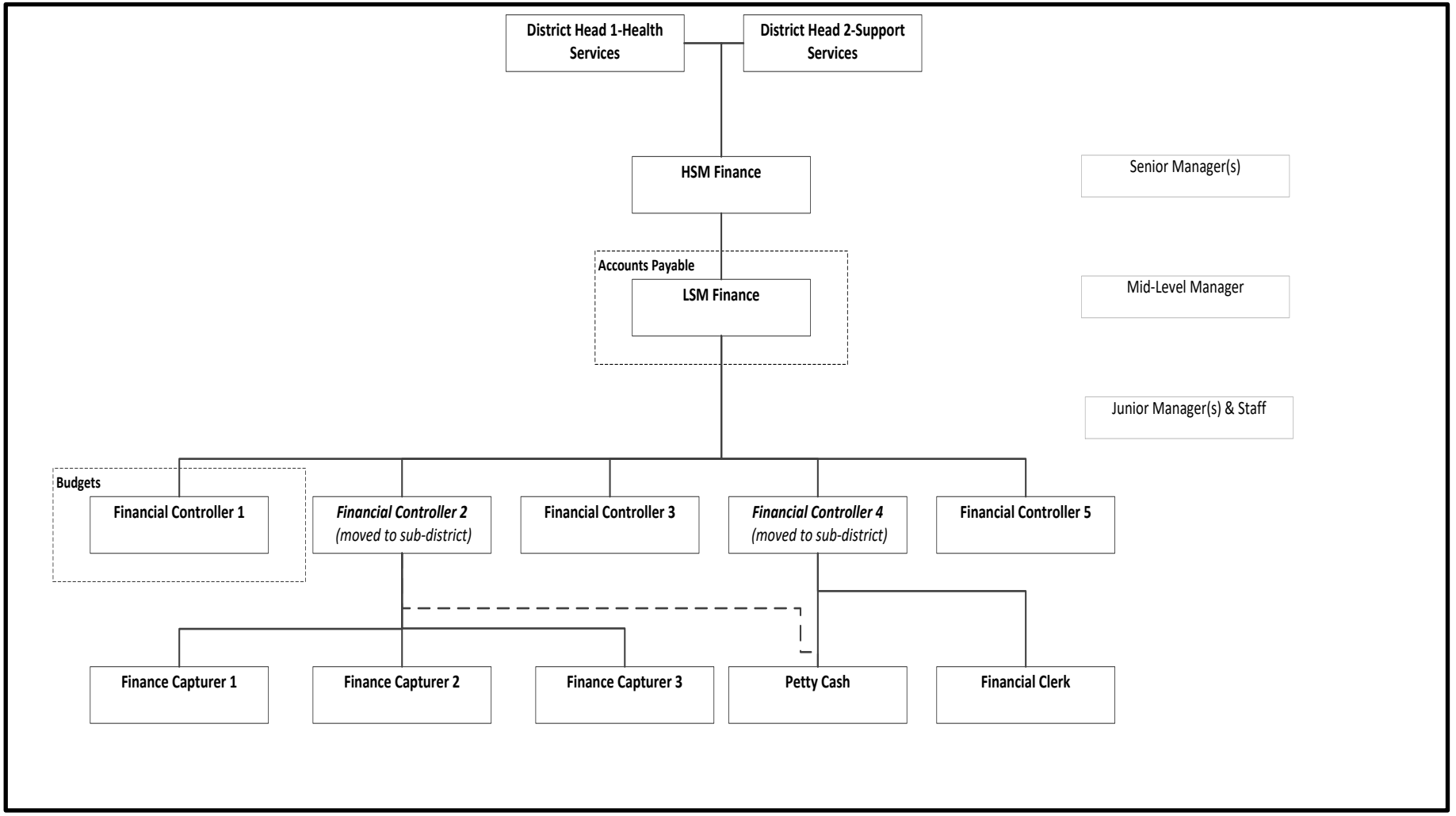


Figure 5.2 serves as a basic introduction to the general structure of districts in province x. senior managers in the district include the head of the district, followed by the higher level senior managers (HSM) across various units ranging from health programmes to finance. Lower level senior managers (LSMs) who report directly to HSMs and below them are junior managers and staff e.g. clerks in the finance unit. Sub-district staff are generally HSMs/ LSMs in primary health care (PHC), including sub-district managers and facility managers. It is however important to note, that there may be slight variations in structure depending on district appointments (internal and external- section 5.2.1) or vacancies, for example not all sub-districts have administrative officers in place (further expanded in section 5.2.2).

Figure 5.3: Indawo District Finance Team



5.3.1 Indawo district (figure 5.3)

The district has a newly appointed head of the district (corporate services) that is meant to be on the same level as the head of the district (health services). The head of the district of corporate services is responsible for support functions, including the finance unit, comprised of 12 staff members, ranging from senior managers including the HSM finance, a mid-level manager (the LSM), and more junior managers and staff – controllers, clerks and data capturers. The senior managers particularly the HSM and LSM carry out higher-level functions such as compiling the DHER and are given the authority to carry out budget-shifting on an annual basis (these processes are however subject to higher level approval-PDoH). Both senior managers are meant to carry out Performance Management and Development System reviews (PMDS) of their staff on a quarterly basis. Their activities (senior finance managers) include liaising with the province through official meetings, for example budget request/motivation meetings, attending high level district management meetings, hosting budget meetings to provide an update on expenditure and to support different divisions such as human resources (HR) procurement and health programs at a district level as well as sub – district managers and facility staff.

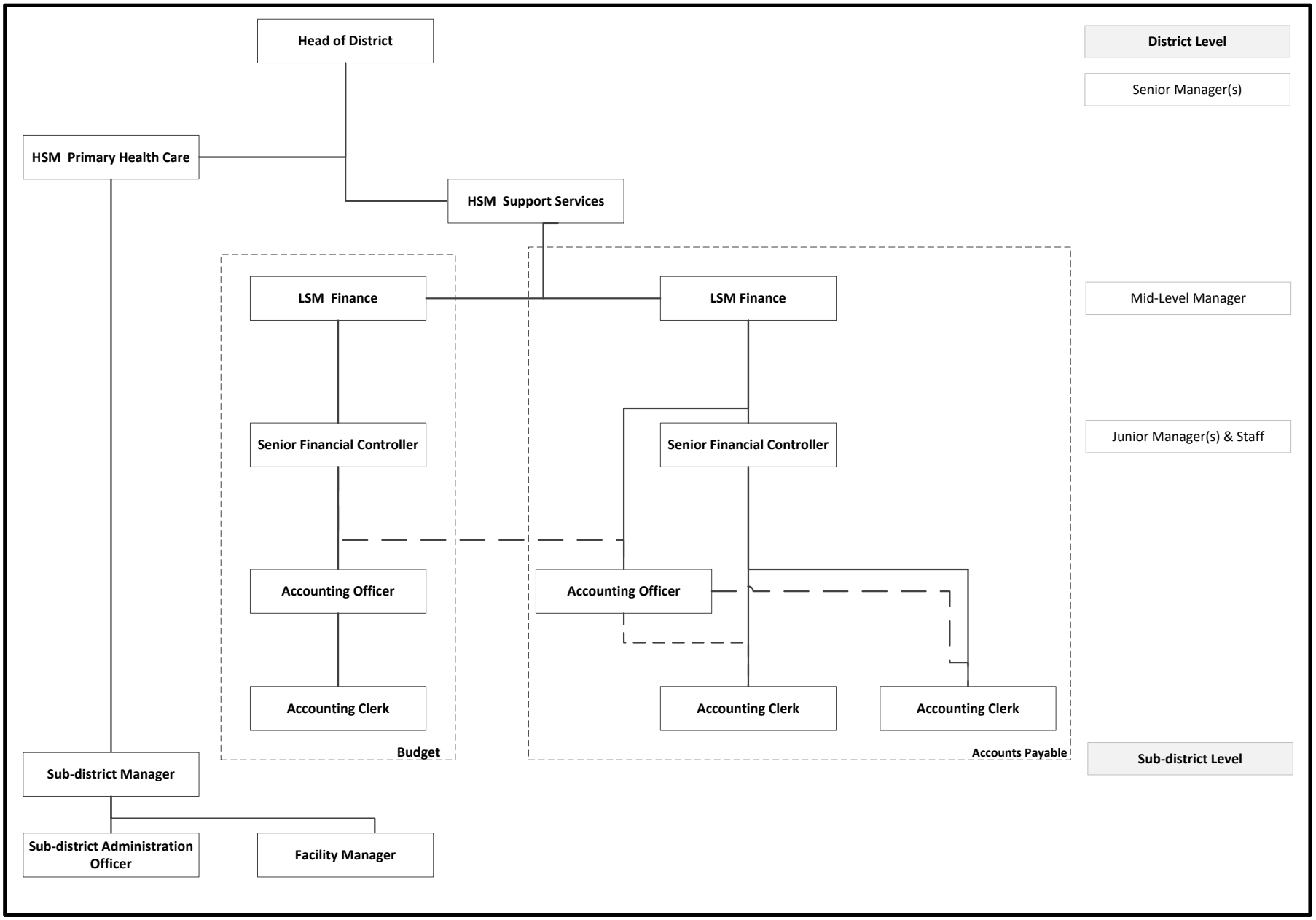
Broadly speaking, the accounts payable section is handled by the LSM finance with financial controller 1 handling the budget section. However, other than this distinction, there is no clear demarcation of staff into either the accounts payable or budget section as all staff report directly to the LSM and carry out functions related to both divisions. When the research commenced there was no finance capacity at sub-district level, however managers indicated that they are in the process of decentralising the finance function- some district staff have been moved to the sub-district. But their roles and functions remain the same; they are now based sub-district offices (relocated to lower levels). Table 5.1 outlines tasks carried out by these financial controllers, two of whom are managers. There are few financial management functions carried out at the sub-district level, the sub-district managers specifically are required to give inputs for the DHP and budget, and participating in bi-monthly budget meetings however handling of resources (reconciliations), approval, reporting and all other functions are carried out by the district or sent to the province.

Table 5.1: Financial controllers roles and responsibilities

Staff/Participant	Functions/Tasks
Financial controller 1	• Budget capturing • Budget allocations, including sending out budget letters to the sub – district • Confirming the availability of the budget for procurement of items • Assisting with expenditure reports and requests for new budgets • Correcting misallocations –journalising
Financial controller 2	• Sundry payments • Payment of mental health (Non-Governmental Organisations - NGOs) • Journalising • Managing capturers (payments)
Financial controller 3:	• In- Year-Monitoring (IYM) reporting/ tracking expenditure • Reconciliations between HR (PERSAL system)[12], procurement (SAP)[13] and finance systems (BAS)[14] • Managing staff (petty cash and interns)
Financial controller 4 & 5:	• Management of conditional grants

[12] PERSAL- Personnel Salary System- HR system
[13] SAP - System Application and Products – procurement system.
[14] BAS- Basic Accounting System – finance system

Figure 5.4: Isikhala district & Isifundo sub-district finance



5.3.2 Isikhala district (figure 5.4)

The HSM support services has a well-established role in the district and provides oversight and management of procurement, IT, HR and finance units. In total, nine staff members are placed in the district finance team. There are two LSMs who are responsible for the finance section - the accounts payable and budgeting section respectively. Since 2009, the finance unit has been divided into these sections. The separation was implemented to deal with increasing workload and to clearly define roles/ tasks and place staff within each of these sections. The LSMs provide strategic direction for the unit, ensure that all instructions and policies are implemented, carry out higher-level functions such as compiling reports, guide operational tasks and are responsible for managing staff and ensuring that performance management process are completed. The two LSMs are responsible for the accounts payable and budget section respectively, although they work closely together to ensure that both sections are well-coordinated and integrated. The managers also ensure that the finance section provides support to other areas e.g. PHC, health programmes and even the sub-district offices. Irrespective of placement of staff in specific divisions all staff are trained on tasks and processes across both units allowing for teamwork and continuity if staff resign / leave (more information is provided in chapter 7, section 7.5.2). Besides these senior managers, there are several lower level managers, as well as clerks whose functions are discussed in table 5.2. Moreover, table 5.2 also details roles of the administrative officers in Isikhala sub-districts. Similar to Indawo, sub-districts also provide feedback for either budget inputs or adjustments with the majority of finance related tasks being carried out at the district level. Although since December 2012 (approx. 3 years) Isikhala has decentralised its support function via administrative officers which applied for the available posts and were then placed in sub-districts. The organogram depicts lines of authority of administration officers under the sub-district manager and HSM PHC.

Table 5.2: Isikhala district & Isifundo sub-district (description of finance tasks/ roles)

Staff/Participant	Functions/Tasks
Senior financial controller 1	• Compile IYM • Check available funds/ release funds for procurement • Budget shifting • Demand plans • Manage junior staff
Senior financial controller 2	• Payment submissions to province – NGOs • Petty cash • Manage junior staff
Accounting officer 1	• Budget Shifting • Reconciliations e.g. BAS PERSAL • Manage junior staff
Accounting officer 2	• Payment submissions to province - NGOs Reconciliations • Manage junior staff
Accounting clerk 1	• Reconciliations, e.g. BAS PERSAL • Inter-responsibility clearing account (charge accounts when borrow good s between facilities)
Accounting clerk 2 & 3	• Reconciliations • Capture payments and supplier invoices (when not sent to the province) • Accruals templates
Sub-district administrative officer	• Procurement • Transport • Security • Finance support e.g. costing facility plans, budget inputs **The sub-district officer coordinates and collects all information/ requests from facilities and passes on to relevant district staff in finance/ procurement. Additionally, the sub-district officer coordinates communication between the district and sub-district around budget inputs or adjustments and other matters arising.*

5.3.3 Comparison of finance structures in districts

Table 5.3: Comparison of finance organograms between districts

District(s)	Total no. finance staff	No. HSM	No. Ads	No. junior managers & staff	Decentralisation to sub-district
Indawo	13	1 -HSM Finance	1	10	Some progress/ In process
Isikhala	10	1 -HSM Administration)	2	7	Yes

Section 5.3 provides useful organograms of the finance units in each district, there are some differentiating features between the district organograms. Indawo district now has two head of districts, one being the recently appointed/ responsible for support services. Whereas, in Isikhala there is only one head of the district and one HSM of support services. Table 5.3.3 shows that the finance unit is comprised of a total of 13 staff which includes the head of the district in Indawo and 10 staff members in the Isikhala, with a few more financial clerks and controllers in Indawo.

Isikhala district has two finance LSMs, each responsible for the budgeting and accounts payable section respectively. Since 2000, staff were positioned into clearly defined roles within either of the sections. In Indawo, there is only one LSM, with the accounts payable and budgeting section not clearly demarcated as all staff functions overlap and report directly to the LSM. Isikhala has for the past three years established some level of finance capacity (administrative officer) in each of its four sub-districts. While Indawo has relocated some of its district staff to the sub-district, the process is still underway and there have not yet been any changes to the role/functions of financial controllers who will be based at sub-district offices.

5.4 District Procurement Function

The proceeding chapters (6 and 7) deal quite substantially with district procurement processes in relation to centralisation and district finance (access and use of available resources as well as tracking expenditure) – i.e. in line with objective 3 (comprehensive account of financial management). This section provides an overview of the procurement unit and functions which have been standardised across both districts under investigation. There are two possible ways/methods of procuring goods/services at a district level.

The first method involves suppliers signing contracts with the province and being loaded as suppliers/vendors onto the districts procurement systems, this enables districts to procure (authorise, order and release funds under R500 000) relatively quickly as there is no need for a purchase order (PO) number. Districts may procure goods and services through this process until fixed-term contracts between the supplier and the province expires.

The second method involves purchasing items or services which requires provincial approval through the creation of PO numbers. This has various checks within the process to ensure quality of goods purchased and to avoid corruption and fraud. Checks during this first phase include:

- Financial authorisation at a district or provincial level, confirming whether sufficient funds are available for purchases.
- Provincial oversight, vendor selection and conformity to guidelines such as BBBEE.

Districts procurement units are divided into two distinct sections, namely the buying and transit divisions. The buying unit ensures that quotations are sourced, funds are available, procurement requests are approved and captured onto the system and that approved orders are passed on to the transit unit. The transit unit deals with the order and delivery of goods/ services and distribution of goods. Once goods are delivered, the transit unit is responsible for the third check;

- Confirming the quality and quantity of goods or services received/ rendered and quantity against the order, this is then captured onto procurement systems such as a Goods Received Voucher (GRV).

Thereafter suppliers send invoices to the province (Provincial X Health Processing Centre - PHPC) for payment. The third control/ check-

- Tracking payments and purchases through the reconciliation of the finance and procurement systems (BAS and SAP) occurs at both provincial and district levels.

5.5 Conclusion

This chapter provided a broad overview of financial management processes and units in respective districts. Figure 5.1 provides insight into specific finance processes and tasks which take place at a district level. It sets the tone for understanding these key processes (routines), particularly challenges and successes in the next chapters. Organograms also show marked

differences in terms of structures, number of staff and division/ demarcation of units between districts.

CHAPTER 6: DECENTRALISED FINANCIAL MANAGEMENT – INDAWO HEALTH DISTRICT

6.1 Introduction

Objective 2 of this thesis attempted to examine organisational realities, financial processes cognisant of hardware and software of the District Health System (DHS). This chapter thus provides an in-depth analysis of financial management in the Indawo district. It focusses on the routine processes of the financial management cycle. It discusses the impact of poor internet connectivity (hardware) on financial management, as well as the closely linked procurement function which is affected by access to and utilisation of available resources and non-payment of suppliers. The chapter also outlines how daily financial tasks are affected by centralisation of some functions by province and external influences e.g. non-governmental organisations (NGOs). Attention is also paid to the importance of software factors i.e. managerial skills, interpersonal relationships and personnel development/ empowerment and its role in fostering agency with regards to financial management challenges.

6.2. District Financial Management

Structuration theory does not exclusively refer to larger structures e.g. rules and resources recognises everyday organisational routines through which structures are enacted. Within this framework this section details everyday tasks of financial management, how these tasks are conducted and what some of the difficulties are.

6.2.1 Financial management process 1 – poor coordination of planning processes

The District Health Plan (DHP) in Indawo is co-ordinated by the primary health care (PHC) and health programme units; however input for the document is required from other units including finance and human resources (HR). The DHP is meant to allow for districts to put forward their priorities and strategy for the forthcoming year, however documents do require final approval by the province and are subject to available and allocated resources. According to the DHP guidelines, the following timelines should be adhered to (section 5.2):

- DHP first draft (August – September)
- DHP second draft (October – December)

- Final DHP (end financial year – March)

One of the NGOs temporarily operating in the district assists with three key areas, namely finance, HR and service delivery. Three NGO representatives together with a few other staff members support the district in these areas. For the past two to three years in the district, the NGO representative responsible for service delivery has assisted the higher level senior manager (HSM) of health programmes with coordinating the DHP. Findings are based on participant observations of DHP meetings and processes (Field Notes, October 2015-March 2016).

The first meeting to draft the DHP took place in October 2015 which was approximately three months later than the advised date (August). Relevant stakeholders, ranging from finance, procurement, HR at a district level and sub–district managers were invited to the meeting. Numerous attendees were between 2-3 hours late in arriving and there were also technical difficulties. A projector was required to carry out a PowerPoint presentation around the DHP, however it malfunctioned and some of the attendees attempted to resolve the issue for over four hours. However, a PowerPoint presentation was not necessary as the NGO representative was only going to present the DHP template, with which many of the attendees were already familiar. Nonetheless, the researcher continued to observe the process and how participants tried to resolve the issue - one of the HSMs attempted to fix the projector line, while a few others tried calling for technical support. After four hours, the researcher liaised with the NGO representative around his presentation and suggested that the presentation could be saved on a Universal Serial Bus (USB)/ memory stick and that participants sit together in groups around those with laptops to go through the presentation. The meeting eventually commenced without the use of the projector and was facilitated by the NGO representative.

During the presentation there was limited interaction and discussion between the NGO representative and district staff around filling in the contents of DHP template. Instead an overview of what the DHP is and its different sections were presented. After a meeting of approximately six hours, the meeting concluded with the HSM health programmes allocating different sections of the plan to different units. The researcher was considered to be part of the finance team and was allocated certain areas of the DHP to complete: the sections were linked to the DHER – which is further outlined in section 6.2.3. A second meeting was planned for the consolidation of the DHP, however the meeting failed to be held and the final report was then

submitted (with minimal consultation and discussion) by the March 2016 deadline. Two issues were highlighted by participants; conducting the DHP was more of a compliance task and that these planning processes were also de-linked from their everyday activities including other financial management processes such as planning or budgeting (Field Notes, October 2015).

6.2.2 Financial management process 2 – resource allocation & budgeting dilemmas

A number of respondents explained that the resource allocation process is still largely controlled at a provincial level. On an annual basis (October), a range of stakeholders in the province including regional hospitals and districts are invited to present their budget requirements to province for the forthcoming financial year (also outlined in section 5.2). The province does make it clear that it too is constrained by limited resources, and budget requests cannot be approved unless they are sufficiently motivated, there is an imminent need for the request and if there are available funds. It was observed that there was minimal interaction or interrogation of the document at a district level (only the lower level senior manager (LSM) - LSM and HSM of finance put together the presentation), prior to it being presented to the province. The HSM also stated that some of the other units in the district did not provide the finance unit with relevant inputs before the deadline leaving the finance team to put together a presentation covering all other units. Interestingly, other reasons for a weakly put together presentation was that district staff felt that these processes are more of a compliance task and that provincial allocations are usually made without cognisance of their budget requests/ motivations:

> The province is meant to look at and consider budget inputs from the district; however what happens is that allocations are usually made without any feedback and are often not in line with district inputs –NGO Staff 1.

The province (Provincial Department of Health- PDoH) described the presentation as 'poor and inadequately motivated' which resulted in the district having to carry out corrections to the presentation *(Field Notes October- November 2015)*. Some provincial staff further argued that finance skills at a district level affect the quality of budget motivation presentations/ requests:

> Each institution or district tends to obtain their previous year's budget with an inflation adjustment, but there is sometimes room for new activities to be funded. The mo*tivation that we receive from the institutions are weak* and do not provide sufficient detail or

> evidence, most of the time they are unsubstantiated e.g. they will want to employ new staff but not provide evidence of why. We operate in a resource-constrained environment and cannot approve requests that are not convincing enough- Provincial Manager 1.

Other district staff were in agreement with the provincial view of budget presentations:

> At a recent budget interrogation at province, we went for a meeting and I had to present my unit/ divisions' figures provided by our district finance team. When presenting, even the province was also picking up that the figures weren't tallying, especially the slides with a cumulative total. If you added it up it, it was clear that things weren't right. Then *I said to our HSM finance that something was wrong and instead of rectifying it, she said that all figures are correct and I was wrong because I was calculating these figures on a cellular phone. We are saying that 1+2=6; there is definitely a problem* – District Senior Manager 13.

Other budgeting issues pointed out by senior managers in the district was that provincial resource allocation processes were not cognisant of political mandates (promises made by politicians) or some unfunded policy instructions from the National Department of Health (NDoH). The managers reported instances where the district was expected to implement activities without the necessary financial resources – unfunded mandates. Some participants mentioned that resources were already constrained and this made it difficult to meet the needs of the district.

> We usually never receive what we requested, usually it is less. At the beginning of the financial year we need to decide how we will achieve our objectives with the tiny budget we were allocated. Another problem is when politicians want certain activities to be implemented with immediate effect; these requests are usually not accompanied by money, to implement these activities we have to take the very same minimum resources at the clinic to implement these demands– District Senior Manager 3.

Others noted that it was difficult to make use of the allocated budget due to centralised approval processes and unspent resources are not usually reallocated back to the district.

> The senior finance officer who is based at province, is supposed to sign and approve IT requests, though he doesn't and then by the same token will ask you why you haven't

> spent your budget. The best way to describe it is that it is a catch-22 situation. On the one hand, they encourage you to spend but at the same time they stop you from spending – District Senior Manager 6 -interview and observations notes.

It is important to note that even though district participants have stated that unspent resources are often not re-allocated, the province has made provision for an annual budget-shifting/ re-allocation processes between July and August. The district finance team is meant to liaise with the rest of the district as well as all sub–districts when shifting unspent resources. The finance team requested budget shifting information during two meetings, namely; the district budget meeting and during the sub–district budget meeting (held with stakeholders – e.g. programs, primary healthcare, facility managers, IT and HR). The finance team and in particular the HSM and LSM requested information during these meetings, with a deadline for information/ requests to be sent through the next day. The HSM and LSM stated that the short timeframe was due to PDoH communicating the deadline quite late. However, the budget-shifting process is an annual process which the district doesn't necessarily need the go ahead for – they are able to prepare without waiting for provincial instructions. Participants voiced concerns that they would not be able to meet the deadline. There were also questions around how sub-district/ facility managers would provide the necessary information without access to financial systems and errors with the expenditure reports provided (described further in section 6.2.3). Only a few requests were received and put forward, contributing to the province not reallocating resources for the next financial year.

6.2.3 Financial management process 3 & 4– oversight & evaluation

The District Health Expenditure Review (DHER) is a document which is usually compiled between July – August and its purpose is to review district expenditure retrospectively (as detailed in section 5.2). Its core function is to track over- and under-expenditure across the district's clinics, PHC services, hospitals and even includes population and demographic information. It essentially brings together service delivery indicators/ outcomes and finance. In Indawo, the DHER is coordinated by the HSM finance, which requests necessary information from PHC, programmes, HIS (Health Information Systems), hospitals and clinics. The HSM finance stated that often units would delay in sending through the requested information. It was also observed that some staff did not have adequate financial management skills e.g. staff were

unable to make use of financial systems, or extract information which was needed to compile the report (Field Notes, October 2015). Again, similar to the DHP process, the document was not thoroughly interrogated or discussed, and completed to comply with provincial deadlines/ requirements.

Oversight documents such as the DHER are also considered to be flawed due to expenditure tracking at a district level being described as 'difficult'. The majority of participants stated that expenditure tracking difficulties were due to the payment function remaining centralised. The Provincial X Health Processing Centre (PHPC) makes payment to suppliers for district goods/ services rendered (as discussed in section 4.2 and section 5.4). Participants stated that invoices are sent through directly to PHPC and the payment/ non-payment of suppliers is not communicated back to the district level. Interestingly, one participant (District Senior Manager 13) with substantial experience in PDoH across finance, HR and risk management and now based at the district level, reported that it is possible to track expenditure. This senior manager depicted the value of institutional memory and stated that she also tried to assist the district:

It is possible to track expenditure

> I learnt these systems by asking questions across departments and created a template while I was at province on reconciling the two systems. *Everyone should be able to track where the money is, you use the Basic Accounting System (BAS) to track expenditure and once goods or services are rendered, a Goods Received Voucher (GRV) is captured onto the procurement system (SAP) which is even linked to a specific purchase order (PO) number.* One is able to get a report and carry out a reconciliation between the two systems. It is supposed to be done on a monthly basis to see what has been ordered, received and paid. *This is where you need finance and supply chain to work together.* Supply chain doesn't have access to BAS but it is possible to have access, all one needs to do is request the enquiry functions in BAS for supply chain and it's easy to get this. I started working with procurement to get these reports, although I'm currently doing very operational tasks and tending to a high workload so it's difficult to continue assisting – District Senior Manager 13.

