An assessment of the 'PHC Facility Governance Structures Trainer-of-Facilitator Learning Programme' in Nkangala District, Mpumalanga Province

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Health Systems Trust

An authentic journey

Preamble

Declaration

I, Natasha Esau, hereby declare that the work on which this dissertation/thesis is based is my original work (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree in this or any other university.

I empower the university to produce the purpose of research either the whole or any portion of the contents in any manner whatsoever.

Signature: Signed by candidate

Date: 9 April 2018

Preamble

Abstract

In South Africa, one of the ways in which communities have been participating in health has been as part of governance structures or better known as clinic committees or health facility committees. The South African health system is unique in that it is decentralised affording greater decision-making powers to its nine provinces. This has however led to differing legislations particularly for clinic committees and had a particular effect on training of clinic committees. Even though clinic committees are a national priority the training of clinic committees have not received this prioritisation. In 2014 the National Department of Health, in collaboration with the Health Systems Trust, developed a set of training material which would be best presented through the adoption of a trainer of trainer approach. The training was called; *'PHC Facility Governance Structures Trainer-of-Facilitator (ToF) Learning Programme'.* Its overall goal was to strengthen the capacity of facilitators so that they may deliver the ToF Learning Programme to the clinic committees. The material was first piloted in uMzinyathi District, KwaZulu-Natal and presented according to the original design and processes of the study. In 2016 a second pilot was conducted in Nkangala District, Mpumalanga with deviations in the delivery process. This study aimed to assess whether the deviation in the delivery process in Nkangala had any effect on the aim and objectives of the study. Ethical approval was received from the University of Cape Town Human Research Ethics Committee and all participants consented to participate in the study. A retrospective qualitative single case study using key informant interviews, focus group discussions and a document review was guided by the Illuminative Evaluation Framework. All interviews were recorded and transcribed verbatim which was followed by a manual analysis of the data. Overall the results showed that despite the deviation in the delivery process, the training achieved its overall goal. Based on the results of the study, recommendations for policy and practice does however include better legislative prioritisation, standardisation of the training, availability and accessibility of material and a national position to be fast tracked on the issue of stipends.

Preamble

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PART A: RESEARCH PROTOCOL

An assessment of the 'PHC Facility Governance Structures Trainer-of-Facilitator Learning Programme' in Nkangala District, Mpumalanga Province

Abbreviations

APP	Annual Performance Plan
CEO	Chief Executive Officer
DoH	Department of Health
FGD	Focus Group Discussion
HFC	Health Facility Committee
HPA	Health Policy Analysis
HREC	Human Research and Ethics Committee
HST	Health Systems Trust
IEF	Illuminative Evaluation Framework
KII	Key Informant Interview
MPH	Masters of Public Health
NDoH	National Department of Health
NGO	Non-Governmental Organisation
NHA	National Health Act
NHC	National Health Council
PHC	Primary Health Care
ToF	Trainer of Facilitator
UCT	University of Cape Town

1. Introduction

In South Africa, as part of specified governance requirements, community participation in health facilities were established through the establishment of clinic committees (legislated bodies who provide management oversight alongside facility managers at health care facilities) and hospital boards (legislated bodies that provide management oversight alongside the Chief Executive Officer (CEO) at hospital level). This research will focus on clinic committees. Governance and leadership are essential parts of any health system. One aspect of health system governance concerns the formal structures put in place by government. An essential dimension of health system governance is the participation and contribution of communities and formal structures, such as hospital boards and facility committees have been put in place globally to provide a vehicle for community participation in how facilities execute their health service mandates (1-3).

South Africa has nine provinces that are each divided into districts and some of these districts are further divided into sub-districts. All of these provinces have approached governance requirements for community participation in health in different ways. Some provinces have chosen to formally train their clinic committees through contracting external contractors to conduct the training. One of these external agencies is a well-established Non-Governmental Organisation (NGO), called Health Systems Trust (HST) that was contracted by one of the nine provinces, Mpumalanga Province, to do such training in one of their districts called Nkangala. In order for clinic committees in this district to understand their role better and to be properly capacitated for their roles, they were earmarked to undergo training and the Nkangala Department of Health (DoH) identified potential trainers, at district level, who in turn would train the committees. In the district these trainers are known as master trainers.

Towards the end of 2015, the DoH requested of HST to conduct a trainer of facilitator programme for the district's master trainers in order for them to train the districts health clinic committees. The training was called 'Primary Health Care (PHC) Facility Governance Structures Trainer-of-Facilitator

Learning Programme'. Different variations of the name of the training currently exist, but for the purpose of this assessment, the training will be referred to as Trainer-of-Facilitator (ToF) Learning Programme. The training took place in February 2016, in Nkangala district. The overall aim of the training was to capacitate facilitators in order to deliver the ToF Learning Programme to the clinic committees in the district. This meant that the participants of the training had to conduct the same training programme with the existing clinic committees in the Nkangala district and sub-districts. In addition to master trainers, senior staff members from the district DoH also attended the training. The training and curriculum were compiled and coordinated by HST.

Prior to this training it is not clear whether the district had trained their master trainers and what the nature and format of this training was. This will be one of the areas that this study will seek to explore. Due to the districts' time and budgetary constraints it was decided that a train-the-trainer approach would best serve the district. Since the training in February 2016 no assessment of the training had been done; whether participants were appropriately capacitated, whether the training programme had been transferred and clinic committees trained and also what the effect of this training has been at facility level. This study is mainly aimed at assessing the training, the capacitation of the master trainers and whether the training programme had been transferred. Due to the timeframe between the initial training and this assessment as well as the scope of this study it would not be possible to assess the training of clinic committees and what effect this training has had at facility level. This assessment will focus on DoH staff, DoH support (senior) staff, HST facilitators of the training and phase one participants (phases are explained further on) in two purposively selected sub-districts.

Clinic committees are not unique to the South African context. In keeping with the 1978 Alma Ata Declaration's appeal for community participation in health , clinic committees have been established in various countries across the globe (4). Peru, Zimbabwe, Kenya and Uganda are some of the countries in which clinic committees are operational (5). In Nigeria clinic committees have been

operational from as early as the 1980's (6). These countries, like South Africa, are classified as low and/or middle income countries.