Commitments (invoices in the process of being paid)

> *We fought terribly when I first started working at the district, in both our executive and finance meetings where the finance team would report on our unit's expenditure.* I asked about commitments because of the cash-flow issues we had. Expenditure is obviously affected, you think you have a budget but there are commitments. It seems we are now starting to take commitments into account; it doesn't make sense [that] they are doing it manually, nowadays there are commitments but they aren't correct- District Senior Manager 13.

Why there continues to be difficulty tracking expenditure?

> *I don't want to speculate but I think the managers are falling short - perhaps they don't know these functions and if they knew they would tell people on the ground*. It's also that people don't want to know how to do it. In this sense centralisation was negative, district staff rely on someone else to do the job for them and people stopped to think for themselves or be exposed to other work e.g. finance to supply chain and vice-versa. In the past province also used to host finance forums which included supply chain and issues such as expenditure were discussed. For some reason this sort of support has fallen apart – District Senior Manager 13.

Even though it is clear that expenditure can be tracked, it is important to note that district staff stated that provincial payments were often substantially delayed, further compounding expenditure tracking problems:

> I put through payments for the telephone supplier several times, though they refuse to provide any further services because we are so far behind on our payments – District Senior Manager 2.

> We follow all the necessary steps at a district level, suppliers are meant to be paid in 30 days, though I don't know what happens, it is sent to central office and there are delays. It's a problem when suppliers are knocking on my door for payment – District Junior Manager 2.

Other participants noted that it is difficult to track expenditure due to other key functions/ support systems also being centralised. A few participants explained that many of the HR

system- Personnel and Salary Administration System (PERSAL) - functions are centralised, information updates (placements/ resignations) are delayed, thereby affecting finance/HR payments, particularly salaries;

> The PERSAL function does not reflect accurate data; the vacancy rate alone is a false number. The issue is that a lot of the functions remain centralised, only province can make certain inputs (which is sometimes delayed), the districts cannot – NGO Participant 1.

> We in finance do work hand-in-hand with HR at the district and at province. There are constant variances in the staff establishment, incorrect information and this remains a huge challenge when trying to do the BAS-PERSAL reconciliation- District Junior Manager 1.

As a result and observed during a number of meetings, expenditure reports do not reflect payments which have gone through or which are yet to go through i.e. commitments (Field notes, August 2015 – December 2015). Expenditure may reflect items incorrectly: some of the items listed were never purchased by their divisions (misallocations). In response, financial controllers explained that they do journals to correct misallocations on a monthly basis (they usually dedicate an entire week to this function); though passing journals (correcting misallocations, placing them in correct budget classifications/ categories and charged to the correct centre) are questionable.

> *If an organisation budgets properly there won't be a need to pass so many journals.* It tells you that there is something wrong with our budgeting system- District Senior Manager 13.

The issue at both the district and provincial level (section 4.2.2) shows that journalising is carried out when expenditures are incorrectly allocated/ placed in the budget and carried out to avoid audit queries. An organisation would usually pass journals to balance the budget, i.e. to ensure that the budget matches the expenditure. Both participants at provincial and district level raised concerns that passing journals should not take place continuously, and it is not required if budgeting and expenditure functions are carried out correctly (quotation above). Thus the high levels of journals passed indicate that the budget is not an accurate reflection of district

expenditure, it masks this and affects other parts of the financial cycle e.g. one cannot plan accurately with incorrect budgets/ expenditure reports.

It appears that even though the DHER is used to provide an overview of expenditure, the district experiences issues such as limited capacity. While the effects of centralisation, in terms of accessing resources and control of certain systems affects financial management, it is important to note that the district itself did not adequately motivate for additional resources or plan and track expenditure effectively. Moreover, this section shows the centrality of financial management in ensuring that available funds/ resources utilised for procurement and the importance of timely payment of suppliers to render services e.g. the telephone supplier (affected by centralisation delays) did not work smoothly.

6.3 Weak Centralised and Decentralised Institutions

6.3.1 Hardware factors & financial management - internet connectivity/ equipment

A number of participants based at a district level reported difficulties with internet connectivity and a lack of IT equipment, seriously impacting financial management routines. The internet connectivity line in the district has 'not being upgraded since the 1990s'. The connectivity line is outdated and its connectivity speed is inadequate to meet district needs. Chapter 4, figure 4.2 outlines a centralised internet connectivity broadband/cloud which is shared by a number of health districts and hospitals in the province contributing to poor internet connectivity being experienced at a district level. IT staff at the district explained that their functions are also limited; the majority of system issues can only be resolved by province instead of at the district level e.g. if certain functions on BAS are not working or if district IT cannot resolve server issues around connectivity. The impact of having a centralised line coupled with outdated and limited technology is explained:

> The challenge is BAS. I usually use the system on a monthly basis to compile a report for province. The deadline is usually the first week of each month. If I *don't open the system by 7:30am in the morning, the system will be extremely slow and I will not be able to access the reports throughout the day.* The problem is that all the departments in the province use the system around the same time. I'd say the systems and connectivity is unreliable, it often malfunctions or it is slow. Sometimes, these challenges last for a few

days or even a week. *Emails are a problem, sometimes you receive them and sometimes you don't.* I usually log a call with district IT, though there are many instances where I have to notify the province to address these issues. They have a very high workload at the province. Once you log a call, you are given a reference number and you wait- District Junior Manager 9.

We are quite reliant on systems, whether it is to capture invoices or to release payments. I can't do anything if the network/server is not working. Most of my tasks are reliant on emails, or suppliers email quotations - without the internet it hard to communicate with suppliers or to process any quotes – District Mid-Level Manager 2.

There is an intern here who could have assisted me with the expenditure report. The problem is that we don't have resources here, computers are full of viruses, and you cannot use any programs or even save your work - District Senior Manager 4.

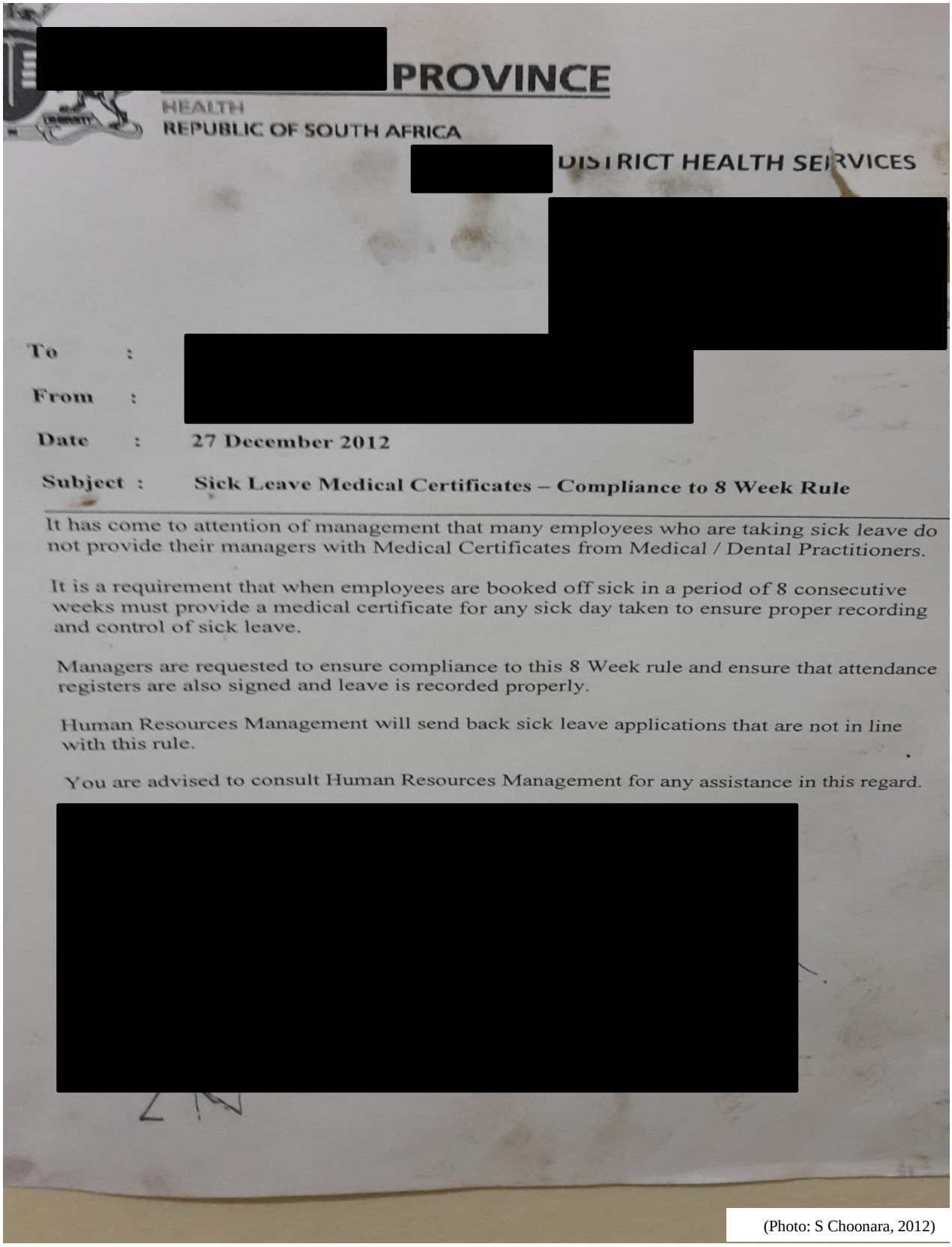
Some staff mentioned that the sub-district level is even more constrained in terms of internet connectivity, infrastructure and IT equipment. Only some clinic-based data capturers for statistics and health indicators reported having computers, while others had to carry out these tasks manually and even sent through statistics as hard copies to the district.

The main challenge is that our facilities have little or no IT infrastructure and equipment. *There is no method of communication through emails and it is a serious challenge.* The other issue is that our server is very slow. To deal with this, no one besides heads of the district and those from procurement have access to the internet. Those who do have internet lines are usually shut down from 10h00 to 15h00 when needed, so that the server can handle necessary items such as processing procurement submissions- Sub-district Manager 1.

The sub-district managers explained that they did not have adequate office space for IT infrastructure to be put in place and as a result they resorted to purchasing and to using their own 3G services to connect to the internet. *During the observation phase of the research, at almost every meeting, the IT issue was highlighted as a major challenge at both the district and sub–district level.* In fact some participants stated how it was difficult to communicate with the sub-district. To set up budget meetings, the participant responsible had to print and send out

expenditure reports, minutes of the previous meeting and the agenda to all attendees with the district driver. Electronic meeting requests/ invitations could not be sent out and instead individual telephonic calls had to be made (Field Notes, August- December 2015).

To deal with these challenges, important notices or communication were also printed and placed throughout the district to notify staff of important events or deadlines and were either placed in elevators, or office entrances (Field Notes, August 2015- December 2016). Below are pictures taken of HR and procurement notices at the district offices:



[redacted] PROVINCE

HEALTH
REPUBLIC OF SOUTH AFRICA

[redacted] DISTRICT HEALTH SERVICES

[redacted]

To : [redacted]

From : [redacted]

Date : 27 December 2012

Subject : Sick Leave Medical Certificates – Compliance to 8 Week Rule

It has come to attention of management that many employees who are taking sick leave do not provide their managers with Medical Certificates from Medical / Dental Practitioners.

It is a requirement that when employees are booked off sick in a period of 8 consecutive weeks must provide a medical certificate for any sick day taken to ensure proper recording and control of sick leave.

Managers are requested to ensure compliance to this 8 Week rule and ensure that attendance registers are also signed and leave is recorded properly.

Human Resources Management will send back sick leave applications that are not in line with this rule.

You are advised to consult Human Resources Management for any assistance in this regard.

[redacted]

(Photo: S Choonara, 2012)

Image 6.1: Regular HR notices placed around district offices due to IT challenges

Image 6.2: Regular procurement notices placed around district offices due to IT challenges

(Photo: S Choonara, 2015)

Difficulties with IT were also associated with service delivery. For instance, a pharmacy representative explained that the printer's toner was running out. Requests were made, however several months later the issue was not resolved and soon they would not be able to print labels for medications (Field Notes, August-September 2015). Reasons cited for delays in meeting the pharmacy's IT requests and other IT equipment challenges in the district include provincial delays, particularly relating to bureaucratic procurement processes -

> Let me take you through what is happening, I write a submission and the buyer gets quotations and documents are submitted to the district's procurement approval committee. The decision is taken to approve it; documented and then sent to the IT department at head office (province). It has to be approved by various channels including the head of Information Communication Technology (ICT) and the senior manager. This process goes on for many months or even years and because of these provincial delays, I haven't bought any computers for the district for the last four years. The documents either get lost then you have to resubmit them or in other cases you don't receive a response. I submit requests for IT every financial year, though for the province IT is not on the agenda. The National Health Insurance (NHI) receives priority- District Senior Manager 2.

6.3.2 Difficulties of procuring

As mentioned (section 4.2.3 and section 5.4) financial management and procurement functions are inextricably linked. For example, the procurement of goods or services depends on financial authorisation (budget availability) and utilisation of the actual budget. In cases where budgets are not utilised, resources will not be reallocated by PDoH (section 6.2.2). Moreover, expenditure tracking difficulties at both province and district result from a lack of interaction between procurement and finance at both levels (chapter 5). Understanding procurement processes is pivotal to any analysis of financial management. Section 5.4 dealt with the different processes districts use to procure items e.g. either creating a PO or purchasing items on contract. Some managers at the district outlined the difficulties associated with continued role of province over procurement:

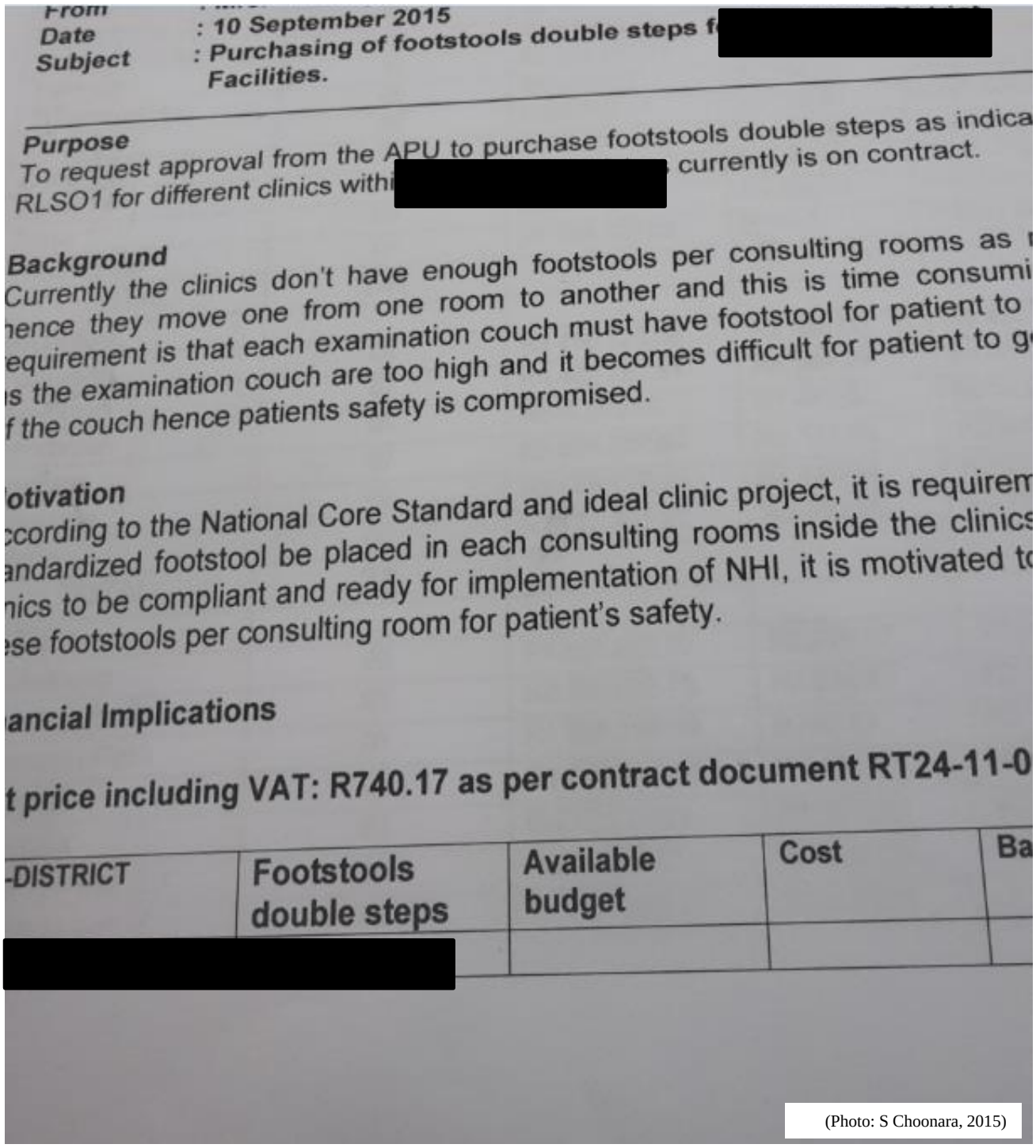
Policies are confusing, for example there is a policy on cost-containment which states that you should not procure IT equipment. Then on the other hand there is a policy on IT purchases which states that you should procure equipment. There are managers at a senior level which urgently require laptops, though requests are dependent on which policy is applied during the provincial approval process- District Senior Manager 6.

POs are created at a provincial level, it is very important to procure items and sometimes there are very long delays. The Public Finance Management Act (PFMA) states that companies cannot be paid without a PO. There was a case, when I was acting as the head of procurement, where bread for the maternity and obstetrics unit was delivered without a PO. At some stage a new PO was required but not created, though the supplier continued to deliver bread. I let this continue because the patients needed the bread and it became an expose factor (risk factor) which amounted to irregular and wasteful expenditure, a violation but I had no choice - I had to put patient rights first – District Senior Manager 6.

6.3.2.1 District procurement process – Foot Stands

In case study one, a complete procurement process for foot stands[15] was observed and documented from the step 1– 3, i.e. from the end-user request until delivery of the foot stands (see Image 6.3, figure 6.1). Image 6.3 depicts the district submission for foot stands which was compiled, approved and processed further. The difficulties associated with creation of the PO have been outlined e.g. the procurement of IT equipment or bread for maternity wards. The process below deals with items/services procured through contract, particularly the foot stands and discusses other procurement challenges linked to both centralisation and decentralisation.

[15] Foot stands - are used to assist patients to climb onto the hospital bed.



From
Date : 10 September 2015
Subject : Purchasing of footstools double steps f[redacted]
Facilities.

Purpose
To request approval from the APU to purchase footstools double steps as indica
RLSO1 for different clinics with[redacted] currently is on contract.

Background
Currently the clinics don't have enough footstools per consulting rooms as
hence they move one from one room to another and this is time consumi
equirement is that each examination couch must have footstool for patient to
s the examination couch are too high and it becomes difficult for patient to g
f the couch hence patients safety is compromised.

otivation
cording to the National Core Standard and ideal clinic project, it is requirem
andardized footstool be placed in each consulting rooms inside the clinics
nics to be compliant and ready for implementation of NHI, it is motivated t
se footstools per consulting room for patient's safety.

ancial Implications

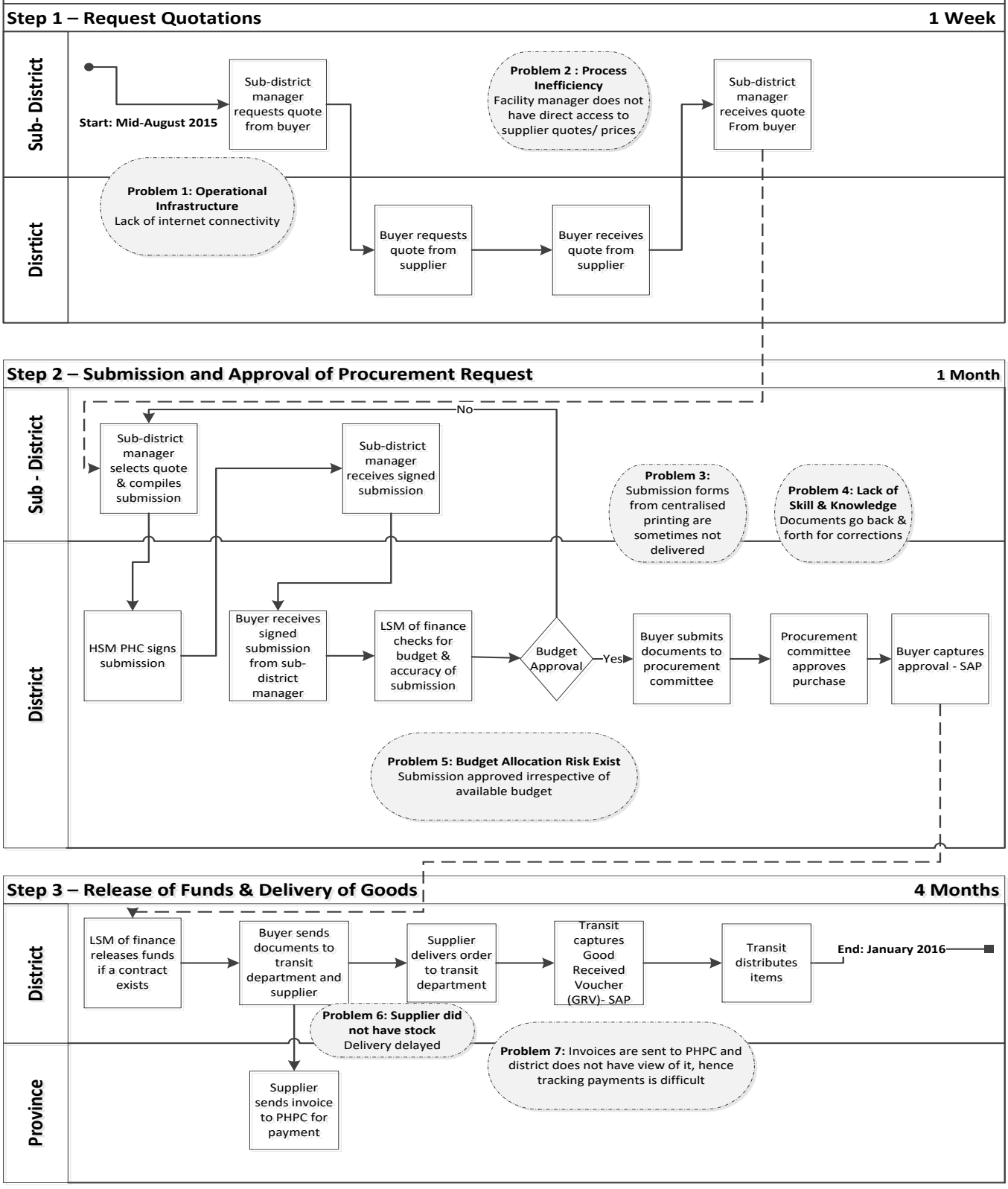
t price including VAT: R740.17 as per contract document RT24-11-0

-DISTRICT	Footstools double steps	Available budget	Cost	Ba
[redacted]				

(Photo: S Choonara, 2015)

Image 6.3 Cover Page - Procurement submission for foot stands

Figure 6.1: Procurement Process Flow - Bulk Order for Foot Stands in Indawo District



Step 1 – request quotations

The end-user (sub-district manager) explained that she follows up with facilities on a face-to-face basis. Facility managers call her telephonically to request certain items as they too struggled with internet/e-mails (lack of hardware to facilitate communication for procurement). In the case of foot stands, a number of clinics requested this item and the sub-district manager then put together a request. As depicted in figure 6.1, step 1, the sub–district manager was not in direct contact with suppliers. Instead managers have to request quotations through the districts buyer. There are two main problems noted during step 1 – facility managers stated that they are unable to plan/ budget due to lengthy processes to access quotes and the lack of internet connectivity hampered communication between the sub-districts, district and with suppliers. Accredited suppliers/possible suppliers are loaded onto the procurement system by province. There are processes to load a new supplier; however several participants described them as being quite lengthy. The turnaround time for quotations to be requested and sent back to the end-user is three working days. In this case the process commenced in mid-August 2015 and quotations were returned from the supplier via the buyer to the end-user in a week.

However, in several other instances end-users stated that such turnaround times are not always adhered to:

> The turnaround period we've experienced is not the set 3 days but rather 3 weeks or 3 months. There are even requests we put through and haven't received the quotations in 4-5 months – District Pharmacy Manager 1.

In response, district procurement explained that they have an extremely high workload with multiple requests a day, and also that they require internet connectivity to source quotations. Nonetheless if step 1 proceeds smoothly, step 2 then follows.

Step 2- submission and approval of procurement request

The submission and approval process for the foot stands was carried out between mid-august to mid-September 2015 (one month). Once the end-user receives quotations, he/she must select a relevant quote based on quality and price. The complete procurement submission was then put together and sent to the relevant HSM .e.g. HSM PHC for approval. Some delays in submissions

are attributed to the sub–district being unable to print submission forms due to the lack of printers, toner or paper (again the evident lack of hardware and its associated implications). The province prescribed route for distribution; is that districts distribute these forms to the sub-district. Although a procurement representative explained that recently the province is failing to renew its contract with its printers for the forms, and as a result there have been some delays in providing these forms to the district / sub–district (problem 3).

Once the submission was approved by the relevant HSM, the end-user sends the manual submission through to the buyer in the district procurement unit, who liaised with the LSM finance to confirm whether resources were available or not. Problem 5 shows that this is meant to be a control measure for expenditure (check or control 1 described in section 5.4). However participants stated that even in cases where there is no budget, some items are still passed for approval as they may be essential to provide health services, i.e. there are some cases even where there is no budget that items are still procured. Further, the budget doesn't truly reflect expenditure thus it is seen as more of a compliance check than actually prescribing what can and cannot be procured given the available budget (section 6.2.3). As a result there are implications on the district finances (operating within the available budget).

In addition to checking the budget, it is the finance managers' responsibility to ensure that the submission will be charged to the correct cost centre, that item descriptions are correct and that the relevant stakeholders have signed and authorised the submission. In addition to the finance LSM checking submissions, the district also has in place an Accredited Procurement Unit (APU) which is comprised of the head of the district and several HSMs who meet on a weekly basis to approve/reject or request corrections to submissions, it was observed that the submission was sent back to the end-user for corrections several times indicating the lack of procurement capacity in the district (problem 4). The corrected submission was approved and was sent back to the buyer for capturing and to proceed to step 3.

Step 3- release of funds and delivery of goods

Between step 2 and the delivery of goods, the submission, post district approval, is sent back to the buyer to capture the order on SAP and to the finance LSM to release funds for the foot stands. Since the foot stands were on contract, there was no need to submit documents for a PO. Activities in step 3 were carried out within a space of a few days by the buyer.

However some participants raised delays:

> Under normal circumstances everything should be captured in a week. I would say that procurement processes are also affected by human factors, for example district staff don't attend to them (capture submissions) or are on leave. Otherwise, there are also delays at the head of the districts office, sometime she is not there to sign off on requests- District Mid-level Manager 2.

The new head of the district of support services in case-study 1 was now meant to ensure that all submissions are authorised on time. However, section 6.4.1.3 outlines the complexities of having an added head within Indawo. Once the order is authorised, captured and funds released, the order is then handed to the procurement officer based in the transit department (which handles orders and delivery of goods. Foot stands were only delivered in January 2016- the total time for step 3 to be completed was 4 months and the entire procurement process from mid-August to January (approximately 5 months). Participants based in the district's procurement unit and a few at the provincial level stated that most delays were on the supplier side. These delays may be due to suppliers who have been not been paid previously being reluctant to provide services, and hence requiring a new submission or it may be due to suppliers not having capacity/ stock to meet bulk orders – problem 6 (also detailed in chapter 4, section 4.3.1).

The delivery and receipt of goods marks the end of the district's role in the procurement of services. The PDoH was placed under administration (for high levels of debt), with oversight and approval required from Treasury and as a result, the payment function remains centralised (chapter 4). Problem 7 results from suppliers sending invoices to the province which the majority of district staff attributed to difficulty related to tracking payment of suppliers. District staff are unable to track what has been paid or not and province does not provide regular communication around which payments have been processed (section 6.2.3). It is evident the procurement process requires both the province and the district to carry out their tasks, however this has not been the case. Provincial delays are linked to the choice of vendors, the creation of POs/ approval of POs, inability to print submission forms, and the payment of suppliers). At the district level, inefficiencies around procurement (incorrect submissions) and difficulty tracking expenditure contribute to procurement delays as in the case of the foot stands.

6.4 Manoeuvring Constraints & Displaying Agency

These findings indicate factors which either constrained or enabled agency. In addition to the routines and its associated difficulties e.g. hardware factors (lack of IT) and centralisation, further influences on district functioning are outlined. These influences are linked to both politics and trade unionism and in turn financial management. Secondly, the importance of software issues, interpersonal relationships, motivation and communication are discussed as predispositions to problem-based coping strategies and fostering agency - effecting change especially amongst dysfunctional routine processes (e.g. failed procurement).

6.4.1 Debilitating factors – Constraining Structural Environment

6.4.1.1 Broader political & unionised context

The need for centralisation over certain functions and processes linked to finance and procurement at a district level has been discussed in sections 6.1 and 6.2. In fact one of the senior managers described the district as having little room to manoeuvre constraints and minimal space allowing for innovation. Instead the senior manager states that district is expected to follow instructions or adhere to certain requirements e.g. completing the DHP and DHER; 'head office thinks that the district exists for their purposes only, it is a typical bureaucracy'. The influence of trade unions in affecting management of poorly performing individual's means that financial tasks were affected, furthermore the influence of politics in affecting procurement or HR processes are interlinked and explained. Politicians for example pushed through unfunded mandates irrespective of district planning or allocation processes thus impacting financial management. Politicians also (discussed in chapter 4) influenced vendor selection for IT resulting in escalated costs and districts having no equipment/ connectivity, thereby affecting financial management. Thus politicians were found to often negatively impact district financial management processes. For example in the case of poor performance, it was clear in section 6.2 - how districts are unable to track expenditure (commitments and other flawed processes). However, as shown, broader district processes poor performing staff, including those in finance are often not held accountable due to the influence of trade unions -

> *There is animosity between managers and the unions…people are scared to manage.* The performance management tools are merely compliance tools, the same documents are used year after year with just the dates changed – District Senior Manager 5.

> I have some staff who are not performing well. I will make use of the performance development tool documents, sit down and discuss issues with her. I tried to look for ways to empower this person; if I had the opportunity I would recommend that this person isn't suitable in the district though this is government, it's not the private sector. You cannot even give a warning, the HR departments aren't really able to assist, and the unions will stop you from addressing poor performance- District Mid-level Manager 2.

A number of participants voiced concerns that the public sector is highly unionised, most staff are not held to account due to union influence. This was found to limit manager's authority and their agency, especially when dealing with difficult staff and as a result it was reported that some 'incompetent' staff remained at the district level.

6.4.1.2 The role of NGOs

One of the NGOs was involved in improving financial management within the districts (outlined in 6.2.1). Several staff reported that the NGO primarily interacted and supported senior managers; most lower-level staff indicated that they had no interaction with NGOs or did not receive any assistance. The NGOs were perceived in the following light:

> To be honest, when they initially came in to assist I wasn't sure what their role was. They started off by asking us questions about the work and would criticise us, without understanding our situation or the challenges we face. Even in the other units they assist with, we do not see the role or value they add. NGO staff sometimes comes here with attitudes that I don't like- (District) Senior Manager 4.

6.4.1.3 Software components of financial management- difficult relationships & demotivation

The nature of interpersonal relationships emerged as a major contributor as to whether and how staff manoeuvred constraints or displayed agency. Some cited difficult and unsupportive relationships as contributing factors to being demotivated. For example, some respondents stated that introducing a new (second) head of district for corporate services complicated and blurred the lines of authority, accountability and led to difficult relationships i.e. staff were unsure which head of the district has ultimate authority, which head to report to or request assistance from. The second district head was not recruited through standard district processes further contributing to tension; instead staff stated that he is a political appointee i.e. placed in the position due to his political affiliations or connections irrespective of his skills or qualifications. In the general

district structure (5.3) there is usually one district head to allow for clear lines of authority to be drawn. However, in Indawo a second head was appointed not necessarily to address the districts need of having a HSM support services in Isikhala but instead to follow political instructions.

In the broader district, managers went on to report that this type of leadership was autocratic and instructions were often given with no room for negotiation or discussion. Moreover, relations between the two heads in the district also appeared to be strained:

> Things are a bit confused, one is the overall head of the district and the other is the head of support services. I came to the district seeing that the relationship between the two is not good. As a HSM I send reports to who I think I need to; however the other head says the report shouldn't go there. All of this is unnecessary and petty and causes tension – District Senior Manager 5.

> *I get instructions from both sides, the two heads of the district do not speak to each other about these issues and this causes conflict. Communication is another issue,* sometimes I do not hear from either of them for a long time - District Senior Manager 9.

In addition to difficult relationships between the heads of the district and their immediate staff, junior staff including those in finance touched on their own challenges. Some managers were described as being unsupportive and in turn staff stated this was one of the factors contributing to being demotivated:

> I wouldn't describe my managers as supportive, they are not supportive. I never have feedback on whether I am doing my job right or wrong, or if tasks are carried out correctly. I feel like there is no one grooming me, and that there is nobody there to support me – District Junior Manager 3.

> For me, I am understaffed, there are multiple issues and I do get frustrated. However, my current superior is someone who just doesn't care, he is a weak manager and I feel like I'm alone in this unit – District Mid-Level Manager 2.

Staff members also stated that there was a lack of teamwork and difficult relationships among junior staff:

> Staff even scream at each other, there was actually blood and I thought someone got injured. Though it was just a case of people being aggressive with each other, they don't respect each other here – District Senior Manager 13.

> We do not have leadership hence we do not work as a team. If the top is not together (leadership is weak), you can imagine what happens underneath. *There is no teamwork here* – District Mid-Level Manager 3.

Difficulty in holding staff to account due to trade union influences coupled with difficult relationships between managers and with each other has left both managers and staff feeling demotivated in their present roles and conforming to the routines put in place, including dysfunctional/ ineffective ones e.g. not being able to track expenditure effectively.

6.4.2 Problem-Based Coping, Transforming Routines & Predispositions to Agency

6.4.2.1 Supportive relationships

While managers were cognisant of the challenges linked to the NGO mentioned, they felt that there was also benefit, for example the NGO trained district staff on how to use existing systems e.g. Vulindlela which could be used for financial reporting:

> The NGO representative did start to assist me, for example assisted with the budget and reporting, also taught me how to use one of the financial systems which is faster and more user-friendly – District Senior Manager 4.

Some staff explained that they were able to draw on provincial staff for support –

> I am new to this post, if I need anything or if I am unsure of anything there are specific people at province that I am free to contact for support – District Senior Manager 4.

Not all managers reported weak leadership or unsupportive relationships; in fact a number of managers reported good relationships with their superiors -

> The district head supports and offers advice to me 100 percent of the time. There are times when I have to put the patient first, service delivery is a priority, and she allows you to take a risk. She is also consultative, innovative and encourages us to strive for our goals even when there are no resources – District Senior Manager 2.

> I understand that the district head is under pressure from all sides, but she is easily accessible and she has an open door policy, we can go to the office and discuss issues with her – District Senior manager 3.
>
> My immediate supervisor, I would describe as a mentor and a mother who is always approachable and ready to assist us. We are able to share our problems with her – District Mid-Level manager 6.

There was also a change of management in the human resources (HR) unit in the district, which brought about significant change to routines - one newly appointed manager brought changes to the district and specifically her unit by encouraging more communication between team members, supporting staff and guiding staff in resolving issues i.e. she strengthened essential software components for organisational functioning. The manager displayed leadership by bringing about changes in behaviour and fostering team work in a unit that was fragmented and amongst staff who were previously de-motivated. Moreover, staff also commented on the mentorship and support she provided –

> *Previously the unit was a mess, but with the new manager, things are changing.* She encourages us to know each other's tasks/ activities, so that if anyone is on leave, their task can be easily carried out. There is also a constant follow-up on our activities, *and this has definitely improved communication in our unit,* we now know what everyone else is doing– District Junior Manager 4.
>
> The new manager has also encouraged a change in management style among our superiors, who are now more hands-on and supportive. *She also works together with these managers to show us how to resolve issues, for example when we had a few cases of conflict,* she taught me how to control my anger, sit down and discuss and resolve issues – District Junior Manager 4.

Other managers also found it important to keep their staff motivated:

> I understand that sometimes it is difficult to promote staff at a district, there is limited upward mobility but it is important to still groom and develop them so that they are marketable outside. If there is a winter school, or advanced courses, training or any way

> to develop them it is important to build them in any way possible for a better future – District Senior Manager 6.

Such examples were found to be critical in creating an enabling environment, whereby despite constraints a few individuals were able to take initiative, be innovative and display agency. Moreover, the importance of leadership, mentorship and nurturing software elements in facilitating this was also noted.

6.4.2.2 Displays of agency

Some of the problems outlined include: a lack of IT equipment, limited internet connectivity (a few hardware factors) as well as difficult procurement processes and weaknesses in financial management tasks (structures – routines). Below are a few instances whereby individuals implemented some coping strategies and in other instances agency and innovation to manoeuvre such constraints. The finance unit expressed difficulties associated with interns not having adequate laptops or being unable to access systems. A junior manager organised for the two interns to make use of provincial level computer facilities:

> At some stage we didn't have enough computers for the two interns which were appointed. I didn't have permanent solutions, though I tried to get them to use laptops in the district (when staff were on leave) and when that didn't work out I called province to assist. Province organised transport, they would save everything onto a USB (memory stick) and go to work at the provincial offices – District Junior Manager 9.

Other participants discuss how they dealt with IT issues –

> There was a case where I was sitting with two condemned laptops, one had a broken hard drive and the other one had a cracked screen. I combined the two where possible, and *despite policy prescriptions we were able to use the laptop for another year or two.* The other way we have dealt with issues, is to start up mobile software messenger groups (WhatsApp) – District Senior Manager 9.

> There is no internet connectivity of the sub – districts, however as the manager it is important that I have access to emails, I purchase and use my own 3G to ensure that we have the necessary communication – District Sub-district Manager 1.

In section 6.3.2 (difficulties in procuring), *Senior Manager 6 explained how he worked around certain policies, by knowingly allowed suppliers to deliver bread without the PO to meet the needs of maternity patients.* Although it is important to note that the manager had good knowledge of the system and knew that the accountability committee[16] –at province was dysfunctional i.e. that he took the decision knowing that he would not face any consequences. This institutional knowledge (software factor) propelled his agency. Another example is linked to the district having limited storage space for items procured and insufficient staff, the manager dealt with these issues in the following way:

> We are highly understaffed, especially in the warehouses/stores. I tried to advertise for the position; however this process was stopped and I am unsure as to why. As a result, we don't have the necessary number of store-men, *I placed a driver to carry out this job (storeman), this could have serious implications, however it was needed* – District Mid-Level Manager 2.

In other instances, some participants stated that to deal with limited resources, they requested donations from the private sector to fund equipment. Other acts of innovation in particular could be linked to the new unit manager who essentially displayed leadership and brought about change in managerial styles and communication and also displayed how to resolve issues;

> When I came to the district, there was a lot of negativity in the unit I was managing. There were a lot of issues and the easy way out would have been to issue warnings. However, I advised my LSM that we should not go down that road and instead deal with the root cause of the problem. There were a lot of tears, and challenges, but eventually attitudes changed and the issues were resolved, and instead of staff shouting at each other, they are now starting to treat each other with respect – District Senior Manager 5.

It is clear that even in the face of constraints, there are some actors who are motivated to take risks, innovate and resolve challenges i.e. display some levels of agency, clearly influenced by software elements such as communication, supportive relationships and mentorship.

[16] Bid Adjudication Committee (BAC)

6.5 Conclusion

This chapter has drawn out district level challenges linked to the financial management cycle in Indawo. So for example, despite the DHP being coordinated by HSMs with assistance from NGOs, the document was not interrogated and consolidated as a team effort. Budget bi-lateral presentations were not sufficiently motivated and were sent back to the district for corrections. The process of reallocating unspent resources was rushed- yet districts reported several challenges attributed to this e.g. other units not submitting information through to finance for the presentation. Lastly, the DHER compilation was carried out with minimal interaction and consultation. Expenditure tracking issues were evident, particularly the loss of institutional memory and challenges around provincial support. These findings essentially pointing out the weaknesses of financial routines examined. The provincial role in approval of POs and selection of vendors as well as centralised payment mechanisms was discussed in this chapter. This was discussed in relation to district challenges namely, procurement and IT. These findings indicated weaknesses at both the district and provincial level hampering effectively functioning decentralised institutions. The challenges linked to the district operating within a politicised and unionised environment were also discussed. A focus on software elements, such as difficult relationships especially between managers and staff were noted. However, there was evidence of good leadership and supportive relationships, specifically enabling positive interpersonal relationships and creating an environment whereby constraints were manoeuvred – e.g. a manager using the driver as a warehouse manager to deal with staff shortages, allowing bread to be delivered to maternity wards despite not having a PO and managers who found ways to foster teamwork amidst difficult relationships. The chapter thus concluded with displays of agency, showing the key role of software components in facilitating and nurturing agency to deal with the shortfalls of financial management and other constraining factors.

CHAPTER 7: DECENTRALISED FINANCIAL MANAGEMENT – ISIKHALA HEALTH DISTRICT

7.1 Introduction

This chapter outlines key financial management processes in case-study 2, looking at specific routinised tasks, associated challenges and in relation to centralisation of some finance functions, information technology (IT) - hardware factors and procurement. Constraining factors which are considered to limit agency are outlined e.g. strained relationships with trade unions or between district staff. Finally, the informal learning environment fostered with mentorship is considered in relation to being solution-driven and encouraging innovations as well as plays a role in motivating staff. Several displays of agency due to these supportive factors, specifically software elements are also discussed.

7.2 District Financial Management: Routines and Practices

This section unpacks the realities of district financial management, with particular attention to larger structures such as rules and resources guiding these processes, the actual routines, which actors are involved in how they are conducted as well as weaknesses and successes.

7.2.1 Financial management process 1- engaging with planning

The DHP process, authority and purpose have been described in section 5.2 and section 6.2.1. Due to delayed approval for observations to commence in case-study 2, the District Health Plan (DHP) process could not be observed (discussed in section 3.5.2.2 and section 9.4). Results are therefore based on interviews which probed several managers and staff retrospectively around how activities such as the DHP were actually carried out in Isikhala. A number of participants explained that the head of the district oversees the DHP and has appointed a senior committee at the district to discuss the contents and compilations of the DHP providing critique (thorough interrogation with the document), advice and support if necessary i.e. feedback. The higher level senior manager's (HSM) of health programmes and primary health care (PHC) are together responsible for co-ordinating the DHP in liaison with the appointed committee. District staff stated that the DHP is a continuous process with meetings held at least bi-monthly/ quarterly to discuss progress on the previous DHP and then note issues for the next plan. A non-governmental organization (NGO) also provides technical assistance to the primary health care (PHC) division of the district which is responsible for coordinating and compiling the DHP.

Input was requested from other units including finance, IT, PHC as well as the sub-districts. Once plans were put together, a second meeting was held with stakeholders where the document was presented to the oversight committee, corrections and inputs were made - displaying more thorough district engagement and consultative team effort around stage 1 of the financial management cycle (planning). However, there were also some delays in holding meetings and gathering input from different units with the DHP being submitted in May 2016 (approximately 2 months later than the advised date – March 2016).

7.2.2 Financial management process 2- navigating resource allocation & budgeting processes

The budget bi-lateral process discussed in section 5.2 provides room for districts to put forward their financial needs and if sufficiently motivated, the province may be able fund any additional activities, depending on available resources. The Isikhala budget bi-lateral presentation was put together by the finance middle-managers with their staff and in liaison with relevant stakeholders e.g. PHC, programmes and IT. Sub-districts are also meant to be consulted and provide input. Some participants argued that sub-district motivations were quite weak, although facility managers said that the administrative officer only provided them with a day/ two-day notice to provide inputs (inadequate communication around tasks and deadlines), with little acknowledgment that these are standard process taking place at set dates during the year. Once a draft is complete, the head of the district requires that the finance managers present the bi-lateral motivations to the district's executive committee. Inputs and corrections are made; the head of the district then presents the districts needs and budget requirements to the province alongside finance managers and other individuals from the district such as the HSM of PHC or support services. It was evident that a process of self-critique and thorough engagement yielded positive results - the province mentioned that the Isikhala district always had one of the best presentations; however allocations were reliant on Treasury.

Even though additional resources may be allocated after the bi-laterals, staff said that the process was affected by unfunded mandates–

> We usually receive political mandates or mandates from national and province. However they are not aligned to our plans or are not coupled with resources yet we need to implement these activities – District Mid-Level Manager 6.

> There are some projects we are instructed to run, though there is no money for us to execute these projects- District Senior Manager 2.

Regarding allocated resources, some participants stated difficulty in accessing available resources/ budgets and cited centralisation weaknesses as barriers – e.g. approval for new infrastructure;

> We have limited storage space so we drafted plans to increase storage space (build) since I started working in the district in the year 2000. I drew up and submitted all the necessary plans and documentation, though our infrastructure budget is handled by the Department of Infrastructure and Development (DID) at province, they control the budget. They are one big elephant in the room for us no matter what we do it is difficult to spend funds when they're involved - District Mid-Level Manager 5.

> You have a budget on paper, but despite having this budget it is difficult to use it. We do have a supportive finance division at the district and they always try and assist you with spending your budget. I find it easier to use conditional grants (national transfers which direct funds sent to and accessible to the district which are earmarked for specific activities) instead of using our own budget- District Senior Manager 2.

> *Let me give you an example, if I want to create a post, I have an available budget but I will be stung by red tape.* At head office, you could be told that documents have to go through the Head of Department (HOD), and if you complete that, they will tell you it needs to go to treasury*. It's a very tedious process which simply takes too long, you have a budget yet it's next to impossible to spend it*- District Mid-Level Manager 6.

The province does not usually re-allocate unspent financial resources further compounding the issue of utilising the available budget. But there is room for negotiation, budget-shifting (see section 5.2). Again, sub-district staff felt that they were given too short notice (a day or two) to contribute to the budget shifting process. Although district finance stated that they consulted relevant managers and extracted expenditure reports to track where resources are unspent. This was followed by the finance team (middle managers and junior staff) holding several meetings to discuss and put forward budget- shifting figures. These suggestions were then loaded/ captured onto the systems for province to note district requests. Observations indicated that staff were

delayed by internet connectivity issues when trying to capture requests on to the system (Field Notes, November 2015). The process allowed for unspent resources to be shifted/ for the district to re-allocate these resources.

7.2.3 Financial management process 3 & 4- oversight & evaluation

The District Health Expenditure Review- DHER (detailed in chapter 5) is considered to be an essential financial oversight tool which reviews the districts expenditure in relation to service delivery indicators. Even though the finance unit has a crucial role in populating the DHER, in Isikhala it is coordinated by the HSM PHC and health programmes to ensure that there are linkages between planning (DHP) and expenditure (DHER). The finance unit works together with the HSM PHC and programmes to populate the template and provide expenditure reports or any other finance information required. Throughout the financial year, the district carries out routine expenditure tracking activities, e.g. tracking sundry payments, completing a monthly accrual template, compiling expenditure reports from the Basic Accounting System (BAS) for budget-shifting and presenting commitments during its bi-lateral presentations (suppliers to be paid). However, district participants stated that some of their expenditure tracking activities were difficult due to some functions being centralised and not complementing decentralised processes;

> Finance, procurement and human resources (HR) were centralised when the Provincial X Shared Services Centre (PSSC) was put in place. This was when we, sort of lost control over what was ordered and paid. *Now it is difficult to ensure payment, as a result suppliers refuse to give you quotations or provide any further services until the company is paid.* You know at one stage there were suppliers that haven't even been paid since 2005 and this is a persistent challenge- District Mid-Level Manager 5.

> *We only process and capture documents, it is province that pays. There are always delays* and as a result the district sits with a lot of accruals which keep affecting our budgets – District Junior Manager 3.

> District finance usually captures all the necessary documents onto the system; the problem is with head office where there are always substantial delays. *Some suppliers that I have used have not been paid for a year now* – District Mid-Level Manager 3.

However, section 4.2.1 outlined the rationale for centralisation - the Provincial Department of Health (PDoH) faced high levels of over-expenditure and cash-flow problems. Centralisation was necessary to address over expenditure and the lack of sufficient district capacity at lower levels. *However, it is important to note that province argues that these delays are a result of being placed under administration, PDoH requiring Treasury approval and that the resources (approx. R4 billion) allocated to facilitate the payment backlog was insufficient.* However, despite the need to centralise some functions, some impacts of poorly functioning central level (province) on district financial management were noted;

> We at the district are trying to decentralise effectively, however there are certain processes which are still centralised. The BAS- Personnel and Administration System (PERSAL) reconciliation is meant to ensure that the correct payments are made to staff, though HR staff at the district have limited access to PERSAL as a result it is difficult to ensure that corrections are made and this is an ongoing problem- District Mid-Level Manager 3.

It is evident that centralisation over some HR functions on PERSAL impeded the district's ability to effectively track its expenditure or even hire new staff especially where payments are concerned. The In-Year-Monitoring (IYM) report is a monthly tool/ process to track the district's budget and expenditure. Observations of the IYM indicated that even though the district was able to collate figures around expenditure, they were unsure as to where to place figures in the correct budget classification (category such as machinery and equipment) and were unable to confirm if figures listed on the budget were correct. The October IYM for instance had a misallocation of R1.6 million, which was the total figure captured from the BAS reports, however when doing the IYM the district struggled to understand where the amount came from and in which budget category it should be moved under. In such cases figures were split and placed into classifications which usually displayed misallocations i.e. where the district usually placed them – goods and services / medications (Field Notes, November 2015- February 2016). Below are explanations for this:

> You know, sometimes it's an issue of not knowing where to place the misallocations, so they usually place misallocation amounts in the lowest spending categories to avoid audit

queries, because the Auditor-General (AG) often does not focus on lower amounts of the budget – NGO Staff 1.

Although as mentioned and explained in Isikhala district (section 6.2.3), it is possible to track expenditure through reconciling finance and procurement systems. However, in Indawo difficulties tracking expenditure were noted at a district and sub-district level, where several facility managers said that even though they were provided with monthly reports there were several inconsistencies regarding what was spent, ordered and paid, i.e. the reports did not accurately report their activities. Findings indicated that while the district units certainly worked together by coordinating financial processes and thoroughly interrogating documents, some shortfalls were noted around accurate expenditure tracking e.g. inability of the district to track hence need for centralisation of some functions (section 4.2.1).

7.3 Hardware affecting Finance - Unreliable Internet Connectivity

Chapters 4 and 6 have outlined challenges linked to IT infrastructure and equipment. In Isikhala, most participants were able to procure adequate IT equipment (laptops). Connectivity still remained a challenge due to the centralised provincial line and/ or delayed payments-

> Our systems, our networks and everything is controlled centrally. We are unable to use it most of the time; networks are too slow or cannot be fixed at a district level. There were a few times where payments for the hospitals electricity was outstanding, hospitals cannot be cut-off so instead the supplier cut the district's electricity off and this affected our internet connectivity. We had no electricity for up to a week and it affected our deadlines – District Junior Manager 3.

> The problem is that the province is sitting with close to ninety-eight institutions connecting to just one line which is outdated and slow, then they are also responsible for resolving issues which takes long and the connectivity is too slow – District Junior Manager 2.

> *The thing is, we can never predict or plan our tasks, it all depends on the system, sometimes it is available and other times it is not*, there is nothing we can do as the finance unit until it is restored- District Mid-Level Manager 2.

The sub-district appeared to be even more constrained. IT equipment was procured for district staff, however there were challenges encountered when trying to purchase equipment for the sub-districts and most facilities did not have connectivity (IT infrastructure lines). The admin manager for example has no IT equipment (laptop) and had to make use of the sub-district manager's laptop or had to drive to facilities and the district office with hard copy information. E-mails were described as 'being non-existent', with only the sub-district manager receiving e-mail communication. Participants at this level either engaged telephonically or through the mobile application - WhatsApp.

> There is no equipment or essentials at the sub-district. You know, I work at the district and it is hard to communicate with the sub-district. I have to phone a person for everything that needs to be done – District Mid-Level Manager 4.