2. Background and rationale

2.1 The South African health system

Following the 1994 change in national leadership, the South African health system moved from a centralised to a decentralised system in terms of governance and certain decision-making powers, giving provinces greater legislative autonomy. Clinic committees serving as governance structures were established as vehicles through which decentralised management and oversight of the health system at facility level would take place. In 1997 the then Minister of Health, Dr Nkosazana Zuma introduced the government's plan to transform the South African health system, through the decentralisation of the management of the health system from a national system to a provincial system with particular emphasis on service delivery at a district level (7). The South African National Health Act, 61 of 2003 makes provision for the development of a range of structures that would serve as accountability measures, amongst others, within the health system, as well as the active involvement of the members of the community as members of the various committees (8).

The health system is thus structured as (1) the National Department of Health (NDoH) which oversees the delivery of health services nationally and reports to the National Health Council (NHC), (2) the provincial departments of health which are responsible for the establishment of health services in each of the provinces, in accordance with the National Health Act (NHA) and relevant legislation, and which reports to the NDoH and is guided by Provincial Health Councils, (3) each of the provinces are further divided into districts, where the district management team reports to district health councils as well as the provincial department of health (9). In most provinces, districts are further divided into sub-districts. Each sub-district renders health services through health facilities where clinic committees who are members of the community and are elected by the

community, serves in a governance capacity. It is the responsibility of the provincial departments of health in accordance with provincial legislation to establish clinic committees and to determine its functions (9).

Within the South African context the concept of health governance has always been both referred to and used to mean 'clinic committees, community health-centre committees, hospital boards and district health councils' (8). In South Africa, clinic committees is centred upon the principle of community participation in health and governance structures such as clinic committees, hospital boards and district health councils are meant to express this principle at both local and district levels (10). This expression of community participation is meant to serve as a linkage 'between communities and health services as well as provide a conduit for the health needs and aspirations of the community to be represented at various local, district, provincial and national levels' (10).

It is the responsibility of Provincial legislatures to ensure that clinic committees and or community health centre committees are established and that a clinic committee should consist of at least a local government councillor; members of the community within the catchment area; and the facility manager (9). The Provincial legislatures are also responsible to clarify the functions of the committees and should ensure that these are outlined in the respective provincial legislations. The NHA does not, however, provide much more information or clarity with regards to what exactly is expected of the members of clinic committees; how they are to operate in relation to the community and government, the timeframe for establishing a committee, the need for a clinic committee and the training requirements of clinic committees. The NHA further fails to express who the committees will report to within the respective Provinces, and the requisite logistics and resources such as stipends necessary for optimal operation. It is not clear whether and how, day to day operations like organising of meetings, transport costs, administration costs, name tags, supplies and procurement of office space and necessary equipment are funded. Some provincial legislatures however do indicate fundraising as one of the functions of clinic committees, but the legislatures are

not clear whether these funds are to be used for this purpose. The NHA does not clarify the link between governance structures (clinic committees, community health centre committees, hospital boards) and community participation (8). In referring to Haricharan 2012a, Levendal et al (2015) points out that governance structures as represented in the NHA gives it the appearance of existing within a vacuum.

Clinic committees are expected to function within a governing role (i.e. overseeing facility management processes) alongside facility managers at facility level. A recent study conducted in Mpumalanga, which included interviews with members of clinic committees showed that these committees generally do not perform governance functions. Instead they often function as nurses' aides, queue marshals and are put in charge of receiving various complaints from the public (11). It also became apparent that many clinic committee members do not have high school certificates and struggle with literacy and numeracy skills, which makes reading, writing and communication difficult. Yet this is required for their day-to-day functioning as committee members. Despite some policy guidelines a number of factors impede the effective functioning of clinic committees (10). These impediments, as aforementioned, refer to the structural make-up of committees and the fact that existing policy guidelines are not always adhered to; members do not always operate according to the stipulated functions; member election processes are not always transparent; there are no clear linkages to the broader governance structures or other government sectors; and inadequate financial and technical input and lack of training amongst others (10).

With regards to PHC, the Alma Ata Declaration of 1978 highlights the importance of enabling individuals from the community through capacitating them to fully engage within all the phases of managing the health system. It states that the health system should develop through providing appropriate education that would enable communities to participate in the PHC system (4). It does not however specify what this appropriate education should look like, but infers this to be context and level of involvement specific. Countries are thus bound by the Declaration to encourage

community involvement in PHC and are liable to equip communities with the appropriate skill sets to be effective in their areas of involvement.

As pointed out earlier, the training of clinic committees have been noted as a factor lacking in the management of clinic committees and thus affects their functioning. In the available literature on clinic committees, very little mention is made on the training of clinic committees and where training is mentioned, even less mention is made on the types of training, specifically geared towards clinic committees. In Kenya, for example, health facility management committees are expected to engage in financial management tasks, but a study inspecting the committees' readiness to assume this role indicated that less than 18% of committees – and only certain individuals – reportedly received facility and or financial management training (12). There is, however, a body of literature in existence, focussing on train the trainer programmes, but these are largely geared towards other disciplines such as Human Resources and Education and do not refer to the training of clinic committees specifically (13, 14).

2.2 Problem Statement and another Purpose

Based on a review of the HST facilitator's preparation material for the training, the Nkangala DoH planned a training programme for each of its sub-districts clinic committees in 2013. For this training the clinic committees within the six sub-districts were divided into groups ranging between thirty five and fifty people per group and training was conducted over a three-day period covering a total of 860 participants, during the month of August. Each of these groups had designated trainers from the district and each sub-district had designated venues. The district has since moved from training clinic committees directly to prioritising the train-the-trainer approach so that the trainees in turn could train the clinic committees.

The Nkangala DoH requested that a strengthening of the capacity of clinic committees be effected through the Trainer-of-Facilitator Learning Programme for the districts master trainers. A model was

proposed whereby, following this initial training, it would be the responsibility of these newly trained district master trainers to train the members of the clinic committees in the six sub-districts.

Since the implementation of the training, no assessment had been done on the actual training or this newly proposed training model. The training of clinic committees is a very important part of strengthening health systems governance. As this training programme is one of only a few in existence, it is worthwhile assessing it to ascertain whether improvements are required and whether it can be scaled up. The study's overall aim and objectives are described in a later section.

The train-the-trainer approach was decided upon because it capacitates and empowers the district's trainers (master trainers) to transfer the same training to clinic committees within their own sub-districts. This method of training has the benefits of financial savings on travel costs, enhancing training capacity in the district, promotes sustainability and affords the district the freedom to arrange on-going training as and when needed, without having to contract an external trainer.

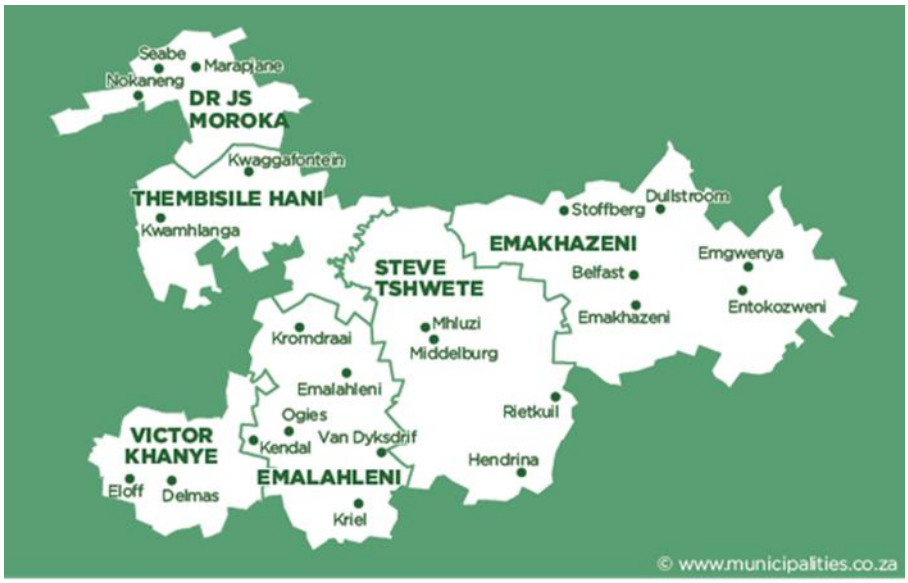
After having done a documentary review of key documents; the Trainer-of-Trainer Programme manual, the National Health Act, the Province's Annual Performance Plan (APP) 2015/16-2017/18 (15), it is still not entirely clear what the contextual factors were leading up to and at the time of the training. Context refers to the environment in which policy decision-making takes place and this can be referred to as the micro environment (organisational and local) and the macro context (national or societal and international environment) (16). The contextual environment will be further explored to get an understanding of the various macro factors such as the societal and political pressures and interests, historical and socio-cultural context, international context, economic conditions and policy as well as the micro factors such as the organisational climate and culture, other policies and experiences and organisational capacity in the district (16).

2.3 Study setting

Mpumalanga Province, has three districts; Gert Sibande, Ehlanzeni and Nkangala. Nkangala district has six sub-districts; Dr JS Moroka, Emakhazeni, Emalahleni, Steve Tshwete, Thembisile Hani and Victor Khanye. See Image 1 below.

Map of Nkangala district

Image 1 Map of Nkangala district



Source 1 www.municipalities.co.za

The district is strategically situated on the Maputo Development Corridor and borders Gauteng Province which has contributed to it being the economic hub of Mpumalanga. Nkangala has a total population of 1 308 129 and 115 health facilities (fixed clinics, community health centres, mobile clinics, hospitals) across the six sub-districts. Of its 279 facilities, the province has established a total of 188 functioning clinic committees (17). Governance structures such as hospital boards and clinic committees have however been in operation since 1999 (18).

2.4 The training of facilitators training

Following a two-step commissioning stage towards the end of 2015 (see Table 1) a PHC Facility Governance Structures Trainer-of-Trainer/Facilitator Learning Programme, or as referred to in this assessment, a ToF Learning Programme, was conducted by Health Systems Trust in Nkangala district

in February 2016. The five day training followed a set curriculum that was compiled by HST and was informed by a literature review and extensive consultation with the NDoH, existing clinic committees and communities. The training material consisted of; a Pocket Handbook (A guide for PHC facility governance structure members), a Learning resources for PHC facility governance structure members (participant's manual), a Facilitation guide for capacity strengthening of health governance structures (facilitator's manual) and a set of 16 Posters. A pre-test was conducted on day one and a post-test on day five to test changes in the participants' knowledge and understanding of governance structures.

Table 1 Indicating the steps and phases of the assessment

<table>
<tr><th colspan="2">Prior to implementation of the ToF Learning Programme</th><th colspan="4">Unfolding of the training process in Nkangala</th></tr>
<tr><th colspan="2" rowspan="2">Commissioning of the training programme</th><th colspan="4">Phases of the training</th></tr>
<tr><th colspan="2">Phase 1</th><th rowspan="2">End of this assessment</th><th>Phase 2</th><th>Phase 3</th></tr>
<tr><td>Step 1
Nkangala Department of Health (DoH) in consultation with HST Towards the end of 2015
(Training material and programme compiled by HST)</td><td>Step 2
The training of master trainers and district support (senior) staff February 2016</td><td>Training of district master trainers at the district office by HST facilitators</td><td>Training of district support (senior) staff at the district office by HST facilitators</td><td>Training of PHC facility governance structures (clinic committees) by phase 1 participants</td><td>Outcome at facility level</td></tr>
<tr><td colspan="2">Steps leading up to the training in February 2016</td><td colspan="4">Assessment covers phase 1 only (master trainers and support staff) Phase 2 and 3 to form part of a later evaluation to assess the outcomes of training at facility level</td></tr>
</table>

Overall, the training had a three phase approach and the phase of the training that this assessment will be focusing on is phase one (see Table 1). Phase one of the training was geared towards the training of the district's master trainers. This training was conducted by HST facilitators at the district DoH offices in Nkangala. During this phase, as implied, the master trainers were trained. Phase one was also attended by high level district staff: the PHC manager, acting directors, deputy directors,

coordinators, chief operational managers, master trainers, assistant managers and information officers. From the participant attendance list it is not clear whether all the participants would be responsible for conducting training within the district. Phase two of the training was geared towards the training of the clinic committees, by the master trainers. During this phase the master trainers were meant to transfer the training, as initially intended in phase one, to the clinic committees in the various sub-districts. Phase three of the study refers to the impact and outcomes of the training at facility level. Phases two and three will not form part of this assessment as the scope and timeframe of this study does not allow for a full blown impact and effectiveness enquiry, which requires an assessment of both phases two and three.