7.4 Failing Procurement Processes

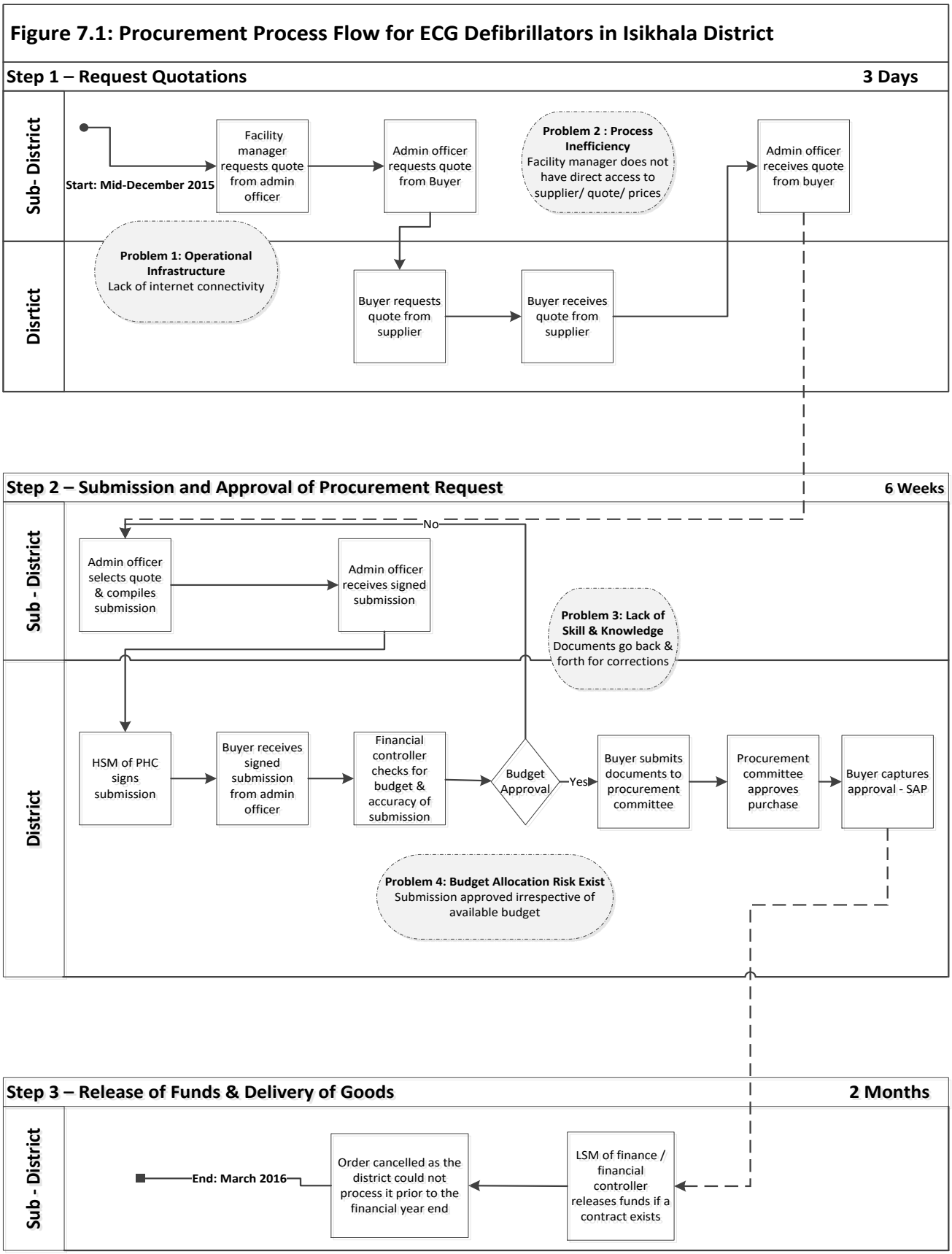
Difficulty procuring items were attributed to both centralisation and decentralisation challenges. Section 7.2 details some of the centralisation challenges linked to district procurement, particularly the impact of suppliers not being paid on time which results in their refusing to provide quotations or further goods/ services and the lack of storage space (due to DID managing infrastructure funds). Further examples of the impact of effective processes at central level on district procurement are listed below:

> For the past two weeks I've been to province on a daily basis to get signatures for dry dispensary items such as gauze. Our facilities do not have stock of these essential items, leading to unnecessary referrals to tertiary hospitals when services could have easily been provided at a clinic level. The documents are still not signed, our services will suffer. Currently we do not even have paper or the correct files for patients. These items are usually provided by province, we sent a truck for stock though the truck came back empty and patients' information is being written on small pieces of paper. This has serious implications on medical records and treatment and if any medico-legal cases arise – District Mid-Level Manager 5.

The observation phase of this doctoral research attempted to document district procurement processes and points to challenges attributed to both provincial and district factors which resulted

in procurement delays. Figure 7.1 outlines the procurement of Electrocardiogram (ECG) defibrillators for several clinics in one sub-district totalling close to R430 000 (approx. $40 000). The head of the district is allowed to authorise payments up to R500 000 (approx. $50 000), anything above this threshold requires a PO to be created or authorisation to take place at a provincial level. Procurement which is below R500 000 and authorised at a district level is meant to be a straight forward process with a quick turnaround time in comparison to acquiring provincial authorisation. This section provides a summary of the entire procurement process which took approximately 3-4 months, however the ECG defibrillators were still not procured/ delivered and the process needing to start again i.e. turnaround time longer than expected.

Figure 7.1: Procurement Process Flow for ECG Defibrillators in Isikhala District



Step 1: request quotations

The decentralisation of procurement functions to admin officers at the sub-district is meant to make the procurement process easier. On a monthly basis, all procurement requests from end-users (facility managers) are sent through to the administrative officer who contacts the buyer at the district for quotations. However, as mentioned the sub-district level does not have internet connectivity and the admin officer despite his key role also does not have the necessary IT equipment (problem 1). As a result procurement processes are delayed. Where communication is not possible through e-mail, the admin officer has to drive between the district and sub-district. The admin officer states that requests either come in late or are incorrect which contributes to documents moving between the district and sub-district several times for corrections instead of being processed quickly. These delays can last approximately 3-6 months *(Observation Notes December 2016 - March 2016)*

> We have a monthly schedule for procurement in the sub-district, where all facility managers are meant to submit their procurement requests so that stock is received on time. However, they are always submitting late even though I remind them (telephonically). The other issue is that submissions are sent back because they are incorrect – Sub-district Staff 7.

> We receive no joy from having an admin officer, we send everything to him on time though when *you follow-up with him he says he never received anything and it is difficult because we cannot communicate via e-mail.* There are times when we do not even have cleaning materials despite adhering to the necessary deadlines for submission. *Another challenge is that we have to go through these long processes to get quotes and prices instead of contacting the supplier directly, I have no idea how much things cost and it makes planning and budgeting, i.e. managing my facility, difficult* – Facility Manager 1.

End-users further raised difficulties around planning and budgeting due to long processes to access suppliers/ pricing of goods/ services (problem 2). Facility managers expressed their frustrations and felt that procurement delays were as a result of the admin officer not carrying out his tasks well enough, alluding to difficult relationships- but -

> Since we have an admin officer, I no longer have to do these tasks so establishing these roles have helped. Though he is just one person and has many responsibilities such as procurement (ordering, distribution), HR and security for all fourteen clinics. Additionally he does not even have a laptop or internet connectivity he has to do things manually and drives all over, which makes his tasks difficult – Sub-district Manager 4.

Another factor hindering procurement was the non-payment of suppliers who refused to provide further quotations (section 7.2.3). However in the case of the ECG defibrillators non-payment and IT did not affect the ECG procurement process with step 1, taking place within the prescribed 3-day turnaround period.

Step 2: submission and approval of procurement request

Once submissions are compiled they need to be authorised by the sub-district manager and division manager e.g. the HSM PHC. In the case of the ECG defibrillators, delays were noted around corrections e.g. errors on the submission such as the wrong cost-centre written down, quotations not being detailed or matching the submission so these steps had to be carried out a few times (problem 3). The correct submission for the defibrillators went to the buyer and the financial controller to check the available budget. This is meant to serve as a check for over expenditure. But problem 4 (submissions approved irrespective of available budget) indicates that this is not always the case. Even though the finance unit is meant to check for available budget before passing through any submission, it is argued that health services always have to be delivered to patients and in some cases submissions are passed without the necessary budget. Thus in reality, check 1 detailed in section 5.4 which is necessary for budget control does not actually happen; especially when it comes to a list of essentials e.g. gauze or surgical gloves -

> *I can't even recall a time that the district told us that we cannot order/ procure something because of not having an available budget. We are always able to procure* – Sub-district Manager 4.

> It is difficult to say no to our clinics, even when there is no budget, we get together with our manager and come up with a plan, because if the community suffers politicians will come and hold us accountable. Sometimes the solutions are easy, you look at the misallocations, shift funds and able to meet the needs – District Junior Manager 5.

The submission is then interrogated and approved/ sent back for corrections by the district's procurement committee. In the case of the defibrillators, the request was approved and went to step 3. However in other processes delays were evident due to facilities not having adequate storage space-

> According to the Provincial Administration System (PAS) there are guidelines around minimum and maximum levels of stock which should be on hand in the district. However, we only have two old rooms at the district which were converted into storerooms and a boardroom to store our dry dispensary, but these spaces are quite small and we are unable to adhere to the prescribed minimum and maximum levels of stock e.g. for medications. Instead of ordering in bulk, we often have to order less but more frequently – Mid-Level Manager 5.

Step 3: release of funds and delivery of goods

During this step, the buyer captures the approved document and funds being released. However, these processes were carried out about two weeks before the end of the financial year and could not be processed successfully or quick enough due to documents not being filled out correctly at a sub-district level. As a result after close to 4 months, the entire process was cancelled and had to be re-started during the next financial year. The process was followed up in the new financial year (end April 2016), however the approved submission had not yet been processed - errors were found on the previous submission and would need to be re-done. The cancellation depicts factors, particularly at a district level i.e. an incorrect submission, difficulty with communication (between district and sub-district) and weaknesses of district procurement in identifying errors which affected service delivery of items such as ECG defibrillators.

7.5 Constraining & Enabling Factors- Displays of Agency

With regards to organisational realities of the district, constraints included a lack of IT infrastructure, centralisation factors (delayed payments) and financial management routines which were shaped by trade unionism and political factors, but more importantly by software components. Interpersonal relationships, mentorship and the role of informal learning were particular factors propelling how routines took place as well as displays of agency.

7.5.1 What constrains agency?

7.5.1.1 Considering the provincial & political context

Difficulty accessing financial resources, delayed payments/ procurement processes, tracking expenditure and minimal control over finance/ HR systems were some of the challenges already mentioned in this chapter associated with financial management. Focussing on the provincial context, some participants revealed the impact of provincial delays e.g. approval of sponsorship requests–

> One of the private companies wanted to build an entire clinic in our district. Everything was in order; we signed a contract between the district and the company although we needed provincial approval. I couldn't understand it, we would really benefit though it took several months to convince province and get their approval – District Senior Manager 1.

Some participants also felt that trade union influence made it difficult to effectively manage staff-

> Trying to hold poorly-performing staff to account is a tedious exercise - as a manager you are reluctant to do so because you are either overstepped by province or the trade unions. For the smallest issue, staff will go straight to the unions. The unions do not even try to mediate; they are out for management- District Mid-Level Manager 1.

Some participants raised cases where all the necessary disciplinary process were taken against staff, however the province and unions stepped in to overturn disciplinary decisions and re-instate staff. Although it was also interesting to note that some staff questioned union influence;

> We do have unions and there are some people who turn to them, though I don't think they have much influence here, I'm not a fan, and I think they have their own agenda- District Junior Manager 3.

7.5.1.2 Strained relationships & de-motivated staff

Some junior managers reported having difficult relationships with subordinate staff. Some staff felt that these managers lacked work experience, 'I've been here many years, and he just started

here'. Such sentiments hampered relationships between staff and managers and was also linked to staff being de-motivated-

> I wasn't excited about becoming a manager, there was someone based at the district before me, I just finished university and I have a higher post, so there's this awkwardness – Junior Manager 5.

> I do not want to lie, I am not happy. I tried to apply for the post, I have been here a long time but they overlooked me. They also never admit their mistakes or apologise, I am trying to look for another job- Junior Staff 5.

7.5.2 Significance of nurturing software in the system

7.5.2.1 Role of informal learning

A number of participants discussed the importance of on-the-job learning and its role in their personal development/ growth and motivation. The head of the district for example recounted her previous work experience, informal learning and context:

> Under apartheid, black nurses earned less, had fewer benefits and were not given the space or freedom to be innovative or move up the ranks of an unjust system. Apartheid was both good and bad, it did teach me how to be disciplined, expect nothing and make sure that all targets are achieved. *There was one manager who taught me the importance of delegation, she taught me that you cannot do everything as a manager, delegation is important but it also encourages and empowers staff, it shows them that you have faith in them*. Another important thing that I learnt from my managers, is that it is important to follow-up on tasks, and to have regular feedback and communication with your staff– Head of District 1.

In turn, several other managers at the district explained how they learnt from the head of the district and were encouraged/ motivated when new tasks were assigned:

> The positive thing about our head of district is that she gives you the space and allows you to manage, she puts you in the deep-end but you learn a lot this way. I've also learnt from her how to give feedback and regularly communicate with staff – District Senior Manager 1.

> Being under the leadership of our present head of the district, I would say that it is schooling by itself. I don't work directly under her, *but she teaches me to be versatile, she sends me to meetings outside of my job-description and area of expertise or gives me tasks such as responding to audit queries. This sort of knowledge is valuable. For me it is a joy to work in this district,* you grow on a daily basis and you are allowed to spread your wings – District Mid-Level Manager 2.

Based on their learning experiences from the head of the district, these HSMs and LSMs went on to inculcate a culture of learning in their respective units/ divisions. Positive relationships were noted and the finance managers encouraged their staff to learn every task/ function and this allowed for staff to feel empowered, step in for one another and even fostered teamwork:

> *Every person in the finance team is given the opportunity to learn. We are all trained on every aspect of finance.* If there is a deadline or anyone needs assistance, we are able to assist- District Junior Manager 1.

> The managers here will always try and teach you and broaden your horizon. Sometimes they take me to meetings to learn how things happen- District Junior Manager 3.

> I enjoy working in this unit, we are trained and empowered to learn from each other and learn every finance task. *Our managers also encourage us to work together, for example if there is an urgent task which requires a lot of manpower, example budget capturing or even on the accounts payable side, we are all able to put our own work aside and work together* – District Junior Manager 2.

Moreover, similar to the more senior managers learning from the head of the district, these junior managers revealed learning how to manage others from their superiors:

> Managing others is sometimes a challenging job, I have learnt a lot from my supervisor. He taught me to keep a diary and record every single incident, whether it is good or bad, so that at the time of performance management you have proof when holding someone accountable. Though he also taught me that acknowledging the good is important, send an e-mail and appreciate good work too – District Junior Manager 2.

Such practices were also related to supportive relationships and its role in motivating staff.

7.5.2.2 Supportive relationships

District staff perceived the NGO assisting with finance in a positive light:

> We find that NGOs assist us with our programmes, but also in terms of finance, they are skilled, provide recommendations and advice around documents such as the DHP. Yes, they do criticise us, but we are not defensive at the end of the day they are providing fair criticism and we are working towards a common goal- Mid-Level Manager 2.

A few other staff noted that even though there are various issues which have strained the relationship between the district and the province, provincial support is offered. For instance, to deal with limited internet connectivity/ IT, the province has created a well-equipped room approximately 20 computers which district staff can use. PDoH is able to extend such support as most districts are in close proximity to its offices (able to commute to use these facilities). Provincial participants also re-iterated its support to lower levels such as the district;

> In some cases, the infrastructure isn't there because Telkom is yet to put lines in these areas. We are aware of difficulties connecting to the internet and having out-dated equipment (laptops). We have the luxury of 3G connectivity, but other staff, especially at lower levels, do not have this luxury and then you wonder why things aren't happening or why information hasn't been received, when instead your e-mails are not being received. We have created a computer room at PDoH where district or hospital staff are able to come through and capture the budget – Provincial Manager 1.

> We also support districts by doing site visits, and are thinking of making it more regular to train them on misallocations and how to avoid them, because passing journals to correct this is a duplication of tasks. Whereas, if they ensured that expenditure control took place correctly, there won't be a need to complain about staff shortages or workload – Provincial Manager 1.

Internally, open and regular communication (another software component) was considered to be important in fostering good relationships between managers and their staff. In turn, when staff faced any challenges they reported being able to draw on the support of their supervisors and peers/ colleagues:

> I feel at home here, my supervisors are always willing to help and teach you. I would say they are really supportive, for example if I have an issue we sit down and work together, help each other and find a solution- District Junior Staff 6.

> When I first came to finance, my manager told me that if you don't understand anything my door is always open, don't be afraid and feel free to ask anything. I will show you how it is done, even if it takes you a year. He is a really patient man; *he is not just a manager he is a leader*- District Junior Manager 2.

> *It is really nice working with my managers, they are like work fathers*, in fact I call them my work fathers. Their doors are always open and they assist you with any issues be it personal or workwise- District Junior Manager 3.

Working in an open – planned office also allows staff to easily interact and advise each other on work-related tasks. In fact, staff drew on each other's expertise including their manager's if need be. Nurturing relationships especially between peers and team-work were further strengthened through the district's annual team-building initiative, which took place with no allocated resources. It is important to note that disgruntled staff (approx. 2 staff members from a team of 7 in finance) did not attend the team-building event; however the majority of staff who attended stated that even though they had to pay for it from their own pockets, it strengthened their relationships, especially between units.

> For me the team-building helps us get to know each other outside of the work environment, it enables us to work better together- District Junior Manager 1.

> The team-building includes all administrative functions, you get to meet and interact with everyone. After the trip relationships are definitely better and we even work better, the only downside is we have to contribute to it from our own pockets – District Junior Manager 3.

The next section outlines how some district staff were able to manoeuvre some of the constraints outlined earlier in the chapter and the role of informal learning and supportive relationships in creating such a solution-driven environment.

7.5.3 A solution-driven environment & displays of agency

Several staff pointed out difficulties they experienced when trying to work around provincial barriers including accessing resources or resolving IT system issues. Notably, a few participants alluded to difficult decision-making as authority over some of these decisions remains centred at the provincial level. However, there were a few participants who stated that senior management at the district created a culture of being solution-driven- one participant stated that this was positive and they felt compelled to do their best, 'Management has eyes and ears everywhere, we cannot sit and do nothing'. Similarly, another participant said that given this culture of being solution-driven and accountable within the district; 'We have to ensure that we have a winning district'. While others said that having been delegated tasks, given responsibility, being motivated and given the space to work around bureaucratic processes allowed them to find solutions-

> We are fortunate to have management in the district that works around red tape; if there are challenges we can contact the relevant person, discuss and deal with the challenges – District Senior Manager 2.

> I'm not somebody who will always ask the HSM for solutions or escalate my problems, as a manager I try my best to resolve all issues at my level- Sub-district Manager 1.

This allowed for an environment whereby problem-based coping strategies such as using one's own 3G services or moving staff to places where there was connectivity. There were specific displays of agency e.g. placing shelves in clinics irrespective of available resources (to be further discussed). Innovative motivational strategies such as the awards ceremony were also put in place. Given this supportive environment, managers in this case-study explained how they dealt with difficult relationships through software factors (communication):

> Being a manager is like being a parent, you will always have to manage your staff whether you like it or not. The approach I take is to discuss if staff are wrong or even apologise if I am wrong. I try to strike a balance and if staff do good work, we will send an e-mail to acknowledge it. I also encourage an open door policy where staff are able to come and discuss any issues with us including personal issues – District Mid-Level Manager 1.

Some sub-district staff revealed that even though they had sent through their procurement submissions on time, there were many instances where the sub-district did not have cleaning material or toilet paper for close to six-months. The nurses at the facilities put money together to purchase such materials for themselves and their patients; there was no repayment made to nurses, but this also relates to a display of their altruistic values. Other coping strategies were outlined by staff at the district and sub-district level who explained how they dealt with limited internet connectivity:

> When the systems are down, we do not refrain our staff from going to work elsewhere. We either arrange for them to work in other areas in the district where there is connectivity e.g. the hospitals or even go to province – Mid-Level Manager 2.

> We as facility managers are required to put together presentations and reports, yet we do not have a connectivity line or even a laptop. You cannot do these things manually; I don't even have an e-mail address. Most of us purchased our own laptops, use it to carry out these tasks and use a personal e-mail address as well – Sub-district Manager 9.

As discussed in section 7.4, the district was unable to go ahead with infrastructure development plans for storage extensions due to difficulty in accessing resources which are controlled by DID. One of the participants outlined a case whereby a clinic required shelving and the district worked around these barriers;

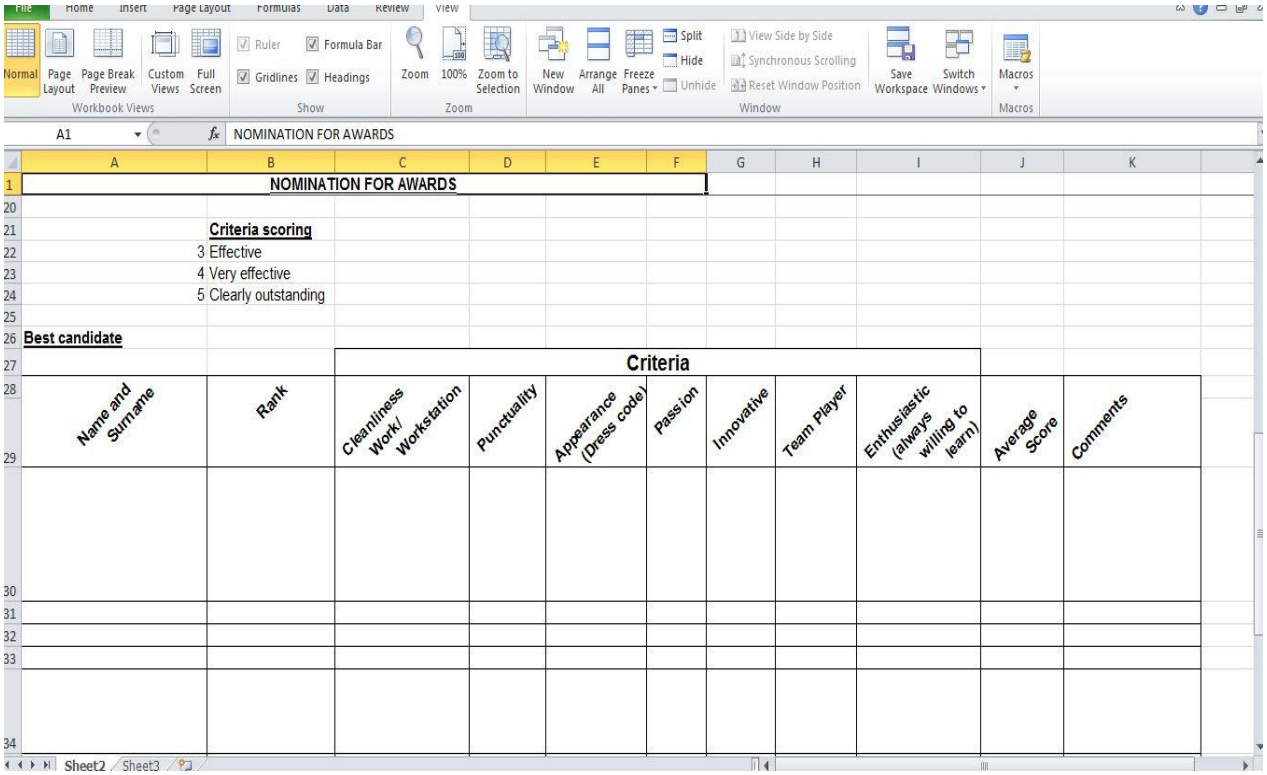
> We were told that we do not have resources and the clinics storage room was a mess, the issue was escalated to the district, that's when I said that there should be no excuses and we should address this issue. I put together a team to address this, asked for petty cash from finance to purchase building materials and then asked one of the medical practitioners in the district who I knew was good at building to put in the shelves. The issue was resolved and the clinics storage room now has the shelves it required for storage of medications and files – District Senior Manager 1.

Other acts of agency are linked to innovation - the ability to motivate staff despite being in a resource constrained environment. One such initiative was the annual awards ceremony. An awards committee was established over seven years ago and coordinates the nominations and a

ceremony. Individuals and teams at both the district and sub-district level are eligible for the award. Specific award categories include:

- ❖ Best performing section.
- ❖ Best individual.
- ❖ Best sub-district.
- ❖ Best clinic.
- ❖ Head of the District's award (for those she knows goes the extra mile, beyond their job description and even assist other units).

In the finance team, managers have linked the award to continuous assessment of staff through an excel template they developed, using it during performance management discussions.



(Photo: S Choonara, 2016)

Image 7.1: Display of criteria – Isikhala District Awards Assessment

Some participants perceived the awards process as follows:

> I won the award last year. I only received a certificate, but it really meant a lot to be acknowledged. I believe it doesn't always have to be a monetary reward, *but just somebody acknowledging that what you are doing is good* – District Mid-Level Manager 4.

> I think it is very good. It encourages a person to perform. It is very important in an organisation to acknowledge good performance; if there are no rewards then we might not be as innovative or creative- District Junior Staff 6.

However, some staff at the sub-district level expressed discontent at having to pay or make a contribution towards the awards ceremony and stated that they were not motivated by this initiative. Informal learning per se was not examined at a sub-district level, it was however clear from most of the interviews conducted that IT and finance constraints impacted sub-district functioning and the gains of such motivational strategies were not sufficient in motivating sub-district staff;

> This awards ceremony, it doesn't motivate us, we have too many challenges, and then we have to pay for it, it's like rewarding yourself - Sub-district Manager 9.

7.6 Conclusion

This chapter shows both the successes and weaknesses of case-study 2, particularly in relation to the financial management cycle and its key processes (routines). Observations and interviews showed that plans and the DHER were thoroughly reviewed and engaged with, as were budget bi-lateral presentations. Some delays and difficulties were experienced e.g. difficulty tracking expenditure. Some provincial weaknesses such as payment delays were also evident. A procurement process tracking ECG defibrillators was outlined, particularly highlighting the district's late and incorrect submissions and challenges linked to IT connectivity, both functions inherently dependent and shaping financial management. Difficult relationships between the district province and trade unions were noted and which constrained agency. Nonetheless, there were several coping strategies employed by staff as well as displays of agency and innovation-largely attributed to the informal learning environment created and supportive relationships especially between managers and staff, which points to the essentiality of software in shaping everyday financial management.

CHAPTER 8: COMPARATIVE ANALYSIS - DISTRICT FINANCIAL MANAGEMENT

8.1 Introduction

This chapter begins with a comprehensive summary of each of the study objectives, its components and key findings. This thesis was primarily concerned with providing an in-depth comparative analysis of financial management between two health districts in South Africa (SA). Chapters 6 and 7 detail each district individually; the aim of this chapter is to provide a comparison of these districts through the four elements of the structuration nexus – structure, agency, hardware and software. The chapter further draws out the conceptual overlap and fluidity between hardware and structure and software and agency through the analysis of results in both districts. Chapter 2 in particular detailed the importance of the structuration nexus and other theories in shaping organisations; this chapter shows the influence and relationships between the four elements of the nexus as well as its necessity in facilitating financial management as well as similarities and differences between districts in this regard.