3. Conceptual framework

Illuminative Evaluation Framework

The conceptual framework that will be drawn upon in this assessment is called the Illuminative Evaluation Framework (IEF) (see Table 2 below). Other conceptual frameworks that evaluate training programmes have also been considered such as Kirkpatrick and Kirkpatrick's 'Evaluating Training Programmes'(19) and Holton's 'HRD Evaluation Research and Measurement Model' (20), which is a revised version of Kirkpatrick and Kirkpatrick's framework. The limitations of these frameworks, for the purpose of this assessment, is that it is very focussed on the learning experiences of the participants in the training and not enough emphasis on the context, content, and the process undertaken. Another framework considered for this assessment is Buse et al's 'Health Policy Analysis' (21), because it is centred within a health system with its complexities, but this assessment is interested in evaluating the content, context and process of the training programme and not in the power dynamics of stakeholders, at this stage, or the outcomes of the training at facility level. A stakeholder's analysis may in fact become applicable at a later stage of the study.

Table 2 Illuminative Evaluation Framework

The Illuminative Evaluation Framework	
Enables researches to →	1. Explore the educational process 2. Explore programme outcomes 3. Explore its consequences
The aims of illuminative evaluation are to study an innovatory programme →	1. How it operates 2. How it is influences by the various situations in which it is applied 3. What those directly concerned think are its advantages and how students' intellectual tasks and academic experiences are most affected
It seeks to document and discover what it is like to be →	1. Participating in the scheme, whether as student or teacher 2. It looks for the most significant features and critical processes of the innovation (in this case, a trainer-of-trainer programme for clinic committees)

Source 2 Taken from Smith, Masterson & Lask, 1995; 246

The rationale and design for the IEF was introduced by editors Parlett and Dearden in 1977 and looks at a learning programme's educational processes or the instruction system (course material), programme outcomes or the learning milieu (through qualitative collection of data) and the consequences of the programme (22, 23). The instruction system also refers to the context within which learning takes place, highlighting the roles of the various actors which enhance aspects of the programme outcomes and its consequences. The IEF continues to be used to evaluate various educational training programmes as well as to inform training policies and implementation policies (24).

The IEF also enables one to assess the ToF Learning Programme to see whether the aims, objectives and methodology of the training programme was clearly conveyed by the facilitators, whether this was understood by phase one participants and whether phase one participants were able to transfer the training programme as intended to phase 2 participants. This assessment will however not measure the overall outcomes or the consequences of the study, how clinic committees were trained, how the training has impacted the way in which clinic committees function at the facility level, because not enough time has lapsed between the intervention and the assessment to respond

to this type of enquiry and the scope of this study does not allow for it. This type of enquiry will be done as a follow-up study at a later stage.

This assessment will thus focus mainly on the output of the training; the commissioning of the training, the training material and will conclude with the training of the master trainers and DoH support (senior) staff during phase one. Specific attention will be given to phase one trainees; how they were trained, who attended the training, what they were trained on and whether the aims and objectives of the training were achieved. This process of the assessment can easily be perceived as linear and each step directly following on the other in a sequential way, but the process is much more intricate and each step is inter-reliant on the other. The IEF is appropriate to be used in this assessment which is set within the complexities of a health system context. The IEF will be used to evaluate objectives 1, 2, 3, 4 and 5 of the study.

4. Aim and objectives

The aim of this study is to assess the PHC Facility Governance Structures Trainer-of-Facilitator (ToF) Learning Programme in Nkangala district, Mpumalanga Province. The specific objectives of this assessment are to:

1. Describe the context in which the training occurred
2. Describe the PHC Facility Governance Structures Trainer-of-Facilitators (ToF) Learning Programme
3. Examine whether the training was done according to the intentions of the ToF Learning Programme
4. Examine whether the master trainers understood the training and whether they were able to transfer the training
5. Describe the role of the DoH support (senior) staff
6. Make recommendations for future training

5. Research questions

Does the training approach adopted in Nkangala work?

- Was the training approach sufficient or comprehensive enough for the newly trained facilitators to train the clinic committees without the assistance of external trainers?

5.1 Definitions of terms in aims and objectives

Table 3 below outlines the terms and definitions within the aims and objectives.

Table 3 Terms and definitions

Terms	Definitions
Assess	To measure or gauge the training programme and how it was conducted based on the programme's intentions.
Context	Refers to the setting or environment within which the training took place.
PHC Facility Governance Structures Trainer-of-Facilitator (ToF) Learning Programme	Refers to the training (programme, curriculum and process) developed and delivered by independent contractors to capacitate the district's master trainers so that they in turn would train the clinic committees in the sub-districts.
Trainer	Individual/s involved in delivering the training programme.
Governance structures	Legislated to provide governance oversight to hospitals and facilities (i.e. hospital boards and clinic committees).
Clinic committee	Legislated committees made up of community members, selected by the community to function as governance structures, providing governance oversight at facility level.

6. Methodology

6.1 Study design

This is a retrospective single case study which aims to assess the PHC Facility Governance Structures Trainer-of-Facilitator (ToF) Learning Programme, which took place in February 2016, through employing qualitative data collection methods (key informant interviews, focus group discussions) and a documentary review. In this qualitative descriptive assessment the outcomes of the training for the clinic committees will not be assessed, nor will the perspectives of the clinic committee

members be elicited. This study will elicit the perspectives of the trainers and how they perceived the clinic committees had experienced the training. The validation of the trainer's perspectives and the clinic committee's perspectives will be considered at a later stage as part of another study. Qualitative methods of research refers to the use of in-depth inquiry into a phenomenon and are most useful when trying to get an understanding of people's perceptions, insights and lived experiences of a particular event or situation (25).This case study will not be compared with another study, but will be assessed as a single case by looking at the different aspects pertinent to the case itself. Using a case study method is highly relevant to this study as it enables the researcher to get an in-depth understanding of a real life phenomenon, the context within which this phenomenon has taken place as well as an overarching view of the methodological flow of the study (26).

6.2 Detailed methods for each objective

The research method for each objective is outlined in

Table 4. The method and variable for each objective will serve as a topic guide that will aid the interviewer to prompt questions that would be asked (Appendices A, B, C, D, E).

Table 4 Methods per objective

Objective	Data collection method	Which variable? How?
1. Describe the context in which the training occurred	Key informant interviews	• Societal and political pressures and interests • Historical and socio-cultural context • International context • Economic conditions and policy • The organisational climate and culture • Other policies and experiences • Organisational capacity • Issues of governance and restructuring of the health service in general • Noteworthy events

			• Things that were happening at community level in the district • Purpose of the training • The short and long term goals for the training programme • Available funding for training • Why an external contractor? • Strategic plan for clinic committees? • Barriers • Enablers
2.	Describe the PHC Facility Governance Structures Trainer-of-Facilitator Learning Programme	Key informant interviews Focus group discussions Review of training curriculum and programme	• Purpose of the training • The content of the programme • Aims and objectives of the training • Participant criteria • Who was it aimed at? • Duration of the training • Training methodology • Different terminology used in naming the training programme – whether these terms were understood by the participants • Whether prior training for master trainers had taken place
3.	Examine whether the training was done according to the intentions of the training programme	Key informant interviews Focus group discussions Review of training material	• Purpose of the training • The programme's aims and objectives • Process of training followed • Was the training methodology followed? • Barriers • Enablers
4.	Examine whether the master trainers understood the training and whether they were able to transfer the training	Key informant interviews Focus group discussions	• Training programme/schedule • When training occurred • Where training occurred • Duration of training • Attendance criteria (inclusion vs. exclusion) • What processes were followed? • Barriers • Enablers • Were the aims and objectives followed? • Was the methodology followed?
5.	Describe the role of the DoH support (senior) staff	Key informant interviews Focus group discussions	• The purpose of the training • Training methodology

	• An understanding of clinic committees? • An understanding of their role with regards to clinic committees?
6. Make recommendations for future training	

6.3 Sampling

Fifty-three trainees participated in the training in Nkangala district. Sampling will be done purposively from this group and will include trainees who have been involved in the training, who will be available to participate in the study and who will give their consent to do so. Sampling for this study will further be done from three predetermined levels or areas:

1. **Nkangala district Department of Health** – Director of Primary Health Care and Director of master trainers
2. **Health Systems Trust** – two facilitators who compiled the training material and facilitated the training
3. **Phase 1 participants**
    - 8-10 from the Nkangala districts' master trainers that attended the training and consents to participate in the study
    - 8-10 from the DoH support (senior) staff that attended the training and consents to participate in the study

    Key informant interviews (KIIs) will be conducted with the Director of Primary Health Care and the district's Director of master trainers. Based on the information received from these KIIs and recommendations made by these interviewees, further interviews may be conducted with other key informants. The study is thus making room for possible snowballing at this level. KIIs will also be conducted with the two HST facilitators who compiled the training material. Two focus group discussions (FGD) will be conducted with the phase one trainees (1) the district's master trainers

and (2) the DoH support (senior) staff who attended the first phase of the training based on their availability (Appendices A, B, C, D, E). See Table 5 below for study population and sampling.

Table 5 Study population and sampling

Level	Nkangala district staff	HST facilitators	**Phase 1 participants**	
			DoH support (senior) staff	District master trainers
Method	KII	KII	FGD	FGD
Total	2 (possibly more with snowballing)	2	1	1
			8-10 participants	8-10 participants

The enrolment of the study participants, especially the PHC director and the director of master trainers may be a potential source of bias which may affect the quality of the data collected. This is true for any qualitative study and bias cannot always be eliminated 100%, but there are methodological ways to manage bias and minimise risk or harm. In order to manage bias in this study the sources of information will be triangulated by referring to study documents, key informant interviews and the literature review. The results of the study will be contextualised within the context of all the other information gathered and in a constructive manner presented back to the PHC director and master trainer in the form of a discussion session. HST has formed good relationships with the departments of health in the different provinces and has a standard report back session as part of its work protocol. The report back session for this study will follow the HST format.

6.4 Criteria

All the study participants will be selected based on their involvement, experience, perceptions and knowledge of the ToF Learning Programme. This insight from the participants will greatly inform the various objectives of the study. At the district level the PHC director and the district's director of master trainers will be selected as study participants because they were involved in initiating the training process in the district by requesting an independent stakeholder, HST, to conduct the

training in the district. Their involvement in the study will also further inform the background and purpose of the study as well as the role of clinic committees and the districts plans for future clinic committees training. The HST facilitators will be selected due to their involvement in the development of the study material and programme, and the execution of the training. Their involvement will further inform about the purpose and intention of the training and what the expected training outcomes were. They will also be able to inform regarding the intended structure and transferral processes of the training itself. Participants from phase one will be selected based on their experience and perceptions of the training itself as well as their experience in transferring the training.

6.5 Data collection

6.5.1 Qualitative data collection

Data collection will incorporate mainly two qualitative forms of data collection; key informant interviews and focus group discussions. The KIIs and FGDs will be conducted in the English language. This study will also look at relevant material: training curriculum and material associated with the training programme as well as a literature review. The data collected here will be crucial in examining objectives 1 to 5 and in turn inform objective 6. KIIs will be conducted at district level with the PHC Director, the director of master trainers and the HST facilitators. FGDs will be held with all phase one participants. All interviews will be audio recorded and transcribed verbatim. All participants will receive an information sheet detailing the aims, objectives and process of the study and a consent form (detailed in the appendices section) to complete should they agree to form part of the study.