Table 8.1 Summary of study findings

Objectives	Specific components	Indawo district (chapter 6)	Isikhala district (chapter 7)
1. To examine the four cyclical financial management processes (planning, budgeting and resource allocation, oversight and evaluation) in each district.	Process 1 – planning (District Health Plan – DHP)	-DHP draft submissions delayed. **-DHP poorly coordinated (little engagement between various units), minimal** interrogation and discussion of the document – compliance instead of actual use in the district.	-DHP meetings held throughout the financial year, however final submission delayed by two months. **-Better coordination, interrogation (feedback district oversight committee) and engagement between units** e.g. primary health care, HR and finance.
	Process 2 – resource allocation & budgeting	**-Poor budget bi-lateral presentation**, PDoH advising on need for corrections – district carried out the task to comply with annual process – budget allocation happens irrespective of motivations. -Budget does not sufficiently cover unfunded mandates. **-Difficulty accessing available resources e.**g. approval of information technology (IT) requests.	-Team effort, interrogation and several drafts of the budget bi-lateral presentation put together. PDoH reported that **Isikhala had one of the best presentations in the province,** however budget motivations were still subject to Treasury allocations. -Budget does not sufficiently cover unfunded mandates. **-Difficulty accessing available resources** e.g. building additional storage space.
	Process 3 & 4 – oversight and evaluation (District Health Expenditure Review – DHER)	**-Expenditure tracking flawed e.g**. DHER – delayed payments or no communication of payments back to district (centralised function), loss of institutional memory (flawed process staff were unable to use systems to track expenditure, although participant in chapter 6 highlights that it is possible). **-DHER carried out by finance with minimal interaction and engagement** with other units and little linkage to DHP. -Expenditure reports did not accurately reflect commitments (payments for goods/ services rendered).	**-Expenditure tracking difficulties** due to no payme**nt** communication/ delayed payments by province. Observed in-year-monitoring (IYM) process, staff were unable to correct misallocations– **could not use systems to accurately track expenditure.** Some tracking of commitments through monthly accrual reports. **-DHP and DHER processes were coordinated by the same units, PHC and health programmes in conjunction with the finance unit to ensure better integration and linkage to planning processes.** Document also interrogated and revised (feedback provided by district oversight committee).
2. To carry out and compare organisational realities of the	Hardware factors	**-Lack of IT connectivity** and equipment throughout the district and sub-district.	**-Slow internet connectivity** and some parts of the district/ sub-district not having computers/ laptops.
	Software factors	**-Strained interpersonal relationships between managers and staff in the finance**	-A few staff (2) reported difficult relationships within the finance team; however this was attributed to not

Objectives	Specific components	Indawo district (chapter 6)	Isikhala district (chapter 7)
districts' financial management units, their financial processes cognisant of hardware[17] and software[18] factors.		**unit** (although some positive relationships reported in other parts of the district). **-Finance staff stated that there was a lack of team work and the majority felt de-motivated**, isolated (little communication between staff and superiors/ with each other).	being promoted. **-Overall, staff reported positive relationships and open communication between each other (team) and their managers.** Staff reported feeling motivated and discussed the value of team work in financial management.
	Structure	-Figure 5.3 and chapter 6, shows the complexity of the system adapting to the new formal structure (organogram) of the district – new head of district responsible for support services. Strained relationships and blurred lines of authority reported in the broader district and the finance unit does not have clearly demarcated budget and accounts payable sections affecting tasks and coordination in the unit. **- Rules and regulations prescribe financial management processes (routines), districts comply but do not necessarily engage or make use of these documents for day-to-day activities (e.g. DHP/ DHER above).** ***Structure and hardware are overlapping concepts, rules and regulations may also be considered to be hardware (further unpacked in section 8.2)***	-Clear lines of authority established through formal structures (organogram). However, finance managers show how they re-organised structures within their unit, into clearly demarcated budget and accounts payable sections to train staff, allowing for better management and coordination of tasks. **- Rules and regulations prescribe financial management processes (routines), districts comply but do not necessarily engage or make use of these documents for day-to-day activities (e.g. DHP/ DHER above).**
	Displays of agency & inherent linkage to leadership	-Some problem-based coping strategies recorded in the finance unit e.g. organising for interns to use computer facilities at the provincial level. -In other units, the new manager who has substantial institutional memory and experience changed the structures (routines) through better communication and team work.	-Problem-based coping to address limited IT connectivity – staff moving to other parts of the district e.g. hospitals with internet. -Chapter 7 details the instance of placing shelves in the clinic despite minimal resources. **-Innovations by finance managers in fostering informal learning in their units (staff learning all tasks in finance). Through informal learning,**

[17] Hardware: elements such as rules, legislations, policies, skills, infrastructure, technology and funding levels of a health system.

[18] Software: knowledge, processes of decision-making, relationships, communication, practices, values and norms.

Objectives	Specific components	Indawo district (chapter 6)	Isikhala district (chapter 7)
		There were linkages between this display of agency and leadership competencies being displayed e.g. communication, people-management and empowerment, problem-solving. -Other examples include the procurement of bread without necessary procurement contracts in place.	**leadership competencies were evident e.g. knowledge management, personal development and empowerment, problem-solving and communication in the finance unit. Broader district innovations were also linked to this - team-building and the annual awards ceremony.** ***Innovations, informal learning and teamwork are interlinked to software issues (conceptual overlap described in chapter 2)***
3. To provide a comprehensive analysis of decentralised financial management linked to other units at the district level - procurement, human resources (HR), information technology (IT) and in relation to broader contextual influences i.e. provincial, political and historical.	Other units in the district e.g. procurement and HR.	**-Procurement processes impacted by limited IT, limited capacity at the sub-district to complete procurement submissions accurately and financial checks not being carried out correctly – the observed procurement process delayed but eventually goods (foot stands) were procured).** -Delayed procurement affecting service delivery e.g. pharmacy. -Poorly performing staff not held to account due to trade union/ political influence.	**-Procurement process observed (electrocardiogram defibrillators) indicates failed procurement processes, difficulties in sub-district staff communication their requests (lack of IT) and submissions not completed accurately – failed procurement process.** -In Isikhala, trade unions influence managerial decisions and processes to deal with poorly performing staff, in some instances where disciplinary processes were carried out, PDoH overturned decisions.
	Province X Department of Health -PDoH	Rationale for centralisation of functions outlined in chapter 5, **however province itself is weak (no coordination between management and accounting units) and politicians influencing procurement processes.** -Centralised IT connectivity affecting district financial management, delayed payments (above) and procurement e.g. IT equipment.	**-Isikhala affected by centralisation e.g. difficulty tracking expenditure due to provincial weaknesses (above), procurement affecting service delivery – basic items such as cleaning materials for clinics, gauze and paper for doctors/ nurses to write on.**
	Non-governmental organisations (NGOs)	-Strained relationships between NGOs and finance staff, NGOs assisted with training district staff e.g. Vulindlela, however some difficult relationships noted and role in the district questioned.	-Staff reported more positive interactions with NGOs, valuing critique and feedback to improve processes.

8.2 Comparison between Districts- Structuration Nexus of Financial Management

Table 8.1 provides an overview of comparative findings and this section attempts to show how each of the components of the structuration nexus relate/ influence and shape each other, how they differ between districts and its impact on every-day financial management routines.

Box 8.1: Recap (chapter 2) - theoretical lenses & definitions

Social science perspective - structuration theory

- Structure: considered to be social structures (rules and resources), enacted through and organisations' daily routines e.g. financial processes.
- Agency- a micro-level phenomena (individual actions), considered to be a resource within the system, contributing to system functioning and change e.g. to take action despite constraints.
- Duality of structure: structuration theory argues that established routines are put in place and either reinforced or transformed by actors. Routines may influence how different agents operate on a daily basis but may also be the outcome of actions if agents attempt to transform/ merely reinforce these routines.

Health policy & systems research *(complementary theory)*

- Hardware: similar and interlinked to structures refers to elements such as rules, legislations, policies, skills, infrastructure, technology and funding levels of a health system.
- Software: similar but an extension to agency includes components such as knowledge, processes of decision-making, relationships, communication, practices, values and norms.

Thesis contribution *(refer to figure 2.3, circle 1)*

- Structuration nexus: relationship and influence between four interconnected elements of financial management (and broader organisational functioning) – hardware, software, structure and agency.

8.2.1 System changes – external influences on formal structures

Financial functions and key routine processes (e.g. timely authorisation or submission of documents to PDoH) within each district were influenced by relationships and structures in the broader district. The Indawo district's formal structure (organogram) initially had one district head with the district hierarchy and authority being clearly set out. Just over a year ago (2015) there has been the addition of another head of district dealing specifically with support service functions (section 5.3.1, figure 5.3). It should be noted that the appointment of this person was a political appointment (table 8.1) and while perhaps support-service oversight was required to strengthen the district, the appointment of the head of district was externally influenced (political interference). This rapid and externally influenced factor required clear lines of authority and responsibility for the second head of district, which could have had the possibility of contributing additional managerial experience and oversight of support functions. This change and division of tasks in the district could have allowed the other head of district to focus solely on service delivery, which is her strength.

No change to routines and systems can always be expected to play out in predictable ways, as systems work towards adapting to any changes e.g. changes in structures or rules. It is commonplace that there will be disruptions in ways of working and new routines will take time to be established. However, these findings indicate that adaptation is largely influenced by human relationships and interaction (software), which could either be positive of negative. Presently, we see poor adaptation of the system in Indawo with regards to changes in its formal structure (organogram and hierarchy). Relationships can be seen as an essential software factor affecting financial management and associated routines. The change in systems brought software factors to the fore, in terms of its interconnection to changing structures/ hardware and routines. Chapter 6, section 6.4.1.3, outlines difficulties associated with relationships and blurred lines of authority. Strained relationships are further compounded by the fact that a new appointee was externally put in place with little consultation. The system is yet to adapt in Indawo, the advantage of drawing on additional

managerial skills for support functions is still to emerge and time is an important factor in system adaptation i.e. it is still early in the process. However, for positive adaptation, there needs to be better communication and clear lines of authority between the two heads of district. This section indicates the importance of clearly functioning structures.

In contrast the role of well-established structures (hierarchy) in a relatively well-functioning organisation can be seen in Isikhala. Structures/ hardware (organogram) in the district have been established over time and there is clarity on the lines of authority. The higher level senior manager (HSM) of support services has been established for several years – figure 5.4. This clearly allowed for definite routines, oversight of support functions such as finance, reporting lines for staff through the HSM and allowing for escalation or higher authority to the head of the district. Thus there is no confusion around who is the head of the district in Isikhala and this points to the importance of this in district functioning, especially around authority. This section briefly alludes to the interlinkages between structure and software, however all four components are interconnected (including agency and hardware) in terms of shaping district financial management (discussed below).

8.2.2. Ineffective financial routines – importance of agency and transformational practices

8.2.2.1 Indawo district

Focussing specifically on financial management, one notes software and hardware challenges which affected routines such as meetings and other activities such as expenditure tracking. Other than difficult relationships being reported in the broader district, respondents in the finance unit in Indawo reflected on the lack of teamwork and support from supervisors as well as feeling de-motivated (section 6.4.1.3). Staff also felt that the lines of communication with others including managers were not open, with few finance specific meetings or avenues to raise concerns or question finance practices. Besides these software challenges, focussing on monthly finance meetings conducted at both the district and with sub-districts, issues with misallocations and incorrect expenditure were raised, however the problems or errors continued to persist. Elements of the structuration nexus indicate why these challenges continue e.g. software challenges including communication but also IT being a hardware component.

These meetings were primarily geared towards updating district and sub-district managers on their expenditure and available budget instead of engaging with misallocations and procedures around correction or budget support. The lack of internet connectivity especially at the sub-district level made it difficult to set up these monthly finance meetings (chapter 6, section 6.3.1). Follow-up communication, regarding errors on budgets presented, was also difficult outside of this monthly forum. This hardware issue (IT) extended to the district level, where finance staff explained that both communication amongst themselves and with the sub-district / province was constrained and their daily financial tasks and access to systems were also affected.

Findings revealed both the functionality and dysfunctionality of financial tasks such as accessing available resources, motivating for additional budgets and tracking expenditure (summarised in table 8.1). Many of these routines despite their challenges continued to be practised in the system, either because of some functionality e.g. in Indawo, despite delays in the procurement process (figure 6.1), foot stands were eventually delivered. This thesis offers another account of why routines were continuously enforced in the district system and finance units despite their shortfalls. Reasons cited is that actors have limited knowledge of alternatives to these rules and processes (structures/ hardware), there is essentially the loss of institutional memory (experience and knowledge of systems), current processes are prescribed by province enforcing conformity but also that there is a lack of agency within the system (discussed later in this section). Routines are carried out e.g. fulfilling job-descriptions and carrying out instructed tasks prescribed from higher levels with little room for innovation or change (Von Holdt's notion of hierarchy). Chapter 6 particularly draws attention to the DHP being carried out to comply with provincial deadlines and requirements instead of being used at a district level. Several participants raised the role of compliance in shaping how other financial routines were carried out (table 8.1).

Another factor contributing to ineffective routines is that there have been shifts between decentralised and centralised functions which have been dealt with extensively in chapter 4. The introductory sections of the thesis recognise that the provincial level may be considered from both centralised and decentralised perspectives, although in this thesis the province is

considered to be the higher level actor in comparison to the district. Several shifts between centralisation and decentralisation (e.g. payment functions or procurement approval) linked to the change of rules (structures/ hardware) and procedures while necessary may have resulted in what Giddens regards as the loss of autonomy due to de-routinisation, leaving many financial practices uncertain as actors have shifted towards reinforcing, understanding and implementing these changed practices. Ill-defined shifts thus hinder system adaptation for actors.

However, at the core of the 'duality of structure' - actors are perceived to hold significant power in their knowledge, reflexivity and that they act with purpose which either reinforces structures which are evident through routines or allow for transformation of these structures (see box 8.1). This thesis considers knowledge particularly institutional knowledge, to be a software factor shaping health systems. Practices continue as most actors are unsure of alternatives at both the district and provincial level or as mentioned they conform and re-inforce these practices. Two specific examples will now be outlined to contrast the impact of software factors such as institutional knowledge, vast experience, coupled with agency in the HR unit in Indawo versus the finance unit which in the absence of these software factors is managed quite differently (chapter 6). The section specifically highlights the pivotal role agency (particularly that of an individual actor) plays in transforming ineffective practices allowing for better functioning organisations and teams.

The lack of individual agency and its influence on collective/team functioning and agency was noted in Indawo. The presence of leadership competencies[19] and their interlinkage with agency in the Indawo finance unit and broader district functioning is discussed in Box 8.1-

[19] Table 2.1 in the literature review, outlines 11 essential leadership competencies (overlap with managerial skills) required within the health system; people management and empowerment, problem-solving, programme and project management, knowledge management, strategic capacity, communication, financial management, change management, service delivery and innovation, client orientation as well as honesty and integrity.

Box 8.2: Reinforcement of existing ineffective financial routines - lack of agency and software element

Example 1: Finance Unit

The HSM finance was newly appointed to the district, with previous financial experience in the education sector in South Africa (SA). The finance unit in Isikhala already had weak relationships between staff with no clear delineation of staff between budgets and accounts payable. Routines around the way financial tasks were carried out had already been established e.g. authorisation of expenditure for procurement or journalising to address misallocations. This manager essentially entered a weakly functioning unit. The dysfunctionality was further compounded by a lack of technical competencies, it was observed that she did not as not having adequate financial expertise to carry out the District Health Expenditure Review (DHER), lacked basic computer skills (could not even use basic functions in Microsoft Excel- section 6.2.3), and was often not open to suggestions. Communication with staff was also strained – she often shouted at staff. In turn and as mentioned staff felt de-motivated and stated that there was a lack of teamwork and support from supervisors.

Two clear examples of this emerged during budget meeting, where the HSM finance argued that there was nothing wrong with the budget to those raising queries and stated *'These figures are from the system, the system is never wrong and this is the budget'*. In another instance, advice was offered from another participant with vast experience across all support functions in terms of tracking commitments, however the advice was not considered in future processes and tensions were heightened when the district presented incorrect expenditure figures to the province (section 6.2.2).

Despite the HSM being in the system for approximately two years, there was no change or innovations from either staff or the managers around addressing weaknesses outlined/ associated with routine financial tasks. Staff in the finance unit continued to be demotivated and relationships between staff and the DD continued to be strained. These strained relationships and difficulty in communication, rendered it difficult for staff in the finance unit or in other units to display agency and challenge ineffective processes thus reinforcing them.

Von Holdt's (2007 and 2010) writings become relevant, when one considers the manager's (HSM finance), lack of technical skills or experience and unwillingness to accept assistance

or advice from others who are more experienced in the district. This may be seen as 'saving face'. Saving face in this context refers to both the manager not willing to reveal her weaknesses and learn, but also the district not dealing with poor performance. Post-apartheid restructuring is centred on achieving racial transformation. Yet there are clearly issues which emerge around technical competency, which according to organisational theorists such as Weber (chapter 2) is critical to well-functioning organisations. However, there is minimal room for developing the LSM's skills/ competencies as routine performance management tools are not carried out with the goal of development but rather compliance. Influences from trade unions and politicians further hamper these processes (table 8.1).

The continuous interconnectedness between software factors, agency and its importance were noted in other units in Indawo. The case of the new HSM HR provides a depiction of the dynamic relationship and four dimensions, namely hardware, software, structure and agency interlinking to influence and shape routines (structure- also hardware). Prior to the new HSM, several staff in the HR unit described the unit in a similar light to the finance section, e.g. a lack of integration of tasks, minimal teamwork, strained relationships and the unit being, essentially 'a mess' (section 6.4.2.1). Looking towards available software in the new unit, the new HSM HR had substantial experience (including managerial experience) working across support-functions at both a provincial and district level. This facilitated her agency in transforming the unit. The HSM introduced informal routines, such as communicating their financial management tasks to each other, which also allowed building relationships i.e. teamwork and new ways of working (discussed in chapter 6). What this shows is that the HSM drew on her own software and found ways to address software issues in the unit, which affected the way the unit functioned and the way actors interacted with each other. Although through these instances of agency, it was clear that the HSM displayed several leadership competencies within the system e.g. people management and empowerment, problem-solving and analysis and communication. In summary, she was able to affect routines; the informal structure of the unit in terms of communication and interaction though her agency, knowledge and experience (including leadership competencies) instead of reinforcing the dysfunctionality in the unit which existed.

The juxtaposition of these two examples in this section indicates how two different units operated in the presence and absence of hardware, software, structure and agency, particularly leadership characteristics. The implications on the financial management unit are particularly noted in the absence of these four critical factors which clearly influence organisational functioning and either the transformation or reinforcement of ineffective routines.

8.2.2.2 Isikhala district

Table 8.1 highlights the key comparative findings between the districts and points specifically to differences in the way some financial activities were carried out (DHP/ DHER, budget-bi-laterals). This section interrogates why there is the enforcement of ineffective routines similar to Indawo, but also how and why there have been transformative practices noted in the finance unit in Isikhala. Giddens puts forward the argument that rules cannot be enacted or played out without resources which in the case of Indawo refer to hardware (IT) and software dimensions including knowledge and experience. This is also the case in Isikhala. The impact of losing institutional knowledge and its impacts on shaping flawed financial practices such as expenditure tracking were also evident (section 7.2.3). Reasons are similar to Indawo - the loss of institutional memory with little knowledge of alternative ways of using systems and carrying out processes to fulfil their job descriptions instead of facilitating change when needed. For instance, staff at the district carried out the monthly IYM reports to deal with misallocations (incorrect expenditure). Section 7.2.3 shows that staff carried out this process routinely yet the process was flawed e.g. unsure where to place R8 million misallocations. Another interpretation is that the actors in the district system feel as if there are no room to foster system / process change i.e. actors may try to express their agency but transformation is constrained by bureaucratic procedures or approval by (PDoH) – section 7.5.1.1.

Despite constant stressors such as limited IT, routines were carried out though in some cases these processes did not yield effective financial management, for example in expenditure tracking and procurement (similar to Indawo). However, there were successes noted in chapter 7 and table 8.1 - Isikhala in particular provided evidence of the importance of

building software, particularly relationships and fostering communication in facilitating teamwork, agency and transformative practices. The broader district management team had already established lines of authority, moreover (chapter 7) discusses the role of informal learning and creating a solution-driven environment at all levels. The role of informal learning captured in section 7.5.2.1 shows that it created a supportive and enabling environment across some parts of the district but particularly in the finance unit. Leadership competencies were displayed by managers who fostered informal learning i.e. knowledge management, also linked to other competencies such as people management and empowerment, communication and problem-solving. In fact, the broader district management also created a culture of 'no excuses' and accountability (informal structures- rules), in terms of the *'head of the district having ears and eyes everywhere'* and this enabled different ways of working and successes noted in table 8.1.

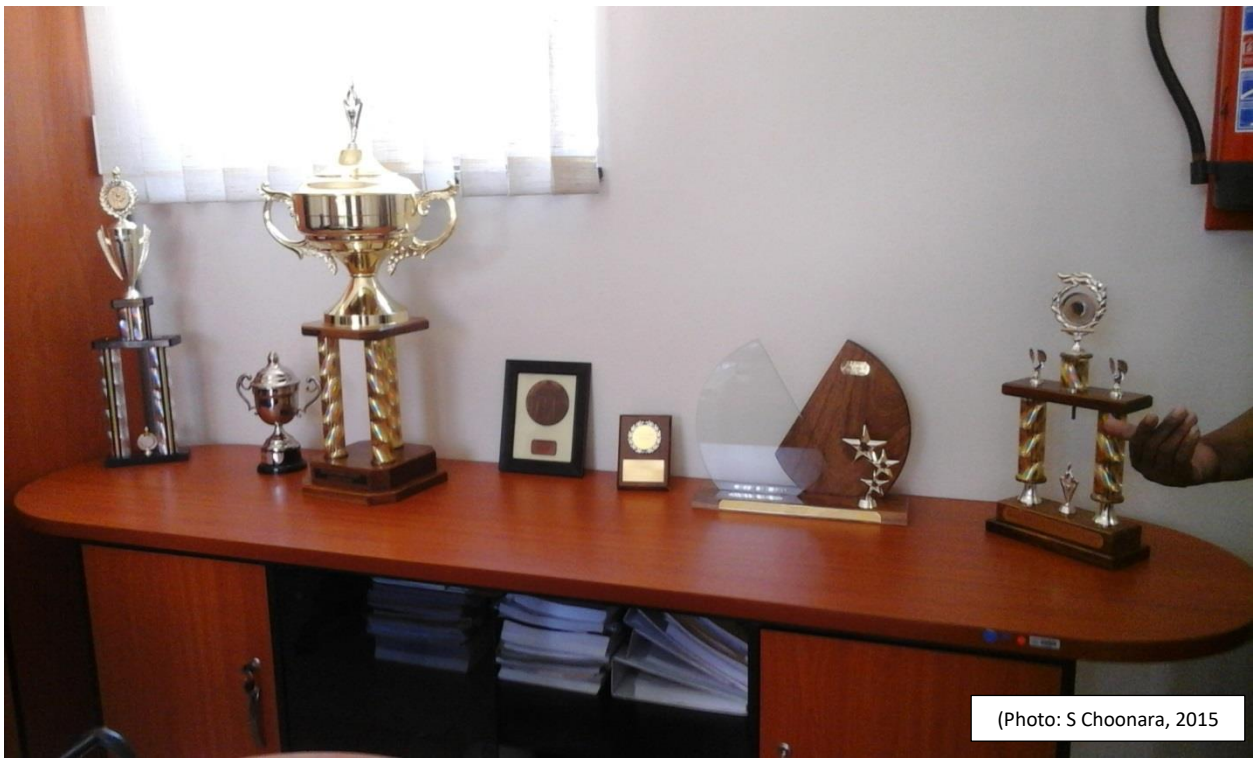


Image 8.1: Isikhala district awards received - service delivery & excellence

A defining feature of Isikhala was nurturing software within the system which gained sustainability through instilling these practices and strategies amongst various managers and

staff in the system, allowing for the development of these leadership competencies which enabled agency to manifest across most of the district (section 7.5.2.1). The narrative in Isikhala essentially shows that by creating an enabling and supportive environment through nurturing software, actors within a system were equipped and encouraged to display their agency i.e. develop their leadership skills. Agency was seen as a predisposition to transformative practices in line with Giddens theory e.g. informal accountability, changing weak practices and making structures (organograms) work particularly in the finance team. Perrow's (1977) writings are also relevant , when considering how the two managers fostered communication and coordination between themselves and their staff (in contrast to the two heads of the district in Indawo), reduced workload by splitting tasks but also facilitating teamwork. Managers worked around these structures (organogram), they did not consider them to be rigid, and instead they encouraged staff to learn every aspect of finance despite their specific job description/ positioning within finance.

Finally, this section shows the continuous and interdependent relationship between software and agency in enabling staff to be proactive, display agency and innovations such as team building or the awards ceremony instead of being dependent on higher levels to bring necessary changes to the system. Displays of agency due to the enabling, supportive and learning environment which was created was also noted e.g. procurement or accessing the available budget and found alternates such as utilising the petty cash (see example, section 7.5.3).

8.3 Chapter summary

The chapter provides a brief comparative overview of findings between the two districts in terms of the objectives of the thesis. Section 8.2 is interpretive and unpacks these findings in light of the study conceptual framework and key theories, particularly the structuration nexus and its components (hardware, software, structure and agency). The two districts were similar in terms of stressors e.g. IT and the reinforcement of ineffective routines and reasons thereof – expenditure tracking and other key financial tasks. Furthermore, findings show that there is a dynamic interaction between structure and agency through routines and which are supported by hardware and software factors e.g. IT, institutional memory (knowledge). In

both Indawo and Isikhala, we see that financial management practices have some functionality in terms of 'saving face', fulfilling job descriptions and carrying out expected financial tasks. Interestingly despite stressors, systems continue to function to an extent and provide some services – e.g. goods are still procured.

However, there were stark differences in the way some activities were coordinated, interrogated and carried out in Isikhala with notable software factors such as teamwork, communication and positive interpersonal relationships in propelling displays of agency and transformative practices. The interlinkages between agency and leadership have been discussed. These examples show it is clear that system survival and adaptation (specifically transformation) is premised on human agency. However, human agency is shown to shift flawed practices, in particular, the value of relationships, communication and motivation in both districts proved to be critical enablers of agency. This thesis shows that both software and hardware are required in the system, both have to come together to either facilitate change or reinforce routines and the rules (structures). Moreover, organisational culture (informal rules and accountability) were critical in shaping how financial activities were carried out and transformed in the presence of software elements (communication and teamwork).

CHAPTER 9: DISCUSSION

9.1 Introduction

This chapter discusses findings from the thesis in relation to existing literature, objectives and the conceptual framework employed in the study. It particularly points to the weaknesses of financial management, areas and mechanisms for improvement. The chapter considers the significance of the structuration nexus – hardware, software, structure and agency (detailed in chapter 2 and 8) in facilitating more effective financial management, with lessons for the broader district and health system functioning. Secondly, its consideration of higher levels (centralised bodies) is discussed in relation to future policy implications – i.e. South Africa's (SA) major health sector reform, the National Health Insurance (NHI).

Box 9.1: Recap thesis objectives

Overall aim

- To understand the micro-level practices of everyday financial management in two health districts in province X, SA specifically focussing on strengths, weaknesses and mechanisms for its improvement.

Specific objective (s)

1. To examine the four cyclical financial management processes (planning, budgeting and resource allocation, oversight and evaluation) in each district.
2. To describe and compare organisational realities of the districts' financial management units, their financial processes cognisant of hardware[1] and software[1] factors.
3. To provide a comprehensive analysis of decentralised financial management linked to other units at the district level - procurement, human resources (HR), information technology (IT) and in relation to broader contextual influences i.e. provincial, political and historical
4. To provide policy recommendations to strengthen decentralised financial management under SA's health sector reform policy (National Health Insurance – NHI).

9.2 Duality of Structure –Why does 1+2=6?

This thesis has set out to examine financial management at a district level, given that decentralisation has been widely accepted and adopted by several developed and developing countries including SA as a key health system reform [14, 5]. Despite existing legislation e.g. Public Finance Management Act (PFMA) which provides insight into delegated roles and the National Health Act (NHA) of 2003, advocating for management and control of the health budget to be decentralised, financial management challenges highlighted in this thesis have also been noted for over two decades at a district level in SA. Persistent challenges at a district level include capacity weaknesses, difficulty accessing resources and minimal authority delegated to lower levels [33]. These challenges were also noted in chapter 2 in other low and middle income (LMIC) settings, such as Ghana [53].This thesis has attempted to understand why financial management difficulties continue to be present at health districts, and what are the possible strategies for improvement.

Objective 1 and 2 of this study are concerned with examining the four cyclical processes of financial management, namely; planning, resource allocation and budgeting, oversight and evaluation. The essence of the thesis (objective 2) was to understand actual practices, the micro-level practices of financial management, interactions and relationships between actors, successes and challenges within and between districts by using an organisational perspective – socio-cultural perspective. The socio-cultural perspective adopted drew on structuration theory which highlights the importance of structures and agency in an organisation which must be complemented by health systems notions of hardware and software factors, termed structuration nexus in the thesis. Chapter two (the literature review) drew attention to the fact that the health policy and systems research (HPSR) discipline is recently established and there is great value in drawing on social science e.g. organisational theory perspectives [76]. Theoretically, this thesis brings together the sociological and HPSR disciplines to show the importance and interlinkages of all four elements, namely structure, agency, hardware and software which continuously influence and re-shape each other to contribute to organisational functioning. While there is a conceptual overlap, Giddens theory alone does not explain why weaknesses continue to be perpetuated in the system, and thus complementing the theory with notions of hardware and software elements from the HPSR field.