6.5.2 Document review

The qualitative data collection will be complimented by a document review. Document reviews are useful in retrospective studies as it enables the analysis of national level policies and can also be used as a way to identify consistency between a country's national level policies (27). Even though

not a systematic review the review of documents does take on a systematic approach and in qualitative studies it is a useful means of triangulation (28). This ensures credibility and rigour of findings. In addition to this, documentary reviews have the following advantages; they are efficient methods, cost effective, not affected by the research process, stable, enables exact extraction of information and affords broad coverage (28). At the same time document reviews have limitations. These include, by nature of its design, not having enough detail for the purpose of answering a research question, possible difficulties to access to information and it may be biased in its selectivity (28).

This review will look for available published and unpublished policies, legislative and appropriate training guidelines that set the stage for how clinic committees are located in the South African health care system and that gives some direction on how their training needs to take place. A set of inclusion and exclusion criteria will be created (see Table 6). Sources of information will consist of publically available national and provincial government websites, health, education, training institutes and HST that supports the development of government departments.

Table 6 Inclusion and exclusion criteria for the documentary review

Inclusion criteria	Exclusion criteria
1. South African documents: a) Policies, laws and training guidelines b) That say something about clinic committees' role, position and training South African documents or policies 2. Speak to clinic committees specifically: a. Role, position and training 3. Policies and or documents dated between 1996 and 2017	1. Documents: a) Not from South Africa b) Speaks to hospital boards or other forms of community participation 2. Policies and or documents outside of the 1996 and 2017 timeframe 3. Says nothing about clinic committees or that says nothing about clinic committees and their training

A list of variables will be used to chart relevant data (see Appendix N). This data will then be triangulated with the objectives of this study, the qualitative results and the literature review. The search terms used included: "health" AND "policy"; "clinic committees" AND "South Africa"; "health

policy"; "South African health policies; "national" AND "policies" AND "clinic committees"; "clinic committees" AND "training" AND "policy", "South Africa" AND "clinic committees; "South Africa" AND "guidelines"; "South Africa" AND "strategic objectives".

7. Data analysis

The data analysis will be guided by the conceptual framework discussed earlier. All interviews will be recorded on a digital recorder in order to transcribe (write it out in full) later. The data analysis will be done manually using an Excel spread sheet. The methodology for the data analysis will involve an iterative process that consists of three phases: (1) data management, (2) descriptive accounts and (3) explanatory accounts (25).

Phase 1: Data management

During this phase the researcher will work through the raw data, minimise it and assign it labels during the synthesis process. Following on to this, themes will be assigned to the labelled and synthesised data. The themes will be colour coded. These initial themes will come from the raw data, in other words it will reflect the participant's use of language and their understandings (25).

Phase 2: Descriptive accounts

During this phase the researcher will start to make sense of the labelled and synthesised data. Staying true to the participants own words and substantive content the researcher will start to develop different typologies or classifications (25). These classifications are useful in describing and explaining the different segments of the data.

Phase 3: Explanatory accounts

Providing explanations for the data is an activity that occurs much later in the analysis process following the first two phases. During this phase the researcher will make connections or identify

patterns within and between the data and then proceed to provide an explanation for these connections or patterns (25).

8. Ethical considerations

In complying with ethical principles this study will adhere to the following:

Ethical approval

Application for ethics approval will be made to the University of Cape Town (UCT) Human Research and Ethics Committee (HREC) for ethics review and approval.

Informed consent

Provide the participants with information and informed consent (Appendices H, I, J, K, L). Participants of this study (for key informant interviews and focus group discussions) will be informed about the purpose, nature and duration of the study. Their participation will be voluntary and they will have the freedom to choose to participate in the study or not. They will also be informed of the possible risks and dangers of the study and how this may affect them. At any point of the study that they feel they no longer want to participate they will be free to leave without this having any negative impact on them or their work situation. Participants will be informed of the value of their involvement in the study. Participants will not be reimbursed for their participation in the study. Interviews and group discussions will take place at the district and sub-district offices respectively. Participants will be allowed to ask questions and clarify information given. Participants will then be required to sign an informed consent form.

Confidentiality

Participants in the key informant interviews will be given the assurance of confidentiality throughout the study. We are however unable to ensure complete confidentiality and anonymity within a focus group setting as the rest of the members of the focus group will know what was said during the

discussion. But we are able to guarantee that anonymity will be secured at a reporting and publishing level by not including any identifying information like the name of the participants. All focus group participants, as part of the consent form that they will be asked to sign for participation in the focus group, will be required to sign a confidentiality statement, in which they are asked to keep the discussions during the focus group discussions confidential. Participants will be informed that all interviews and discussions will be recorded, transcribed and stored in a safe place only accessible to the core research team. Only the research team and project managers will have access to interviews and all material resulting from the study. Anonymity with regards to identity, and address as well as information shared and observed during the study will be maintained. No personal information will be used in the publication of this study or the data collection tools and each participant will be assigned a study code. The data collection tools will have these codes inserted on it and will allow the researcher to make the necessary study site and study linkage which will aid in triangulation of data.

Risks and dangers

There is no likelihood of any risks and dangers during this research study.

Beneficence & Maleficence

This study is of a qualitative nature with focus group discussions and interviews. The participatory nature of the study aims to ensure the welfare of the research participants. Due to the nature of the study we do not foresee that any harm will come to the study participants. The time spent with participants will be minimal and the location of the interviews will be safe.

9. Implementation

9.1 Timelines

The commencement of the study is pending ethics approval. Data collection is presumably scheduled to take place during the last week of April 2017.

9.2 Project management, affiliation and team profile

The project management team, affiliation and profile are outlined in the Table 7.

Table 7 Study research team

Name	Affiliation	Team profile
Dr Maylene Shung- King	• UCT School of Public Health and Family Medicine: (Health Policy and Systems Division) ○ Senior Lecturer	Principal investigator

Dr René English	• Health Systems Trust:
	  ○ Director Health Systems Research Unit
	• UCT School of Public Health and Family Medicine:
	  ○ Honorary Staff Member
		Co-principal investigator

Ms Natasha Esau	• UCT School of Public Health and Family Medicine:
	  ○ MPH student
	• Health Systems Trust:
	  ○ Research assistant
		Researcher

9.3 Budget

The total budget for this study is **R11 924** and Table 8 below has a summarised copy of what this entails. Funding for this study will be obtained from HST.

Table 8 Summarised copy of the budget

Budget				
No	**Line Item**	**Unit Cost**	**Factor**	**Budget**
1	*Personnel Costs*	per day		

	Project Director	0	0	0
	Project Manager	0	0	0
	Researcher	0	0	0
	Data Collector	0	0	0
	Transcribers	0	0	0
	Subtotal			**0**
2	*Travel Costs*			
	Flights	5 000	1	5 000
	Car Hire	260	4	1 040
	Accommodation	1400	3	4 200
	Refuelling cost	600	1	600
	Grand Sub Total			**10 840**
	Overhead Cost (10%)			1 084
	Total Budget			**ZAR 11 924**

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PART B: LITERATURE REVIEW

An assessment of the 'PHC Facility Governance Structures Trainer-of-Facilitator Learning Programme' in Nkangala District, Mpumalanga Province

1. Introduction

In September 1978, an international conference on Primary Health Care (PHC) was held in the region of Alma Ata, USSR. The aim of the conference was to focus on the protection and promotion of the health of all people in the world and governments, all health and development workers and the world community's role in realising this (1). The conference concluded with a declaration that foregrounded the importance of community participation in PHC. Since the Alma Ata declaration in 1978 there has been an increase in active community engagement in decision making, planning and execution processes of the health system that has become foundational to the establishment of PHC systems especially in Low-and-Middle-Income Countries (LMICs) (1). Over time this engagement has taken the form of community health committees or clinic committees, hospital boards, community health workers (CHWs) and home based carers amongst others. Community health committees or clinic committees are also referred to as governance structures and have been legislated particularly in the South African context (2). Available local and global literature on clinic committees supports the existence of these committees by referring to their roles and responsibilities, their make-up and need for training. It is however not clear on how these committees are to be capacitated or the approach to be used in order to assess capacity building initiatives for clinic committees.

2. Objective

The objective of this review is to look at available literature on training of clinic committees and approaches to training of clinic committees in LMICs. A literature search for this study was conducted across 17 databases via the University of Cape Town's (UCT) Ezproxy student database service, Google Scholar and PubMed. The following search terms were used interchangeably; "community AND participation", "community participation in health" "community involvement in health", "community participation in governance", "community participation and training", "health governance structures", "capacity building", "community accountability", "community engagement", "good governance", "local health governance", "clinic committees", "health facility

committees", "clinic committees in South Africa", "clinic committees in low-and middle income countries". Articles that had these terms in its title, and or abstract and text were included in this review.

3. Community participation in health

An essential aspect of delivering PHC services that are effective and adequate is the active engagement of the community in areas of 'planning, organization, operation and control of primary health care' (1). Clinic committees are representative of community participation in the health system and it is 'a structure that is promoted as a strategy for health systems strengthening and health improvement' (3). When considering community participation in health, one also needs to bear in mind that this is a process which is complex and context specific. This means that there cannot be a one size fits all strategy when it comes to community participation in health (3). Adding to this complexity are the differing perceptions that are held of clinic committees by policymakers and communities alike as well as the differing approaches to community participation adopted by different countries (4).

A study conducted in two regions of Saudi Arabia, revealed agreement amongst policy-makers to have community members participating in health. They were however not in agreement that these community members should be involved in the implementation of services. They perceived community participation as being restricted to engaging with policy-makers in its attempt to solving community health related problems. They did not foresee community participation to lend itself to the technical processes of health. This role was reserved for health personnel (4). Greater care should be given to contextual, social, economic, cultural and political factors of each community during policy drafting, implementation and accountability.

Amidst these complexities, community participation in health can also be a rewarding process, when there is adequate collaboration between the community and the health system and this

collaboration is accompanied by specific and clear roles (5, 6). There is thus a need for collaboration between the community and the health system in order to ensure sustainability of community participation in PHC. Facilitating the process of health and community partnerships is also complex and dependent on community readiness and adequate dialogue (7). Effective community participation is dependent on capacitation and authority. A study conducted in Kilifi, Kenya, shows on the one hand how valuable community health sector collaboration can be in the engagement, planning and budgeting for the health sector and on the other hand highlights the limited authority the community has in the execution of such plans (5). Similarly in Manyoni district, Tanzania, health facility committees were left without the necessary authority to function at a managerial level, even though collaboration between the two parties were being fostered (8).

4. Examples from LMICs

In the broader context, examples and evidence of clinic committee's positive contributions to the health system and continuous challenges are mostly located within LMICs. This section focuses on examples from LMICs. The literature reviewed here refers to governance structures in various ways (HCC, CLAS, DHC, HUMC and community health committees), these all mean clinic committees.

A systematic review conducted by McCoy et al (2011) looked at the evidence of clinic committees in LMICs and found four country studies that provided evidence of effectiveness of clinic committees. The studies conducted in Peru, Zimbabwe, Kenya and Uganda showed that clinic committees operating as a means of community participation have the ability to contribute positively towards health outcomes (3). In Peru the facilities with Committees for Health Administration (CLAS), when compared to facilities without CLAS showed better results with regards to user satisfaction and creating access to health care for the poor, amongst other things. These are partly attributed to its outreach mechanisms and ability to secure user fee exemptions for the poor. Despite the successes,

the study also points to differing ways in which the CLAS have been implemented, which highlights disconnect between CLAS and the health system (3).