Understanding and examining financial management routines through the use of the structuration nexus was thus at the core of this thesis. The duality of structure within the structuration framework further allowed for a thorough analysis of routine finance tasks in districts (refer to recap of key concepts- in chapter 2 and box 8.1) – understanding the dynamic relationship between structure and agency in either enforcing/ maintaining routines or transforming practices largely attributed to human agency [6]. Linkages between study findings and understanding the 'duality of structure' reveal the complexities associated with decentralisation and why despite financial tasks being carried out (these routines are re-enforced) they have not yielded effective district financial management. The study has pointed out several weaknesses of routine financial tasks ranging from poor planning to flawed expenditure tracking, although despite these weaknesses such routines continue to be reinforced and carried out by district actors (chapter 8). A participant in the study aptly described the district's poor financial management records in section 6.2.2 as '1+2=6' and this thesis argues that its explanation lies in the complexity and interconnectedness of cycle 1 of the study's conceptual framework (influenced by hardware, software, structure and agency - structuration nexus of financial management).

For example, without system hardware (information technology- IT- equipment or resources), carrying out routine financial tasks were next to impossible in both districts. Thus hardware is clearly required for structure (routines). But also technical competency and skills (overlap between hardware and software skills) are required for functioning rational bureaucratic organisations according to Weber and which this thesis shows affected financial management particularly in Indawo [59]. Existing literature does document impacts of poor capacity (lack of skilled finance tasks) in settings such as Nigeria and SA [33, 52]. Although Weberian analysis does not go far in addressing system context or understanding the essentiality of human behaviour and action within the system (as discussed in chapter 2 and 8 - section 8.2 - the importance of agency).Von Holdt's (2007 and 2010) writings have been relevant in the analysis of understanding why technical competency e.g. skills and qualifications remains an issue and why it does not take precedence during recruitment or disciplinary processes. Poor performance was inherently linked to the notion of 'saving face', redress and post- apartheid restructuring and union influence (chapter 8). The situation facing public sector institutions is

complex in SA. On the one hand there is a need for public sector transformation (racial redress) however the country's National Development Plan (NDP)[20] describes the public sector as 'facing unevenness in capacity that leads to uneven performance' [37]. This is further compounded by political influences over recruitment and management of staff (ahead of technical competencies), skills deficits, poor accountability and authority and low staff morale [37]. This is particularly relevant to the Indawo district, where we see in box 8.2 how staff did not have adequate skills (use of financial systems) and low staff morale.

However, while such challenges were noted in the system, there were also instances of success and innovation in both districts. This was largely due to the presence of software factors and displays of agency inherently linked to leadership in the district. These findings confirm prior HPSR literature which advocates for the importance and value of developing software elements within the health system [9]. Software elements such as personal development through delegation shaped the district head in Isikhala, who then exercised her agency and through leading the district introduced strategies of informal learning which fostered software and enabled agency throughout most of the district. In fact, the finance units between the two districts differed largely due to the presence of software and which shaped the way routines were carried out (transformed instead of re-enforced). The informal structures set up in Isikhala; teamwork, interrogation and feedback are confirmation of this (presence of software in shaping routines and agency). Furthermore these managers displayed leadership competencies which were outlined in chapter 2, such as people management and empowerment, knowledge management (informal learning and communication).

In the finance unit in Indawo district, there was a lack of software and agency reported amongst the majority of staff (de-motivated staff, poor communication and interpersonal relationships). However, in contrast to the finance unit, the influence of software together and importance of agency was noted in Indio's HR and procurement units (section 8.2.2.1). The HR unit in Indawo functioned quite differently to the finance unit and even reported transformative practices, better communication and teamwork. This was largely attributed the manager having institutional knowledge (experience and skills - technical competencies),

[20] The National Development Plan (NDP) is the economic policy framework that aims to eliminate poverty and reduce inequality by 2030.

exercised her agency to foster software components such as communication, better interpersonal relationships – also linked to leadership competencies. Theoretically and empirically, the structuration nexus developed in this doctoral study argues that a continuous relationship between software and agency exists and is critical to addressing weaknesses noted and in transforming practices to achieve better financial management (e.g. Isikhala having the best budget bi-lateral presentation in the province).

Although it is important to note that although agency has proved to be a necessity for positive system adaptation/ change and manoeuvring constraints, it may not always be possible to exercise it. This reverts one to the basis of structuration theory which argues that both structure and agency are critical to well-functioning institutions in society, but also that they are continuously re-shaped and interdependent [78]. The hierarchies (provincial approval, delays and weaknesses- further discussed in section 9.3) coupled with the lack of hardware (IT) were detrimental to displays of agency in Indawo and Isikhala. Existing legislation e.g. the PFMA 1999, while perhaps not necessarily found to be constraining, is considered to be a hardware/ structural component shaping district financial management and provides a framework in which actors at the district need to operate. For example, the PFMA makes provisions for unfunded mandates to be introduced to parliament with financial implications, or how if districts operate in excess of the budget there is access to a revenue fund but there are clear guidelines which stipulate that additional funding should not exceed forty-five percent of the total amount appropriate in the previous budget [111]. Thus even actors who display agency and leadership need to operate within such boundaries, however leaders are able to challenge these boundaries.

This thesis reaffirms the importance of the socio-cultural perspective which places theories such as structuration theory cognisant of human actors and their agency at the core of functioning health systems. Through both findings and the conceptual framework laid out earlier in this thesis, it is clear that for a system and its essential components such as financial management to function, structure, agency, hardware and software (structuration nexus) could be critical to strengthening financial management, conceptual overlap and interlinkages should further be considered.

In summary, insight into the financial management processes at a district level, revealed actual practices and how they were inherently shaped by hardware, software, structure and agency. Few other studies have focussed on micro-level practices/ processes and provided extensive detail on the weaknesses and areas for strengthening financial management in this regard [9]. The findings further show that structure, agency, hardware and software specifically agency and leadership were highly interdependent and necessary for routines to be shifted or improved (duality of structure). When the factors of the structuration nexus are present, its impact on effective financial management was notable e.g. transformational practice by finance managers in Isikhala (section 8.2.2.2). However, it was clear from the study findings that the broader environment including political factors, or a weak centralised level constrained agency for example and hindered transformation or positive adaptation.

9.3 Two Sides of the Same Coin – Centralisation Decentralisation Debate

Earlier in the thesis, chapter 2 (literature review) outlined critical gaps highlighted in the decentralisation literature. Specifically that there is little consideration for understanding decentralisation in relation to higher/ centralised levels of the health system - provincial and national. As mentioned in earlier chapters, while the provincial level is interesting in that it is considered to hold both centralised (from the district perspective) and decentralised (from the national perspective) functions. This thesis considers the province to be a higher level entity carrying out centralised functions in comparison to health districts in SA. Section 1.2.1, chapter 1 discussed four main types of decentralisation, namely; devolution, deconcentration, delegation and privatisation [17]. The SA context shows a mix of deconcentration and devolution [29]. Chapter 5-7 dealt extensively with financial management processes which are decentralised and the delegation to each district e.g. allocative decisions to the sub-district and approval of procurement purchases under R500 000. There is recognition that it is difficult and complex to highlight one form of decentralisation and in SA two forms of decentralisation emerged (deconcentration and devolution), but within the decentralisation framework it is essential that countries should consider the role of centralised/ higher-level functions. Despite the type of decentralisation pursued, this thesis argues that every system will still require elements of centralisation thus both levels need to have adequate capacity (human resources- skills, knowledge), be strengthened and operate in tandem [55].

A focus on organisational factors of financial management has indicated that there are several elements affecting coordination and clarity between the different levels (province and district) – ranging from communication issues to capacity (lack of leadership and agency). Thus the thesis examined decentralised financial management practices and considered broader provincial institutions (Provincial Department of Health- PDoH - objective 3) which has yielded important insights into the structure, functions and coordination or the lack thereof and associated weaknesses within the SA health system.

In fact the findings linked to centralisation and decentralisation resonate with SA's major economic and policy framework, the NDP which has documented challenges facing the public sector since the country's transition to democracy in 1994;

> SA has struggled to achieve constructive relations between local, provincial and national government. *A lack of clarity about the division of responsibilities* together with a reluctance to manage the system has created tension and instability across the three spheres of government…*Improving relations between national, provincial and local government requires a proactive approach to resolving coordination problems*- [37].

The NDP is telling of the complexities which exist within the public sector, including the health sector and in which this thesis shows that financial management is embedded and subjected to such difficulties. Similarly, the literature has noted that there are a myriad of challenges associated with the decentralisation of healthcare i.e. there is a lack of clarity and coordination between different levels of the health system [38]. For example, the Integrated Support Team (IST) report revealed that planning processes between all three levels of government (national, provincial and local) were not aligned in the SA health sector [44]. Such difficulties are persistent and despite landmark legislation such as the NHA 61 of 2003 (expected to) provide clarity on the roles and tasks between different levels and envisaged the district as follows –

> "This level of the health care system (district) should be responsible for the *overall management and control of its health budget,* and the *provision and/or purchase* of a full range of comprehensive PHC services within its area of jurisdiction"- [23].

Through an analysis of financial management tasks, it is clear that role clarity, tasks and management/ control of the budget and purchasing of goods and services at a district level remain constrained and affected by broader contextual influences e.g. PDoH (chapter 6-7). This thesis unpacks the issue of ineffective district financial management and argues that such woes are two-fold; firstly there have been some shifts between centralisation and decentralisation and secondly while successes are noted, weaknesses (capacity – financial skills/ knowledge, political factors) at both levels hinder coordination. Both district and province have evidently displayed that they are unable to carry out effective financial management.

Section 2.2 (literature review) offered discussions and insight into shifts between decentralisation and re-centralisation in various settings including SA [52, 109]. The recent National Health Insurance (NHI) policy states that the NHA will be revised, thus changes to centralised and decentralised tasks and delegation are once again anticipated given the reform. The path to decentralisation is not clear cut even in other country settings, for example in Tanzania where recruitment processes were not carried out effectively at the district level and subsequently had to be re-centralised [112]. Chapter 4 covered the rationale for shifts towards centralisation over some functions e.g. payment of suppliers – there was substantial over-expenditure by PDoH in 2009 and a lack of district capacity to carry out financial tasks. The need to re-centralise some finance functions was aptly described by a provincial manager in Chapter 4, '*PDoH was in great financial difficulty, billions of Rands were owed to suppliers and one of the reasons for this is that there wasn't a centralised streamlined processes'*. Besides shortfalls in the district health system (DHS) other reasons which participants stated was to achieve economies of scale (value for money, lower prices for bulk purchases). Many LMICs need to ensure the efficient use of limited resources thus complete decentralisation would not be feasible and there must be elements of centralisation to realise such benefits. Therefore, this thesis argues that there should be tasks carried out at

both levels as each have benefits e.g. responding to local needs (district) or economies of scale (province), however coordination and carrying out these tasks effectively is required within the system.

The benefits of some tasks being centralised is still to be realised in the SA context. Study findings show that it was difficult to establish tasks and levels with shifts between centralisation and decentralisation having negative implications on financial management in both districts (lack of clear roles and functions). Moreover, the establishment of institutions to handle re-centralised tasks was also part and parcel of a broader political process by province x i.e. the creation of the Provincial X Shared Service Centre (PSSC) – largely considered to be politically motivated (outlined in section 4.2).

> Finance, procurement and human resources (HR) were centralised when the PSSC was put in place. This was when we, sort of lost control over what was ordered and paid- District Mid-Level Manager 5.

Thus despite re-centralisation of some key tasks, weaknesses were still noted e.g. budget accessibility, delayed procurement processes affecting service delivery (PDoH not the processing the purchase order for the procurement of bread in maternity wards on time). For example, as one of the participant described;

> 'We have a budget yet it is next to impossible to spend it'- District Mid-Level Manager 6.

This statement essentially draws attention to PDoH not being able to carry out some basic financial tasks such as the release of funds for the purchase of goods and services. Structuration theory, expanded to the structuration nexus, has shown to be central to financial management, but more importantly to organisational functioning even at the provincial level (chapter 8). At the provincial level, software factors such as the loss of institutional memory and the lack of communication between units, finance and procurement. There is also a lack of communication between the financial and management accounting units which have minimal interaction and integration thus affecting financial practices. At a provincial level, participants explained that routine finance tasks such as expenditure tracking and corrections

were carried out to comply with the Auditor-General (AG) yearly audit instead of serving district or provincial purposes (thus indicating dysfunctional financial management practices at a provincial level as well). Existing literature attributes four weaknesses associated with decentralisation reforms, namely; inadequate power or authority (especially over financial tasks), vague or inappropriate systems and procedures, inadequately qualified and demotivated staff, and political interference [112]. Indeed, this thesis has shown the influence of the political sphere on both the centralised and decentralised levels (discussed further below) in terms of vendor selection for IT, recruitment of staff and unfunded mandates. This is despite the hardware/ structure components such as the PFMA clearly stating the need for accounting officers to ensure that there is an appropriate procurement and provisioning system which is fair, equitable, transparent, competitive and cost-effective. Software components were thus weak at a provincial level and further compounded by external influences (politics and trade unions).

The districts depicted similar issues to the province (discussed at length in chapters 5-8). Von Holdt's (2006 and 2010) writings outlined in chapter 2 discusses political influences on financial management issues in SA hospitals and are relevant to understanding the dual process of racial redress (transformation) and decentralisation in this thesis. The policies of redress such as Broad Based Black Economic Empowerment (BBBEE) and the Employment Equity (EE) Act outlined in section 1.2.2 are difficult to achieve at least in the short-to medium-term. While these legislations are deemed necessary to ensure the use and promotion of black owned companies or employing skilled black workers, they do add further complexity to the decentralisation process and in this case affect PDoH procurement processes. Chapter 4 (section 4.1.2) discusses how provincial procurement is dependent on the promotion and use of black owned companies which may not be as well established, either without stock or often acting as middle-men for established (often white owned) companies. In such instances, procurement of goods or services in line with BBBEE has contributed to cost-escalation or delays in procuring items as these companies are unable to meet bulk order requests with delays noted at the district level. For example, foot stands in Indawo were delivered after four months due to supplier delays (no stock). Albeit, and as mentioned, districts also displayed weaknesses by not completing documents correctly or on

time for procurement approval are evident in figures 6.1 and 7.1 (procurement process flows in Indawo and Isikhala). Thus it is not only provincial level weaknesses which are present in the health system. Similar findings around district financial management and high-level weaknesses (national/ provincial) have also been documented in other LMIC settings such as Uganda [20].

Thus the findings show that shifting tasks to the centralised or decentralised level may not necessarily achieve effective financial management. Moving beyond the allocation of tasks to different levels it is essential to strengthen each level. The issue at present moves beyond assigning tasks to different levels and establishing roles, but what this thesis shows is that the system, particularly the two levels are not functional. Again the NDP rightly alludes to this –

> There have been extensive debates about whether the basic structures set out in the Constitution are the right ones, or whether restructuring is required. *This has deflected attention from the pressing question of how to make these structures work effectively*- [37].

This further demonstrates the importance of Perrow's (1977) writing (outlined earlier) which is pertinent to the argument that both centralisation and decentralisation are required within a system. He draws attention to the importance of how these levels function, divide tasks and coordinate activities which determine organisational success [55]. Thus critical to systems functioning is maintaining authority yet allowing for a balance between levels, clear delineation of tasks and roles and effective communication for coordination and integration of functions [55]. Similarly, the finance managers (lower level senior managers –LSMs) who allowed for transformative practices in their unit in Indawo serve as a microcosm of how tasks should be centralised, decentralised and coordinated within a team and attributes the four elements of the structuration nexus at play and its achievements. The gains included motivated staff, better relationships (teamwork), personal development creating an effective environment and contributing to the way the unit functioned (propelling agency), how some processes were engaged with and associated outcomes e.g. engaging with planning processes (District Health Plan- DHP). The higher level senior manager (HSM) of human resources (HSM HR) in Indawo is another such example of nurturing software through her leadership

and agency. In both districts the presence of such software factors, including informal learning (leadership development and competencies displayed) were critical to displays of agency. The focus on the structuration nexus emphasises the role of agency in addressing challenges i.e. going against the odds to find solutions, irrespective of political forces (external influences), or even higher level authority (province).

There are multiple challenges facing the health sector ranging from service delivery to support functions (financial management). It appears that it is essential to determine which tasks are carried out at which level and their impact on complementarity which ultimately shapes the degree of central influence and the aims of decentralisation [15]. But this must be coupled with addressing weaknesses at both levels – propelling province and district to function effectively and coordinate tasks better. It would be critical for systems to foster such enabling factors (particularly, software, agency and leadership) which could possibly allow for effective financial management, with some lessons for broader organisational functioning.

9.3.1 Implications of study findings - managing resources under the NHI

Section 1.2.2 discussed the NHI as the main health sector reform in SA. The NHI policy details specific financing strategies e.g. raising revenues through taxation, emphasising the need to achieve Primary Health Care (PHC) which is to be incorporated into the district health system and the establishment of the NHI Fund – NHIF and its role as a strategic purchaser[21] of health services. A major critique of the NHI is that while it rightly focuses on service delivery it fails to consider strengthening support-side functions which this thesis has shown to be critical in procuring items such as foot stands or ECG defibrillators. The policy points towards strengthening financial management and procurement, yet it does not detail specific mechanisms or strategies for improvement and instead it has placed emphasis on the NHIF and its role in the procurement of health services, pool resources and ensure the efficient usage thereof. As such, this thesis findings, particularly around financial management, the centralisation – decentralisation debate and procurement provide crucial

[21] Strategic purchasing - A purchaser is an organization that buys health services, using pooled funds, for certain groups or the entire population. The purchaser can use levers to influence the behavior of providers to improve quality and efficiency in health service provision and facilitate equity in the distribution of healthcare providers – Source: http://www.wpro.who.int/asia_pacific_observatory/country_comparative_studies/strategic-purchasing-china-indonesia-philippines.pdf

insights into evident weaknesses and demonstrates that for the NHI scheme to achieve its service delivery aims, there must be consideration of these issues.

Evidence from the doctoral study shows that presently the 4.1 percent of total national resources spent on the country's public healthcare system is not effectively managed. Additional financing strategies of the NHI aimed at increasing taxation or redistribution of resources from the private to the public sector will only yield benefits if resources are allocated, used, accessed and tracked for planning processes to ensure service delivery. This thesis shows that there are fundamental flaws in the expenditure tracking processes (districts and provinces have proven that they are unable to track expenditure) rendering planning processes largely ineffective due to the lack of institutional memory (skills and experience) and staff re-enforcing instead of questioning or transforming these routines (chapter 8). Moreover, there are substantial delays in procurement processes, particularly a lack of capacity to carry out these processes at a district level. Moreover, the NHI document pays little attention to why there are delays in the procurement processes particularly at a district level. These issues are further compounded by the shifts between centralisation and decentralisation with a lack of clear roles and tasks still not clearly allocated or coordinated between districts and the province. Since 1994, the literature has noted persistent challenges around role clarity and coordination between the different levels of the health system which also extends to other public sector institutions –

> The foundations have been laid but weaknesses in how these structures function (national, provincial, local) constrains the state's ability to pursue developmental objectives…Improving relations between national, provincial and local government requires a proactive approach – [37].

Thus far the health system in SA has failed to clearly de-lineate tasks for both procurement and financial management. The NHI policy further calls for the amendment of existing legislation e.g. the NHA 2003 which is anticipated to bring further shifts and uncertainty to roles e.g. the province which is not clearly detailed in the policy. The addition of complex structures – the Contracting Unit for Primary Health Care (CUP) - to be based at the district level will contract services from hospitals and facilities. However, attempts at placing tasks at the level with most benefit e.g. re-centralising to achieve economies of scale has not been

achieved due to dysfunctionality; capacity constraints, political influences and the lack of software/ agency in the system which extends to both levels, the district and the province. This is indicative that structures (province, district) of the health system remain weak. The NHI, despite being the country's dominant reform, fails to recognise and provide clear details around enabling structures/ different levels to function effectively and even in the white paper the role of the provinces still remains unclear. Furthermore, the NHI reform has essentially failed to deal with the complexities of centralisation and decentralisation, moving forward the role of provinces remains a contentious issue -

> Better coordination in the health system is required between national and the province… communication between the two isn't good, you will find that *they duplicate each other's tasks* –NGO Staff 1.

> The role of the province and specifically within the NHIF is a million dollar question. *At this stage, it is not clear in the white paper what the role of the province will* be and determination of its role will be largely political (not functional) – National Health Expert 1.

Since 1994, the SA health system has grappled with allocating tasks to different levels, there has been overlap of roles and tasks (quote above) and the NHI is unlikely to resolve issues of coordination and function as its core focus has been on service delivery. While the NHIF is not meant to procure goods and services, there are important lessons for such institutions to consider. The NHIF is meant to separate the purchase and provision of health services (directly for health providers e.g. hospitals, districts).The fund will be a completely separate entity to present health structure with a single national pool of funds which will purchase health service on behalf of the entire population through CUPs for example. It is argued that as a single-payer the NHIF will be able to meet population needs. In addition, the NHI policy further argues that the benefits of central procurement of health services will result in other advantages e.g. price determination, risk/ fraud prevention and cost reduction of health services [35].

The policy has for example emphasised the role of the NHIF as a centralised body but it may not yield expected benefits. Findings from this thesis shows that re-centralisation of key

finance/ procurement tasks to the PSSC and later to the Provincial X Health Processing Centre (PHPC) (chapter 5) have not addressed persistent woes e.g. delayed procurement, districts experiencing difficulty in accessing available resources and no procurement of IT in Indawo district. The thesis pointed to weaknesses at both levels attributed to micro-level organisational factors (lack of hardware, software, agency) and broader contextual issues (political factors and legislations e.g. BBBEE). In fact, the NHI pays little attention to the broader SA context, the influence of political factors, transformation based on racial re-dress and its influences on the health system which clearly affects financial management for example. For the NHI to be successful it must consider the centralisation-decentralisation debate and strengthen each level of the health system to effectively carry out its tasks cognisant of these factors. Thus it is not merely the establishment of structures but their functionality which this thesis has shown is linked to the hardware, software and agency, particularly leadership. Often macro-level policies such as the NHI are not cognisant of organisational functioning and the impact of software elements, whereas this thesis has shown the importance of nurturing organisational elements e.g. motivation, relationships and communication for success. For the NHI to succeed, achieving functionality of existing structures in terms of these elements will be required and increased focus is required for strengthening support-functions such as financing and procurement (beyond just the NHIF and purchase of health services) which will clearly impact other areas of the NHI e.g. service delivery.

9.4 Limitations

There were five key constraints in terms of this doctoral study. The primary aim of this thesis was to provide an in-depth analysis of financial management in two districts. Through the snowballing sampling technique and emerging themes linked to financial management, several participants across procurement and IT were interviewed (this is also in line with the conceptual framework setting out to understand financial management in relation to the broader district). This showed the inherent interlinkages between support functions at a district level – finance, procurement and IT. However, only a few interviews were conducted in HR and thus while the study does touch on some themes, limited data has been collected and reported on the HR unit and its processes. In Indawo however, the HR component was

examined within a broader project in which the doctoral study was nested. Another colleague focussed substantially on the HR unit and its functions, additional information could be drawn on e.g. the display of agency and software in the HR unit (chapter 6). However this was not the case in Isikhala which had a limited HR specific focus. Yet elements closely linked to HR such as personal development, supervision, mentorship (leadership competencies) and trade unionism emerged from data in the finance unit in Isikhala (also considered to be software elements).

While, results may not be completely reflective of all sites in SA or in other LMIC's the study showed similar challenges noted in the literature especially around financial management, decentralisation weaknesses e.g. weak capacity and continued centralisation over key financial functions. The thesis did not aim to provide generalisable results, but rather rich in-depth accounts of decentralised experiences made possible through the use of qualitative study design and techniques. Although the analysis of case studies using structuration theory offered analytical generalisability of the two context and what it may offer for future studies. Data collection involved triangulation through two data techniques and rigour was ensured through thorough and detailed data analysis. Comparative analysis based on identifying similar themes within and between data for was useful in providing further depth to the study presenting room for the synthesis of qualitative results through documenting similarities and differences of financial management between two districts within the same province.

Limitations around the comparative analysis are linked to timing of ethical permissions which were granted at a district level. In some cases it was not possible to observe the same processes in both districts e.g. District Health Expenditure (DHER) processes. However, attempts were made to analyse documents retrospectively and probe a range of participants on the processes (section 3.5.2.2). In both districts, it was necessary to ensure that observed processes did not interrupt the natural environment and how observations would be carried out was negotiated between the researcher, ethics committees and district staff. In Indawo for example, the researcher was advised to LSM and attend meetings, whereas in Isikhala the researcher was invited to observe the entire finance team. Both districts did allow for

flexibility, such as attending impromptu meetings or to observe others besides the AD, if necessary. In some cases it would have been useful to attend other meetings in Indawo, though the district finance manager as the head of the unit advised the AD that the researchers' presence would not be required. Overall, the observation process yielded useful data which complemented in-depth interviews and allowed for a richer understanding of processes, practices and social relations between staff, particularly the everyday practices and organisational realities.

Section 3.6.1 discussed the implications of the researcher's positionality; being external to the system, as a possible influence on processes observed and maintaining objectivity. The literature states that reflexivity assists with issues related to positionality which may arise in the research [110]. Positionality was constantly reflected on throughout the research process-reflectivity, frequent feedback and discussions with supervisors regarding data collected, interpreted and researcher's role aided in addressing issues of positionality. The Hawthorne effect (section 3.5.1.2) was another limitation of the study – participants altering behaviour when being observed [105, 113]. It would be difficult for the thesis or any qualitative study to completely eliminate the Hawthorne effect. However, extensive observations were carried out, over time better relationships and trust was fostered between the participants and the transition to the participant observation phase in both districts indicated a shift of participants' views of the researcher, role and allowing the researcher detailed insight into their operational activities (reduced the Hawthorne effect).

Lastly, the study set out to understand decentralised financial management, particularly focusing on the district level however it was clear that district processes and practices were linked to broader issues (political) as well as centralisation over key financial functions such as payments. PDoH and its linkages to district finance were examined but not to the same extent of data collection at the district level. Moreover, district finance activities and processes were found to be constrained and not effectively carried out at sub-district levels e.g. sub-districts only given a day in both case-studies to provide budget inputs for either budget-shifting or increased allocation processes. This level was considered however not explored in-depth as in the case of the district.

9.5 Conclusion

A discussion of thesis findings in relation to existing literature and policy implications are presented in this chapter. The chapter provides a recap of the main objectives of the thesis and interrogates findings in relation to the duality of structure (structuration theory) which demonstrated its importance in explaining why dysfunctional financial management routines continue to be carried out at a district level. The chapter then turned towards an analysis of the centralisation-decentralisation debate, arguing that a lack of clarity of roles and coordination between different levels (district and province) is a persistent problem in the SA health sector. The chapter draws attention to the organisational weaknesses e.g., the lack of capacity at the district and province as well as broader contextual issues (politics, legislation). Section 9.3.1 in concludes with the implications of study findings in terms of managing resources and procurement under the NHI and outlining important considerations which must be taken forward for its implementation. Finally, limitations of the thesis were also discussed.

CHAPTER 10: CONCLUSION

10.1 Introduction

This chapter presents the final conclusion of the thesis, reflecting on objectives and key findings. The study contribution is outlined, specifically the theoretical and empirical contribution to the literature, policy and practice. This is followed by drawing out important lessons in strengthening district financial management – including policy/ strategic and specific practical recommendations.

10.2 Study Conclusion

The core aim of this thesis was to provide an in-depth comparative analysis of decentralised financial management between two health districts in South Africa (SA). The primary rationale for conducting the study is that developing countries in particular need to ensure the efficient use of resources. However, financial management challenges have continued to plague low-and-middle-income (LMIC) settings including the SA health sector e.g. bureaucracy, lack of skills and minimal authority [33, 54]. The Public Finance Management Act (PFMA), number 1 of 1999 puts in place standards for sound financial management in all government structures, although this thesis has shown that this is not necessarily the case in the SA context, especially at a district level. The study was centred on understanding why financial management as a core district function remains weak and adopts the argument that there has been much focus on macro-level processes instead of micro-level practices of an organisation including its social and human elements of the health system i.e. the socio-cultural perspective [9]. Chapter 2 details different theoretical approaches and gaps in the literature with the study adopting structuration theory from sociology (structure, agency – recap in box 8.1) and using health policy and systems research (HPSR) notions of hardware and software which evolved into the expanded structuration nexus. The nexus essentially argues that there is a continuous and interdependent relationship between structure, agency, hardware and software. The study considered how the financial management cycle and specific routines; planning, budgeting, resource allocation, oversight and evaluation were shaped by the structuration nexus. The literature further pointed towards the importance of understanding decentralisation phenomena in relation to centralisation (Provincial

Department of Health –PDoH) and considering contextual influences drawing extensively on public administration literature – the influence of politics, trade unions and the country's history in shaping present day financial management.

Merging the theoretical premise of the thesis with data collected and analysed has shown the weaknesses, strengths and possible areas to improve district financial management. Chapter 4-7 presents the main findings of the study, with chapter 8 offering a comparative and interpretive analysis of both districts. Initially, an understanding or overview of key tasks linked to the financial management cycle was provided (chapter 5) - planning, budgeting and resource allocation, oversight and evaluation. Findings in Indawo demonstrated poorly coordinated planning and budgeting processes in line with the culture of compliance, discussed in chapter 6 and 8. But there were differences in oversight, engagement and team efforts around these financial processes in Isikhala. The comparative analysis shows that there were problems linked to accessing available resources and poor expenditure tracking in both districts. Thus while both districts carried out routine finance tasks they were not necessarily effective. This leads to perhaps the most important contribution of the thesis – to understand why dysfunctional routines such as those described in chapter 6-8 (e.g. flawed expenditure tracking) continue to be carried out in the health system.

At the crux of this thesis has been to understand financial management practices through hardware, software, structure and agency. Chapters 6 and 7 outlined findings in this regard and reaffirmed previous perspectives in HPSR that both hardware and software factors are necessary for core functions within the health system. The lack of hardware factors such as Information Technology (IT) and software factors, such as motivation, communication and interpersonal relationships were pivotal in either reinforcing or transforming ineffective routines – the duality of structure. Chapter 8 particularly showed the importance of hardware and software in either enabling or constraining agency and displays of leadership which were critical to transformative practices – Isikhala better coordinated financial processes, clearly defined structures within the finance unit and the value of informal learning. The example from the Isikhala finance unit specifically, its managers (development of their leadership competencies) and teamwork within the unit offers a quintessential model and points to

possibilities of what can be achieved regarding financial management given the presence of such factors (e.g. software), other support functions and possibly more broadly within the health system.

Besides district level functionality, the present discourse and policy reforms advocated for are linked to decentralisation and there are few studies which focus on decentralisation in relation to centralisation. This thesis, while outlining and showing the importance of centralised bodies and contextual factors (politics, history), has been important in providing a comprehensive account of decentralisation. Financial management in particular has offered one such lens for thoroughly understanding decentralised experiences yet doing so in relation to the centralised level (PDoH) i.e. bringing to the fore the centralisation, decentralisation debate. Decentralisation and centralisation were shown to be interconnected in this thesis - financial routines such as approval of procurement requests or payment delays illustrated that both levels have clear weaknesses, moreover there is a lack of clarity around roles, coordination or communication within districts and between both levels.

This thesis reaffirms previous literature that the decentralisation process in SA has proved to be difficult to implement, although it is important to recognise that worldwide implementation has been complex and challenging [50]. Various sections of this thesis have pointed to the need of more comprehensive accounts of decentralisation experiences, which should be cognisant of contextual factors such as politics and history [14, 21]. There are few studies which offer such accounts. In line with previous studies, this thesis has found that contextual factors specifically linked to post-apartheid re-structuring in SA must be considered to redress past racial injustices, although there are associated challenges. There were noticeable influences with procurement affecting vendor selection costs escalation, or keeping poorly performing managers in the system and other financial routines (at both the province and the district). Such factors have rendered the decentralisation process more complex and difficult to implement. The thesis concludes that both the provincial and district level remain weak and that coordination and role clarity between the two levels remains a problem and must be resolved for financial management and for broader system functioning.

Section 9.3.1 in particular points to implications of study findings for SA's major health sector reform, the National Health Insurance (NHI). It has offered a critique of the NHI which needs to resolve coordination problems within the health sector and strengthen each level of the health system. Results indicate that there is already poor management of resources in the public health sector and the NHI will have to move towards addressing this. Although this thesis argues that it is unlikely to do so as it has made little progress with support-side functions in pilot sites and lacks adequate details around the roles and functions of different levels of the health system. To illustrate this, the thesis has discussed the National Health Insurance (NHI) policy which introduced and outlines the aim of the NHI Fund (NHIF). The NHIF is to be a separate centralised body aiming to pool resources to purchase health services, achieve economies of scale and reduce costs substantially in the health sector. As discussed in chapter 9, the NHIF may not necessarily resolve system woes and overlooks procurement of goods and services. A similar rationale was advocated for the re-centralisation of some finance and procurement functions to PDoH in 2009, yet these benefits have not been realised due to the provincial level itself lacking software factors such as capacity and being influenced politically. Additionally, the shifts between centralisation and decentralisation of tasks e.g. procurement/ payment of suppliers has resulted in a lack of role clarity and coordination and the NHI has little focus aimed at resolving such issues. This thesis argues that policy reforms such as the NHI must instead focus on ensuring that existing structures function effectively, allocating tasks to the level which will yield the most benefit (centralisation to achieve economies of scale and decentralisation to meet local needs) and that coordination between different levels of the health system is still critical and needs to be urgently addressed. Because and as shown in this thesis, expenditure tracking challenges persist at both the district and provincial level, there is little coordination and capacity (institutional knowledge and leadership capacity) to transform such expenditure tracking practices thus rendering the rest of the financial management ineffective (planning, resource allocation, budgeting). Thus other than establishing structures and associated tasks, functioning and strengthening of each level is equally important.

In conclusion, this thesis argues that for too long discourse and policies have focussed on decentralisation, without considering it in relation to other levels of the health system. Every

system requires both centralised and decentralised levels and functions (discussed in section 9.3) [55]. Difficulties have been reported at the district and provincial levels, there is a lack of functionality of each level due to hardware and software factors, contained agency and re-enforcing dysfunctional routines but also contextual factors which the system will need to content with – politics, legislations (Broad Based Black Economic Empowerment –BBBEE) taking precedence over poor performance or cost-effectiveness. The significance of this thesis lies in not only documenting challenges and weaknesses at both levels, but offering theoretical knowledge coupled with practical strategies to facilitate effective financial management. It is clear that the structuration nexus permits an understanding of the ways in which units function and reveals why challenges persist.

10.3 Contribution of the Study

This thesis has contributed to insights around financial management in light of decentralisation experiences, both theoretically and empirically its findings are relevant to the current policy context in SA. The literature has noted that decentralisation analysis often neglects contextual factors (politics, history) and the functioning of decentralised levels in relation to centralised bodies (province or national) [19, 25]. This thesis was cognisant of these gaps and attempted to understand decentralised financial management in light of this. More so, it has been noted that in the SA context, other than Von Holdt (2007 and 2010) there are few other studies in the public administration domain which considers SA's past, its implications on post-apartheid restructuring and present-day functioning of these institutions, especially in relation to healthcare [50]. This thesis has interrogated these findings and contributes to this body of public administration literature, particularly focussing on the district health system. In offering a comprehensive analysis of financial management, through consideration of centralised levels it has allowed for linkages to Perrow's (1977) work on the importance of having both centralisation and decentralisation within a system, and stresses the coordination and clarity of roles between different levels of the health system.

The HPSR field emphasises the need and value of theory-driven research [76]. Perhaps, the most notable contribution of this study is offered by its conceptual framework, which offers a multi-disciplinary perspective to understanding organisational realities, the everyday

financial management routines and associated challenges/ successes through a theory-driven approach. The conceptual framework (figure 2.3) brings together sociological and HPSR perspectives to formulate what the thesis has deemed and proven to be necessary elements for effectively functioning organisation i.e. a social-cultural perspective. The thesis offers a compelling and reflective account of adopted theories in relation to actual financial practices and its improvement.

Existing research and this thesis indicate that financial management challenges, particularly at a district level have persisted for close to two decades in SA. This thesis unpacks why ineffective financial management routines continue to be carried out. The comparative analysis yields insight into organisational factors - hardware, software, structure and agency, particularly agency and leadership which is important to transform ineffective processes. These findings extend to both districts and PDoH which points to the need for urgent functionality and strengthening of each level of the health system – which as discussed the NHI fails to consider.

The contribution of the thesis through its focus on agency has resulted in useful insight into a critical area of HPSR as well as practical ways and strategies of fostering leadership in LMIC settings which is largely attributed to informal learning (chapter 6, HSM HR and chapter 7 finance LSMs). Informal learning remains a largely undocumented and unexplored area within health systems, though findings particularly from Isikhala emanating from this thesis showed how it is possible to be fostered and its positive influences in dealing with system constraints and nurturing leadership which is necessary to transform ineffective financial management processes, linked to innovations and manoeuvring constraints (see chapter 6, 8).

In carrying out a comparative analysis, study findings and conclusions are strengthened; further showing similarities and differences of carrying out routine financial tasks between two districts in the same province in SA. Even though one of the limitations of qualitative research is difficulties around generalisation, it was interesting to see the reaffirmation of theoretical underpinnings in this work and empirical evidence extending across both sites.

10.4 Recommendations

Recommendations from this monograph are divided into broader policy/ strategic directions, need for further research and practical recommendations, particularly around financial management and procurement and the country's major policy reform (NHI).

Practical recommendations- Several challenges linked to procurement, finance and IT have been identified and there are practical areas which need to be considered. Detailed in chapter 4 (section 4.6) three checks/ controls are put in place during the procurement process.

- The first check, district authorisation based on budget availability, tends to occur with little consideration of budget availability especially given that health needs of the population must to be met despite clearly set out guidelines in the PFMA 1999. There should to be re-consideration of the challenges of the first check - budget control and its implications for health departments meeting service delivery needs yet operating within available budgets/ financial management.
- Problems associated with the third financial check (tracking expenditure) have also been listed, including a loss institutional memory, provincial delays on updating systems; IT challenges to access systems and a breakdown of provincial support to district finance. These should be addressed.
- Finally, end-users at the district and sub-district level noted that it is difficult to plan or budget as they do not have access to pricelists or direct access to vendors. Presently, end-users need to request all quotations through the district's procurement unit, lower levels may be able to budget and plan more effectively should they have direct access to quotations or a standard pricing of items (or find ways of ensuring a quicker turnaround time).

Policy/ strategic - For polices such as the NHI to succeed it is clear that there is an urgent need to re-visit the centralisation decentralisation debate in terms of complementarity of financial management and other tasks e.g. for the NHIF. It will be important to address structural weaknesses (e.g. capacity/ lack of institutional memory and leadership) at both provincial and district level followed by better coordination, communication and support of tasks. It is imperative to ensure that personnel have the requisite skills (hardware) to effect

this systems change. In moving towards implementation of NHI and decentralisation, it is crucial for focus to be placed on organisational functioning, allocating tasks to the level which would be most beneficial (provincial for economies of scale and district to meet local needs); role clarity and coordination remain crucial to achieving this. Findings from districts and PDoH have shown that there are contextual issues the system needs to contend with e.g. political, transformation agenda (policies around racial redress) and their impact/ role on the health system.

Further research - The study highlighted the importance of agency and leadership in dealing with constraints. The significance of informal learning and practical strategies in the Isikhala district has provided insight into how agency and specifically leadership competencies can be developed (chapter 6, 8) and is an area for further research identified in the literature. The thesis has shown several displays of leadership and agency in both districts which enabled positive system change (transforming practices) and manoeuvring system constrains e.g. limited IT or limited resources. Furthermore, research, policy and practice needs to be cognisant of these micro-level practices to improve district financial management.

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APPENDICES

APPENDIX A: LIST OF KEY DOCUMENTS REVIEWED

1. Strategic Plans:

   -District Health Plan.

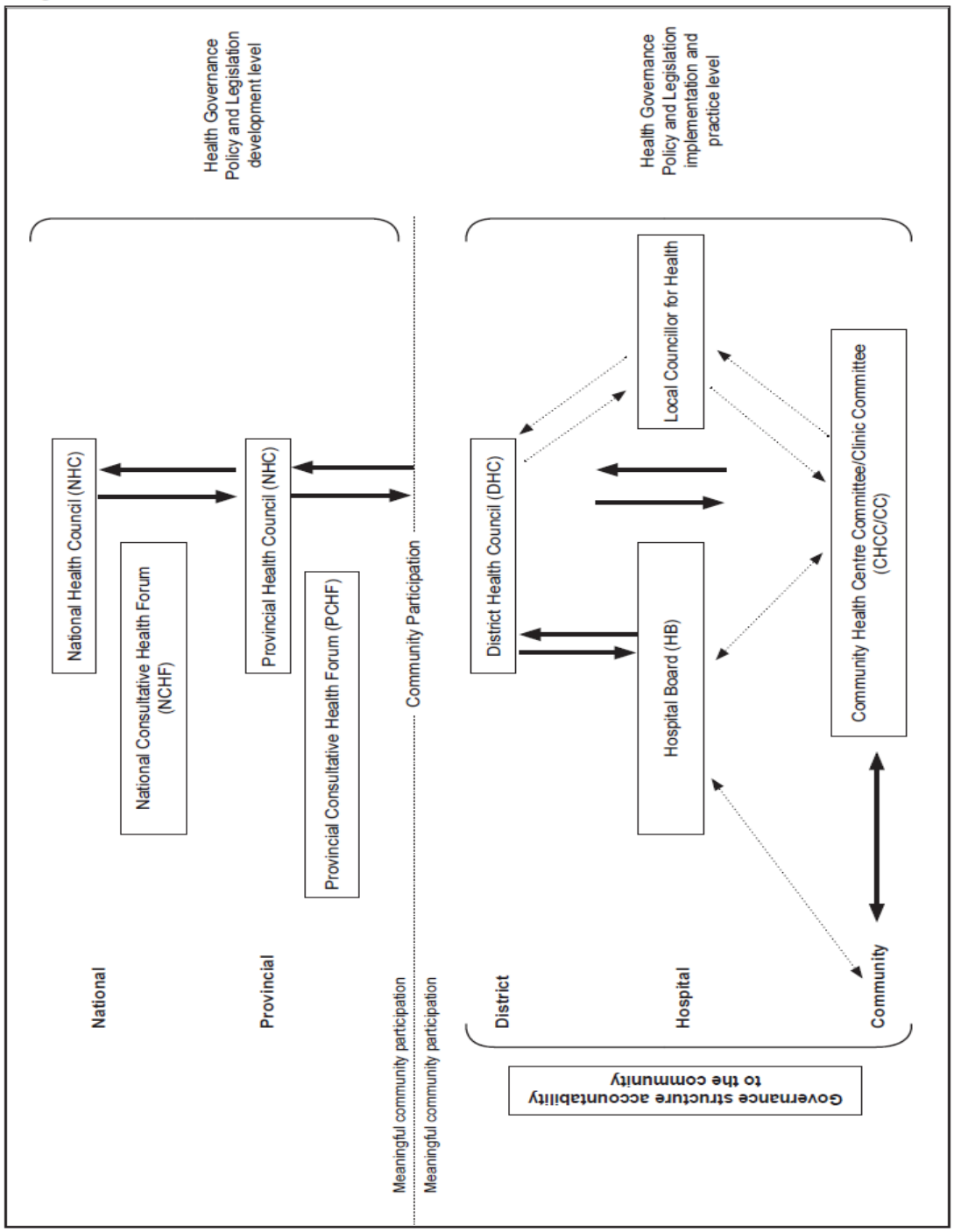
   -Annual Performance Plan.

   -Integrated Development Plan (IDP).
2. District Health Expenditure Reviews (DHER).
3. Job descriptions of key participants.
4. Records/minutes of meetings.

APPENDIX B: STRUCTURE OF THE SOUTH AFRICAN HEALTH SYSTEM

(CHP Broader Project tools adapted for the study).

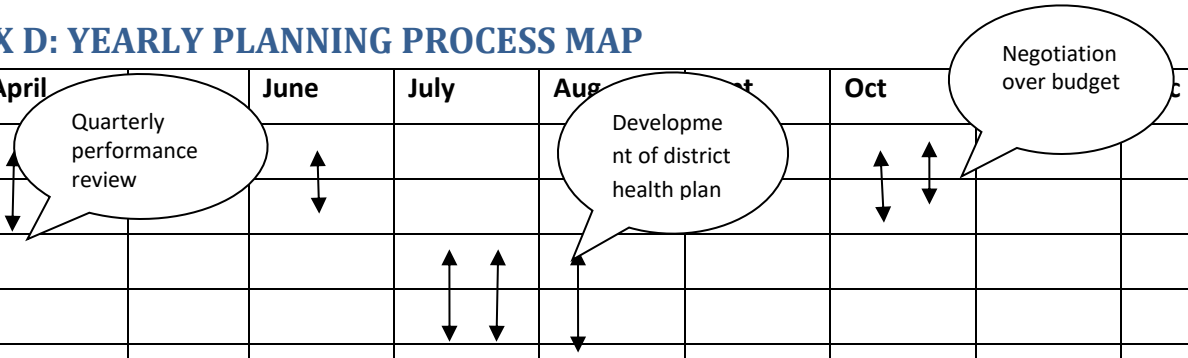
Diagram 1: Governance structures flow chart



APPENDIX C: ANNUAL PLANNING, MONITORING AND BUDGETING CYCLE

		Apr	May	Jul	Aug	Sept	Oct	Jan	Mar
Planning	Strategic Plans				1st Draft		2nd Draft		Final
	Annual Performance Plan				1st Draft		2nd Draft		Final
	District Health Plans			1st Draft		2nd Draft			Final
Budgeting	Provincial Budgets and MTEF		NT issues MTEF Instructions		1st Draft Budgets		2nd Draft Budgets	Final Budgets	
	District Budgets and MTEF		DHER	1st Draft budget		2nd Draft budget		Final budget	
Monitoring and Reporting	Provincial Quarterly Performance Report	2nd Week		2nd Week			2nd Week	2nd Week	
	District Quarterly Performance Report	1st week		1st week			1st week	1st week	
	District Quarterly Performance Reviews	conducted		conducted			conducted	conducted	
	Provincial Annual Performance Reviews		Conducted						
	District Annual Performance Review and DHER	Conducted							
	Provincial Annual Report		Submitted to AG						
	District Annual Report	Submitted to Province							

APPENDIX D: YEARLY PLANNING PROCESS MAP



	April		June	July	Aug		Oct			Jan	Feb	March
Province												
District												
Sub-district												
Facility												
Summary of descriptions of engagements	Assessments felt to be unfair				Focus is on national priorities, rather than local ones							

APPENDIX E: INTERVIEW SCHEDULES- DISTRICT & SUB-DISTRICT

(CHP Broader Project tools adapted for this study).

Interview method

The approach taken in the interviews will be to summarise the scope of the interview using a 'grand tour' question, and then allow the interviewee to take the lead and describe the processes, events, interactions that s/he thinks is relevant to the topic. The approach allows a free flow of ideas and thoughts. The interviewer will have a list of prompts to use when necessary. (Whereas, if the interviewer has a very specific set of questions, there is often a pressure to work through the whole list, allowing only short answers, and little opportunity for the interviewee to develop a train of thought).

Interview 1.A: Overall roles of individuals and meetings/ interaction)

Stimulus:

Structure of the South African health system (appendix b). Annual planning, monitoring and budget cycle (appendix c). Yearly planning process map (appendix d).

After being shown the stimulus (appendix c), participants will be asked the grand tour question and along with the researcher draw an actor map.

Grand tour question 1 (actor mapping):

I am interested in understanding how the district (or sub-district) functions. For this interview, I would like to understand who all the people are in the district (or sub-district), what their different roles are, and importantly where you fit into the picture, and who you interact with. Can we possibly draw a picture, with you in the centre? I have these lines to represent the different levels (district, sub-district), so we can make it clear on the picture who is at what level. I would like us to record job titles of those you interact with, how often you communicate with these individuals, whether they report to you or you report to them, as well as which relationships are strong and productive and which are more difficult?

Prompts:

- Overall role
- Daily Activities
- Hierarchy.
- Frequency of communication (daily, weekly, monthly).
- Medium of communication (e-mail, telephone, face-t-face).

After being shown the stimulus (appendix D and E), participants will be asked the grand tour question and along with the researcher draw a meeting map.

Grand tour question 2 (meeting map):

Can we now draw another diagram to represent the different regular meetings that happen, making it clear which ones you attend. So again this piece of paper has lines for the different levels. Let's draw a rectangle to represent each regular meeting, let's write in the box who attends, and frequency of the meeting, and sorts of issues discussed.

Perhaps it would be useful to start with the most important meetings, followed by the less important ones and also attend how these meetings link up. It would also be useful to know that outside of these meetings who are some of the main people you interact with, and how would you describe your relationship with them?

Prompts:

- In the last year?
- Compulsory meetings?
- Frequency (daily, weekly, monthly)?
- Who attends?
- Purpose/ what happens?
- Where do you meet?
- Are meetings usually formal or informal?
- Decision-making in meetings?
- Challenges?

Interview 1.B: Background, skills, motivations and experiences - daily activities.

Grand tour question 1

In this interview, I would like to get to know more about your role here and why you came to work here in the district/sub-district. For instance, it would be useful if you could share information such as your educational background and the type of skills you have. What motivated you to take up this job and what motivates you to stay here, perhaps you could even tell me where you see yourself in terms of your career in the next few years.

Prompts:

- Qualifications?
- Additional training.
- Work experience?
- Career changes?
- Why did you leave?
- Where do you see yourself in the next few years/ career plans?

Grand tour question 2

In the last interview you outlined your overall role in the district, in this interview I would like to get an understanding of what is it that you do on a day to day basis, who you interact with on a daily basis and how would you describe your relationship with these individuals. Perhaps we could focus on what every day is like for you; from the time you come in until you leave. It would also be useful to know how you manage your workload on a daily basis, what are some of the challenges you face and which aspects of your job would you say you enjoy.

Prompts:

- Current job description.
- Workload practical?
- Daily activities.

- Relationships, productive or difficult?
- Job satisfaction. What is it for find most satisfying about this job? Why is it you Find more challenging and/or dissatisfying about this job?

Follow-up interview 1:

Actor Map drawn in interview 1

Meeting Map drawn in interview 1

- Both maps used as stimuli and ask for any missing information identified (e.g. frequency, attendees, issues discussed).

Request for documents:

In the next interview, I am interested in understanding the planning, resource allocation and budgeting processes which take place. In preparation for the next meeting it would be extremely helpful if you could provide me with some of the documents which you know of, or use which could help me understand these processes ahead of our next meeting. Based on these documents perhaps you would like to also like to think of particular areas or programmes for our next meeting which you would like highlight.

Interview 2: Insight into financial management processes (planning, budgeting and resource allocation).

Stimulus:

Structure of the South African health system (appendix B). Annual planning, monitoring and budget cycle (appendix C). Yearly planning process map (appendix D), actor and meeting maps from previous interview.

After being shown the stimulus material, participants will be asked the grand tour question, followed by describing and filling in processes onto a yearly planning process map (appendix D).

Grand tour question 1:

My understanding of financial management is that it includes four broad processes to manage resources. The four processes include planning, resource allocation and budgeting, oversight and evaluation. I am new to this field; I do not know what each of these processes at the district entails and if there are any other processes. I am interested in your understanding of what financial management is, how it actually happens and if there are any other processes in addition to the ones that I mentioned.

In this interview, I would like to concentrate on how planning, resource allocation and budgeting actually happen. Let's focus on the last year (2014/2015) and what was your role in these processes. Could you take me through how and when these processes take place to fill out this annual planning, monitoring and budgeting cycle.

Prompts:

- Templates/ legislations/ guidelines used?
- Usefulness of templates/ legislations/ guidelines.
- Financial resources?
- What happened next?
- Who's involved?
- Planning processes.

- Resource allocation processes.
- Budgeting processes.
- Key documents?
- Key meetings (frequency, issues discussed)?
- Your role?
- Who makes these decisions?
- Processes linked?
- Any turning points/ critical incidents?
- Challenges during these processes?

Interview 3: Insight into financial management processes (oversight and evaluation).

Stimulus:

Structure of the South African health system (appendix B).

Annual planning, monitoring and budget cycle (appendix C).

Yearly planning process map (appendix D)

Actor and meeting maps from previous interview.

After being shown the stimulus material, participants will be asked the grand tour question,

Followed by describing and filling in further information onto the yearly planning process map (appendix D).

Grand tour question:

Now that I have a better understanding of the planning, resource allocation and budgeting processes, I would like to know more about how oversight and evaluation takes place. Drawing on the map we filled in the last time (annex 8) it would be really useful if you could describe the how and when these processes take place. From our previous meeting, I know that your job is x, so how were you involved in these processes. Considering that these are the last two processes in the financial management cycle, I would like to understand how all of these processes come together, and how are they used for the next financial year.

Prompts:

- Templates/ legislations/ guidelines used?
- Usefulness of templates/ legislations/ guidelines.
- What happened next?
- Whose involved?
- Key documents?
- Key meetings (frequency, issues discussed)?
- Your role?
- Who makes these decisions?
- Oversight processes?
- Overspending/ underspending?

- Other processes (human resources, procurement).
- Processes linked?
- Any turning points/ critical incidents?
- Challenges?

Interview 4. A: Performance management experiences-being managed

Grand tour question 1: processes, experiences, conversations being managed.

In trying to understand more about the experiences of working at the district (including the sub-district and in facilities), I would like to understand performance management processes and experiences, particularly how you are performance managed and how do you performance manage others. For now, let's focus on how you are managed. In this post, what role does your manager play in managing you? How does your manager deal with your day-to-day activities and how does your relationship work? I would like for our discussion today, to talk about how conversations happen between you and your manager, and if there were any instances of tension or where you were dissatisfied with your manager.

Prompts

- Performance management processes?
- Monitoring & evaluation of the processes?
- Mechanisms of support? Example
- Nature & frequency of engagement with person/people who manages you?
- Collective or autocratic? Example
- Is self-organisation encouraged? Example
- Is support provided when needed? Example
- How does a conversation play out between you and your manager? Example
- How has your manager dealt with tension? Example
- How has your manager dealt with change? Example
- How has your manger helped you mange uncertainty? Example
- Are you given space to voice your own opinion? Example
- Challenges.

Interview 4. B: Performance management experiences-managing others

Grand tour question 1: processes, experiences, conversations, managing others.

Now, let's focus on how you manage others. I am interested in knowing more about your management strategy, your experience of managing others and how this has played out. In the actor map that we used previously, you told me that you supervise X number of people, can you please tell me about your relationship with these people, how do you manage them and what sorts of conversations do you have with them. I am now interested in how the conversations happen when you manage all those people that you told me about. Again, talk about how you have had to deal with tension as the manager or when you have been unhappy about how the person you have managed had responded to your decisions.

Prompts:

- Performance management processes?
- Nature & frequency of engagement with the person/people you manage?
- Collective or autocratic? Example
- Is self-organisation encouraged?
- Is support provided when needed?
- How does a conversation play out between you and the people that you manage? Example
- How have you as a manager dealt with tension? Example
- How have you helped the people that you manage to deal with uncertainty? Example
- How do you ensure that you provide the people that you manage space to voice their own opinion? Example

APPENDIX F: INTERVIEW SCHEDULES - EXTERNAL STAKEHOLDERS

(GDoH and NGOs)

Interview 1: Meetings and Interaction

Stimulus:

- Structure of the South African health system (appendix c).

After being shown the stimulus (appendix c), participants will be asked the grand tour questions and along with the researcher draw an actor map and a meeting map.

Grand tour question 1: organogram (actor map)

After having interviewed numerous individuals at the district and sub-district I understand that you are involved in guiding and supporting financial management. I am interested in understanding you fit into the district's financial management, who you interact with at the district and then how you support the district, perhaps also highlighting some of the challenges you face. To understand how you fit into the district, I would like to understand what your overall role particularly in terms of financial management at the district.

Can we also possibly draw drawing a picture or organogram, with you in the centre. I have these lines to represent the different levels (national, district, sub-district), so we can make it clear on the picture who is at what level and how they are linked to you. I would like us to record job titles of those you interact with, how often you communicate with these individuals, whether they report to you or you report to them.

Prompts:

- Your role?
- Frequency (daily, weekly, monthly)?
- Medium of communication (e-mail, telephone, face-to-face)?
- Challenges?

Grand tour question 2:

It would be useful to understand how you interact with these individuals, particularly in terms of the meetings you have with them. This piece of paper has lines for the different levels; national, district and sub-district. Let's draw a rectangle to represent each regular meeting, let's write in the box who attends, and frequency of the meeting, and sorts of issues discussed. Perhaps it would be useful to start with the most important meetings, followed by the less important ones and also highlight how these meetings link up. I am also interested in knowing who you interact with outside of these meetings, who are some of the main people you interact with, and how do you offer support to them. Reflecting on your relationship with these individuals or these meetings are there any incidents positive or negative which stand out in your mind and which you would like to discuss with me.

Prompts:

- Frequency (daily, weekly, monthly)?
- Who attends?
- Where meetings are held (district, province, and NGO offices)?
- Purpose?
- Decision-making?
- Whose involved?
- Your role?
- Challenges?

Interview 2: Involvement and support, district financial management processes

Stimulus:

- Appendix D: Annual Planning, Monitoring and Budgeting Cycle.

  After being shown the stimulus participants will be asked the grand tour question and along with the researcher fill in appendix D.

Grand tour question:

My understanding of financial management is that it includes four broad processes to manage resources. The four processes include planning, resource allocation and budgeting, oversight and evaluation. I am new to this field; I do not know what each of these processes at the district entails and if there are any other processes. I am interested in your understanding of what financial management is, how it actually happens and if there are any other processes in addition to the ones that I mentioned. In this interview, I would like to concentrate on your knowledge of how these processes actually happen and how are documents (templates), policies and legislations actually used in these processes. Could you take me through your how and when these processes took place to fill out this annual planning, monitoring and budgeting cycle document. Perhaps let's focus on the last year (2014/2015) and what was your role in these processes

Prompts:

- Your role?
- Planning processes?
- Budgeting?
- Resource allocation?
- Oversight?
- Evaluation processes?
- Other processes (human resources, procurement)?
- Whose involved?
- Key meetings?

- What happens when there is over or underspending.
- Decision-making?
- Support to district?
- Critical incidents (turning points)?
- Challenges?

APPENDIX G: OBSERVATION CHECKLIST

Meetings: *(Reflections of observations will be recorded in the research diary)*

Where permission is granted the following will be observed during meetings through participant and non-participant observation:

1. Sense of meeting in the beginning and end.
2. Who attends the meeting?
3. Which attendees interact with each other the most during the meeting?
4. Which individuals find it difficult to interact during the meeting?
5. Which attendees are outspoken during the meeting.
6. Who makes decisions / displays authority?
7. Who chairs the meetings?
8. What issues are discussed during meetings?
9. Describe the venue where meetings are held, is it in close proximity to attendees, is it comfortable, what is the seating arrangement and does it facilitate interaction?
10. What is the length of the meetings?
11. Do attendees arrive late or leave early, if so who?
12. Are meetings documented?
13. Are issues from the last meetings discussed or followed up?
14. Are these meetings formal or informal?
15. What type of terminology is used in meetings?
16. Are there any tensions which arise, how are these dealt with?
17. What changes arise as a result of these meetings, or are there any instances of innovation?

Job Shadow *(Reflections of observations will be recorded in the research diary)*

1. What are some of the daily financial management activities of individuals?
2. Are policies, legislations, guidelines used to carry out daily financial management tasks?

3. What are some of the tensions that arise, or the challenges the individual faces while carrying out financial management tasks.
4. Does the individual have adequate resources in the work space (computer, relevant software, telephone, internet, printer, and photocopier)?
5. Does the workspace facilitate or hamper interaction with others?
6. Who interacts with the participant regularly and irregularly?
7. What medium of interaction is used (telephone, e-mail, face-to-face)?
8. Does the individual display any innovation?

APPENDIX H: INFORMATION SHEETS AND CONSENT FORM

Information sheet for interview 1.A: overall roles of individuals, meetings & interaction

Formal Title: Governance in the South African Health Sector: An In-depth Comparative Analysis of Financial Management at a District

What is this doctoral (PhD) research about?

My name is Shakira Choonara. I work for the Centre for Health Policy (CHP) at the University of the Witwatersrand and also pursuing doctoral studies (PhD) in the School of Public Health, University of the Witwatersrand.

With regards to this PhD research, I am interested in understanding actual financial management processes and practices in two districts in province x (Indawo and Isikhala district). Financial management in this study refers to four processes which will be examined (planning, resource allocation and budgeting, oversight and evaluation). This study seeks to understand the actual financial management processes and practices which take place, the individuals involved in these processes and practices at the district, what people actually do, how they do it, why they do it, and what are some of the challenges. In today's interview, we will be focusing on you as an individual, what is your role in the district, what are some of your career goals and who you interact with at the district

I will be talking to a range of people at province, district and sub-district in (Indawo and Isikhala district), and in health centres and clinics. When the work is finished we will combine all the information and feedback the findings to local and national leaders and health care managers. We would like to interview you for this research.

[Where taping]: If you agree, the discussion will be tape-recorded to assist later in fully writing up the information. No-one will be identified by name on the tape.

Voluntary Participation

Participation in this study is voluntary. If you agree to help with this research and later change your mind you are free to withdraw at any time. The discussion should take approximately one hour.

Confidentiality

We are not here to inspect or audit the facility. The information will be used for research purposes only. All the data will be owned by CHP and the School of Public Health, University of the Witwatersrand. Recorded information (written and tape recorded) will be kept in a secure place under lock and key for a period of two years at CHP offices. Thereafter all information will be destroyed. No one other than the main researchers (Shakira Choonara and supervisors, Dr Jane Goudge, Dr Nonhlanhla Nxumalo and Professor John Eyles) **will** be allowed to see or have access to the recorded material and the transcripts. Names of interviewees will not be included and will be kept separate from written transcripts. We will not disclose your identity, or use your name in any reports of this work. The knowledge gained from this research will be shared in summary form, without revealing individuals' identities.

Approval for and benefits of this work

The study has been approved by the Human Research Ethics Committee (Medical) at the University of the Witwatersrand, province x and (Indawo and Isikhala district). The study will contribute new ideas and insights to possibly improving financial management at a district health level.

There are no benefits for participating in the study.

What if I have any questions?

You are free to ask me any question about this research. If you have any further questions about the study, you are free to contact the researcher(s) below:

1. Researcher-Shakira Choonara

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011 717 3438/071 363 3778 or Shakira.Choonara@wits.ac.za

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Telephone / Cell phone/ E-mail:
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Information sheet (district & sub-district) for interview 1.a: overall roles of individuals & meetings/ interaction

Formal Title: Governance in the South African Health Sector: An In-depth Comparative Analysis of Financial Management at a District

What is this doctoral (PhD) research about?

My name is Shakira Choonara. I work for the Centre for Health Policy (CHP) at the University of the Witwatersrand and also pursuing doctoral studies (PhD) in the School of Public Health, University of the Witwatersrand.

With regards to this PhD research, I am interested in understanding actual financial management processes and practices in two districts in province x (Indawo and Isikhala district).). Financial management in this study refers to four processes which will be examined (planning, resource allocation and budgeting, oversight and evaluation). This study seeks to understand the actual financial management processes and practices which take place, the individuals involved in these processes and practices at the district, what people actually do, how they do it, why they do it, and what are some of the challenges. In today's interview, we will be focusing on your role in the district, what are some of your career goals and who you interact with at the district and what are some of the key meetings which you attend.

I will be talking to a range of people at province, district and sub-district in (Indawo and Isikhala district) and in health centres and clinics. When the work is finished we will combine all the information and feedback the findings to local and national leaders and health care managers. We would like to interview you for this research.

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<u>Voluntary Participation</u>

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Approval for and benefits of this work

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There are no benefits for participating in the study.

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Information sheet (district & sub-district) for interview 1.b: background, skills, motivations and experiences - daily activities.

Formal Title: Governance in the South African Health Sector: An In-depth Comparative Analysis of Financial Management at a District

What is this doctoral (PhD) research about?

My name is Shakira Choonara. I work for the Centre for Health Policy (CHP) at the University of the Witwatersrand and also pursuing doctoral studies (PhD) in the School of Public Health, University of the Witwatersrand.

With regards to this PhD research, I am interested in understanding actual financial management processes and practices in two districts in province x (Indawo and Isikhala district). Financial management in this study refers to four processes which will be examined (planning, resource allocation and budgeting, oversight and evaluation). This study seeks to understand the actual financial management processes and practices which take place, the individuals involved in these processes and practices at the district, what people actually do, how they do it, why they do it, and what are some of the challenges. In today's interview, we will be focusing on you as an individual, your work experience and qualifications, your motivations, some of your career goals and explaining what every day is like for you in your current role at the district.

I will be talking to a range of people at province, district and sub-district in (Indawo and Isikhala district), and in health centres and clinics. When the work is finished we will combine all the information and feedback the findings to local and national leaders and health care managers. We would like to interview you for this research.

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Voluntary Participation

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Approval for and benefits of this work

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There are no benefits for participating in the study.

What if I have any questions?

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Information sheet (district & sub-district) for interview 2: insight into financial management processes (planning, budgeting and resource allocation)

Formal Title: Governance in the South African Health Sector: An In-depth Comparative Analysis of Financial Management at a District

What is this doctoral (PhD) research about?

My name is Shakira Choonara. I work for the Centre for Health Policy (CHP) at the University of the Witwatersrand and also pursuing doctoral studies (PhD) in the School of Public Health, University of the Witwatersrand.

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I will be talking to a range of people at province, district and sub-district in (Indawo and Isikhala district), and in health centres and clinics. When the work is finished we will combine all the information and feedback the findings to local and national leaders and health care managers. We would like to interview you for this research.

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There are no benefits for participating in the study.

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Information sheet (district & sub-district) for interview 3: insight into financial management processes (oversight and evaluation)

Formal Title: Governance in the South African Health Sector: An In-depth Comparative Analysis of Financial Management at a District

What is this doctoral (PhD) research about?

My name is Shakira Choonara. I work for the Centre for Health Policy (CHP) at the University of the Witwatersrand and also pursuing doctoral studies (PhD) in the School of Public Health, University of the Witwatersrand.

With regards to this PhD research, I am interested in understanding actual financial management processes and practices in two districts in province x (Indawo and Isikhala district).). Financial management in this study refers to four processes which will be examined (planning, resource allocation and budgeting, oversight and evaluation). This study seeks to understand the actual financial management processes and practices which take place, the individuals involved in these processes and practices at the district, what people actually do, how they do it, why they do it, and what are some of the challenges. In today's interview, we will be focusing on the oversight and evaluation processes which take place at the district, how they happen, what are some of the challenges and your role in these processes.

I will be talking to a range of people at province, district and sub-district in (Indawo and Isikhala district), and in health centres and clinics. When the work is finished we will combine all the information and feedback the findings to local and national leaders and health care managers. We would like to interview you for this research.

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Approval for and benefits of this work

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There are no benefits for participating in the study.

What if I have any questions?

You are free to ask me any question about this research. If you have any further questions about the study, you are free to contact the researcher(s) below:

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Information sheet (district & sub-district) for interview 4.a: performance management experiences- being managed.

Formal Title: Governance in the South African Health Sector: An In-depth Comparative Analysis of Financial Management at a District

What is this doctoral (PhD) research about?

My name is Shakira Choonara. I work for the Centre for Health Policy (CHP) at the University of the Witwatersrand and also pursuing doctoral studies (PhD) in the School of Public Health, University of the Witwatersrand.

With regards to this PhD research, I am interested in understanding actual financial management processes and practices in two districts in province x (Indawo and Isikhala district). Financial management in this study refers to four processes which will be examined (planning, resource allocation and budgeting, oversight and evaluation). This study seeks to understand the actual financial management processes and practices which take place, the individuals involved in these processes and practices at the district, what people actually do, how they do it, why they do it, and what are some of the challenges. In today's interview, we will be focusing on how you are performance managed in your current position at the district and what are some of your experiences.

I will be talking to a range of people at province, district and sub-district in (Indawo and Isikhala district), and in health centres and clinics. When the work is finished we will combine all the information and feedback the findings to local and national leaders and health care managers. We would like to interview you for this research.

[Where taping]: If you agree, the discussion will be tape-recorded to assist later in fully writing up the information. No-one will be identified by name on the tape.

Voluntary Participation

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Approval for and benefits of this work

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There are no benefits for participating in the study.

What if I have any questions?

You are free to ask me any question about this research. If you have any further questions about the study, you are free to contact the researcher(s) below:

1. Researcher-Shakira Choonara

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Information sheet (district & sub-district) for interview 4.b: performance management experiences-managing others).

Formal Title: Governance in the South African Health Sector: An In-depth Comparative Analysis of Financial Management at a District

What is this doctoral (PhD) research about?

My name is Shakira Choonara. I work for the Centre for Health Policy (CHP) at the University of the Witwatersrand and also pursuing doctoral studies (PhD) in the School of Public Health, University of the Witwatersrand.

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I will be talking to a range of people at province, district and sub-district in (Indawo and Isikhala district), and in health centres and clinics. When the work is finished we will combine all the information and feedback the findings to local and national leaders and health care managers. We would like to interview you for this research.

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We are not here to inspect or audit the facility. The information will be used for research purposes only. All the data will be owned by CHP and the School of Public Health, University of the Witwatersrand. Recorded information (written and tape recorded) will be kept in a secure place under lock and key for a period of two years at CHP offices. Thereafter all information will be destroyed. No one other than the main researchers (Shakira Choonara and supervisors, Dr Jane Goudge, Dr Nonhlanhla Nxumalo and Professor John Eyles) **will** be allowed to see or have access to the recorded material and the transcripts. Names of interviewees will not be included and will be kept separate from written transcripts. We will not disclose your identity, or use your name in any reports of this work. The knowledge gained from this research will be shared in summary form, without revealing individuals' identities.

Approval for and benefits of this work

The study has been approved by the Human Research Ethics Committee (Medical) at the University of the Witwatersrand, province x (Indawo and Isikhala district). The study will contribute new ideas and insights to possibly improving financial management at a district health level.

There are no benefits for participating in the study.

What if I have any questions?

You are free to ask me any question about this research. If you have any further questions about the study, you are free to contact the researcher(s) below:

1. Researcher-Shakira Choonara

Centre for Health Policy

Address: 3rd Floor, School of Public Health Building

Education Campus, University of the Witwatersrand

27 St Andrews Road
Parktown 2193
Johannesburg
Telephone / Cell phone/ E-mail:
011 717 3438/071 363 3778 or Shakira.Choonara@wits.ac.za

2. Supervisor-Dr Jane Goudge

Centre for Health Policy
Address: 3rd Floor, School of Public Health Building
Education Campus, University of the Witwatersrand
27 St Andrews Road
Parktown 2193
Johannesburg
Telephone / Cell phone/ E-mail:
011 717 3425/083 616 0041/ Jane.Goudge@gmail.com

Information sheet (external stakeholders) for interview 1: meeting and interaction

Formal Title: Governance in the South African Health Sector: An In-depth Comparative Analysis of Financial Management at a District

What is this doctoral (PhD) research about?

My name is Shakira Choonara. I work for the Centre for Health Policy (CHP) at the University of the Witwatersrand and also pursuing doctoral studies (PhD) in the School of Public Health, University of the Witwatersrand.

With regards to this PhD research, I am interested in understanding actual financial management processes and practices in two districts in province x (Indawo and Isikhala district). Financial management in this study refers to four processes which will be examined (planning, resource allocation and budgeting, oversight and evaluation). This study seeks to understand the actual financial management processes and practices which take place, the individuals involved in these processes and practices at the district, what people actually do, how they do it, why they do it, and what are some of the challenges. In today's interview, we will be focusing on your current role, how are you involved with in the district's financial management, who do you interact with, what key meetings you attend and what are some of the challenges you face.

I will be talking to a range of people at province, district and sub-district (Indawo and Isikhala district), and in health centres and clinics. When the work is finished we will combine all the information and feedback the findings to local and national leaders and health care managers. We would like to interview you for this research.

[Where taping]: If you agree, the discussion will be tape-recorded to assist later in fully writing up the information. No-one will be identified by name on the tape.

Voluntary Participation

Participation in this study is voluntary. If you agree to help with this research and later change your mind you are free to withdraw at any time. The discussion should take approximately one hour.

Confidentiality

We are not here to inspect or audit the facility. The information will be used for research purposes only. All the data will be owned by CHP and the School of Public Health, University of the Witwatersrand. Recorded information (written and tape recorded) will be kept in a secure place under lock and key for a period of two years at CHP offices. Thereafter all information will be destroyed. No one other than the main researchers (Shakira Choonara and supervisors, Dr Jane Goudge, Dr Nonhlanhla Nxumalo and Professor John Eyles) **will** be allowed to see or have access to the recorded material and the transcripts. Names of interviewees will not be included and will be kept separate from written transcripts. We will not disclose your identity, or use your name in any reports of this work. The knowledge gained from this research will be shared in summary form, without revealing individuals' identities.

Approval for and benefits of this work

The study has been approved by the Human Research Ethics Committee (Medical) at the University of the Witwatersrand, province x (Indawo and Isikhala district). The study will contribute new ideas and insights to possibly improving financial management at a district health level.

There are no benefits for participating in the study.

What if I have any questions?

You are free to ask me any question about this research. If you have any further questions about the study, you are free to contact the researcher(s) below:

1. Researcher-Shakira Choonara

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Johannesburg

Telephone / Cell phone/ E-mail:

011 717 3425/083 616 0041/ Jane.Goudge@gmail.com

Information sheet (external stakeholders) for interview 2: Involvement and support, district financial management processes

Formal Title: Governance in the South African Health Sector: An In-depth Comparative Analysis of Financial Management at a District

What is this doctoral (PhD) research about?

My name is Shakira Choonara. I work for the Centre for Health Policy (CHP) at the University of the Witwatersrand and also pursuing doctoral studies (PhD) in the School of Public Health, University of the Witwatersrand.

With regards to this PhD research, I am interested in understanding actual financial management processes and practices in two districts in province x (Indawo and Isikhala district). Financial management in this study refers to four processes which will be examined (planning, resource allocation and budgeting, oversight and evaluation). This study seeks to understand the actual financial management processes and practices which take place, the individuals involved in these processes and practices at the district, what people actually do, how they do it, why they do it, and what are some of the challenges. In today's interview, we will be focusing on your knowledge of the district's financial management processes and the type of support you give to the district through your current role and what are some of the challenges.

I will be talking to a range of people at province, district and sub-district in (Indawo and Isikhala district), and in health centres and clinics. When the work is finished we will combine all the information and feedback the findings to local and national leaders and health care managers. We would like to interview you for this research.

[Where taping]: If you agree, the discussion will be tape-recorded to assist later in fully writing up the information. No-one will be identified by name on the tape.

Voluntary Participation

Participation in this study is voluntary. If you agree to help with this research and later change your mind you are free to withdraw at any time. The discussion should take approximately one hour.

Confidentiality

We are not here to inspect or audit the facility. The information will be used for research purposes only. All the data will be owned by CHP and the School of Public Health, University of the Witwatersrand. Recorded information (written and tape recorded) will be kept in a secure place under lock and key for a period of two years at CHP offices. Thereafter all information will be destroyed. No one other than the main researchers (Shakira Choonara and supervisors, Dr Jane Goudge, Dr Nonhlanhla Nxumalo and Professor John Eyles) **will** be allowed to see or have access to the recorded material and the transcripts. Names of interviewees will not be included and will be kept separate from written transcripts. We will not disclose your identity, or use your name in any reports of this work. The knowledge gained from this research will be shared in summary form, without revealing individuals' identities.

Approval for and benefits of this work

The study has been approved by the Human Research Ethics Committee (Medical) at the University of the Witwatersrand, province x (Indawo and Isikhala district). The study will contribute new ideas and insights to possibly improving financial management at a district health level.

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Address: 3rd Floor, School of Public Health Building

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27 St Andrews Road

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Johannesburg

Telephone / Cell phone/ E-mail:

011 717 3425/083 616 0041/ Jane.Goudge@gmail.com

APPENDIX I: CONSENT FORM

I have had the study explained to me. I have understood all that has been read and had my questions answered satisfactorily

- ☐ **Yes please** *tick I* **agree to be interviewed**
- ☐ **Yes please** *tick I* **agree for the interview to be tape-recorded**

I understand that I can change my mind at any stage and it will not affect me in any way.

Signature: _____ _____

Time: _____

I certify that s/he apparently understood the nature and the purpose of the study and consents to the participation in the study. S/he has been given opportunity to ask questions which have been answered satisfactorily.

Signature: _____ _____

Designee/investigator's Name _____ *(please print name)* **Time:** _____

APPENDIX J: ETHICAL APPROVAL LETTERS

(CHP *broader project & student)*

[redacted] PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

OUTCOME OF PROVINCIAL PROTOCOL REVIEW COMMITTEE (PPRC)

Researcher's Name (Principal investigator)	Dr Nonhlanhla Nxumalo
Organization / Institution	Wits University School of Public Health
Research Title	Strengthening the district health system: routine practices of governance and decision space in South Africa
Protocol number	P160214
Date submitted	03/02/2014
Date reviewed	19/02/2014
Outcome	APPROVED
Date resubmitted	N/A
Date of second review	N/A
Final outcome	N/A

It is a pleasure to inform that the [redacted] Health Department has approved your research on "Strengthening the district health system: routine practices of governance and decision space in South Africa".

The Provincial Protocol Review Committee kindly requests that you to submit a report after completion of your study and present your findings to the [redacted] Health Department.

Approves / not approves

[redacted]

Provincial Protocol Review Committee, Chairperson
Date 10/03/2014

R14/49 Dr Jane Goudge and Ms Nonhlanhla Nxumalo

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M131136

NAME: (Principal Investigator) Dr Jane Goudge and Ms Nonhlanhla Nxumalo

DEPARTMENT: Centre for Health Policy [redacted]

PROJECT TITLE: A Research Proposal to the Resilient and Responsive Health System (RESYST) Consortium Strengthening the District Health System: Routine Practices of Governance and Decision-Space in South Africa

DATE CONSIDERED: 29/11/2013

DECISION: Approved unconditionally

CONDITIONS:

SUPERVISOR:

APPROVED BY: Professor PE Cleaton-Jones, Chairperson, HREC (Medical)

DATE OF APPROVAL: 24/01/2014

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 Secretary in Room 10004, 10th floor, Senate House, University.
I/we fully understand the conditions under which I am/we are authorized 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 the application to the Committee. **I agree to submit a yearly progress report**.

Principal Investigator Signature Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

[redacted] PROVINCE

HEALTH

REPUBLIC OF SOUTH AFRICA

OFFICE OF THE [redacted]

District 1 Approval

[redacted]

TO : MS NONHLANHLA NYUMALO

FROM : [redacted]

DATE : 12 MARCH 2014

SUBJECT : PERMISSION TO CONDUCT RESEARCH CHP REYSEST PROJECT

Please be informed that permission has been granted to you to carry out the abovementioned [redacted]

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.

[redacted]

R14/49 Ms Shakira Choonara

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M140703

NAME: (Principal Investigator)	Ms Shakira Choonara
DEPARTMENT:	School of Public Health Centre for Health Policy
PROJECT TITLE:	Governance in the South African Health Sector: An In-depth Comparative Analysis of Financial Management at a District Level
DATE CONSIDERED:	25/07/2014
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Dr Jane Goudge, Prof John Eyles and Dr Nonhlanhla Nxumalo
APPROVED BY:	Professor P Cleaton-Jones, Chairperson, HREC (Medical)
DATE OF APPROVAL:	01/10/2014

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 Secretary in Room 10004, 10th floor, Senate House, University.
I/we fully understand the conditions under which I am/we are authorized 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 the application to the Committee. **I agree to submit a yearly progress report**.

Principal Investigator Signature Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

District 2 Permission

[redacted]

Your correspondence on the above matter refers.

Thank you for your request to conduct research in [redacted]

Permission is hereby granted to you to conduct researc[redacted]District by conducting interviews of respectives managers. I am anticpating that you will conduct your research with the knowledge of all relevant Managers.

You are expected to share the findings and recommendations with the district in order to improve the service delivery to people of [redacted]

I hope you find the above in order.

Yours faithfully,

[redacted]

DATE: 18/2/2015

APPENDIX K: PLAGIARISM DECLARATION

UNIVERSITY OF THE WITWATERSRAND JOHANNESBURG

FACULTY OF HEALTH SCIENCES

PLAGIARISM DECLARATION TO BE SIGNED BY ALL HIGHER DEGREE STUDENTS

SENATE PLAGIARISM POLICY: APPENDIX ONE

I SHAKIRA CHOONARA (Student number: 3053594) am a student registered for the degree of DOCTOR OF PHILOSOPHY in the academic year 4TH.

I hereby declare the following:

- 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 followed the required conventions in referencing the thoughts and ideas of others.
- I understand that the University of the Witwatersrand may take disciplinary action 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.
- I have included as an appendix a report from "Turnitin" (or other approved plagiarism detection) software indicating the level of plagiarism in my research document.

Signature: _____ Date: 2021/03/21