In comparing wards or facilities with Health Centre Committees (HCCs), to those without in Zimbabwe, the study showed that facilities with HCCs fared better overall than facilities without (3). The results showed better uptake of health services, especially antenatal care, reduction in diarrhoea, increased human resources, better health indicators and better connections between the community and health workers, amongst other things (3). Yet, despite these results HCCs were found to be restricted in functioning in a governance capacity at health facilities. This was said to be as a result of a lack of knowledge on the part of the committees, combined with the perceptions of officials and health professionals of the committees. The former did not perceive these duties to be within the scope of the latter. The study also found that the HCCs had not prioritised service provision to all sections of the community, providing preferential treatment at the expense of, especially the vulnerable and the poor (3).

In Kenya, the Dispensary Health Committees (DHCs) were given much more authority. They had undergone training for self-equipment in health facility governance, participated in the process of developing a DHC constitution or mandate and participated in a range of governance related roles and responsibilities (3). It is only the study conducted in Kenya that prioritised the training of DHCs. The committees were also well supported by the Aga Khan Health Service and as a result had a number of positive impacts on health. These included an increase in health service utility, outreaches to those on the periphery, availability of medicine, motivation of village health workers and improved financial systems (3).

In Uganda an intervention whereby the community monitored health workers in nine districts was conducted in the form of a randomised control study. Following a series of discussions the study yielded positive results in the intervention communities. These included an improvement in health

workers performance, an increase in utilisation of health services, disbursing vitamin A immunisations, antenatal care and family planning as well as other areas (3).

The review also revealed a number of reasons why clinic committees were not effective such as the health system, societal, contextual and process factors (3). The study did however not find much evidence on the impact that health systems have on the effectiveness of clinic committees. It suggests that greater involvement of the health system can ensure effectiveness of clinic committees. Clinic committees should thus be a priority of the broader health system.

In a case study in Tanzania, two districts were compared in order to highlight the different functioning of clinic committees; one well performing and the other not well performing. Both committees were tasked with the management of the community health fund (9). The well performing district showed evidence of being able to bridge the knowledge gap between the community and the clinic committee, functioning in (limited) governance capacity and manages the facility's bank accounts, whereas the other district had less success stories (9). The authors found that the well performing district did so, due to a number of factors including incentives and the availability of funds at facility level. These incentives were however still limited and constrained them in their functioning. The overall finding was that, despite the difference in performance, both districts lacked training on the purpose and function of their roles (9).

In Nigeria clinic committees have been operational since the 1980s and follow the country's national guideline, which encourages a bottom-up leadership approach. Clinic committees are linked to most PHC facilities in the majority of the communities in the country (10). These committees are closely linked to local government structures and are elected through a participatory process which includes federal PHC management, NGOs, and various leaders in the respective communities as well as community members. During this process the limited roles and responsibilities of the clinic committees are defined as: '(1) identify the health needs of the community, and address them by drawing on human and material resources within the community, including raising funds when

necessary within the community; (2) liaise with the government and NGOs in finding a solution to the health needs of the community and (3) supervise and support health activities in the community and at the health facility, including the drug revolving funds where they exist, and for which, where there is a bank account, the signatories are to be the committee chairman, treasurer and secretary'(10).

These roles do not however give clinic committees much authority with regards to the regulation of the health system, government and national health processes (10). The authors are of the opinion that NGOs should use their facilitation visits as opportunities for regular and rigorous mentoring of clinic committees regarding their roles by providing them with the necessary tools. This they hold will allow clinic committees to increase their legitimacy and authority, so that they may be influential in the community. This will also enable them to better respond to their roles and responsibilities. Training of clinic committee members is not mentioned in the national guideline which outlines the roles and responsibilities of clinic committees, nor is it a prerequisite for clinic committees to undergo training.

According to McCoy et al, a new framework should be designed that outlines the differing roles and functions of clinic committees that is to include; governance, co-management, resource generator, community outreach, advocacy, intelligence and social leveller (3). Despite established clinic committees in LMICs, the common thread throughout LMIC examples is that clinic committees are not fully empowered and capacitated. These are major barriers in them fulfilling their roles and responsibilities as governance structures. There is also a clear misalignment between clinic committees and the health system. This infers that clinic committees are operational as entities on their own, without much government support and input. Health professionals' perceptions of clinic committees also facilitate this misalignment.

5. Training of clinic committees in the South African context

In the South African context, literature on clinic committees is slowly increasing and as such there is not a vast amount of literature available on clinic committees and even less literature is available on training and training programmes for clinic committees. This section of the review focuses on some of the available literature on training and training programmes for clinic committees within this country context.

In South Africa, there is the assumption that community members appointed as governance structures knows what they are required to do upon appointment (11). This is however not the case and therefore it is crucial that clinic committees be appropriately trained and capacitated (12). An assessment on the status of clinic committees revealed that, despite widespread agreement on the importance of integrating training with community participation, training of clinic committees still remained neglected(13). It also revealed that, when training did occur it often did not meet the requirements for capacitation that enhances member's functionality. Training would often be a once off occurrence and exclude vital committee members, such as health facility staff (13). Trainings that are conducted on an ad hoc basis, with no systematic plan or direction, cannot be sustainable or effective for clinic committees (14). The assessment has advocated for on-going sustainable training programmes that will serve as a means of continuous capacitation of committee members. It has also called for a more collaborative partnership between the health system and governance structures, through the deliberate support from all levels of the health system (13). This collaboration should involve trust and an investment in training, as well as resources and development, in order for clinic committees to function effectively (14).

There is however, very little evidence to suggest that the health system is in fact providing the necessary resources, to enable the capacitation of clinic committees to fulfil their roles (11). Further to this, a study conducted in the Eastern Cape, argued that clinic committees itself should be platforms for capacity building and personal development of its members that can have an impact

beyond the committee responsibilities (14). However, building capacity in clinic committees alone, will not be sufficient if not considered in relation to clarity of their roles and capacity building of service providers and managers (11). Ultimately, not capacitating clinic committees to perform their roles as governance structures, interferes with the delivery of effective health governance and building of the health system (11).

6. Training of clinic committees

Community participation in health, as mandated by the Alma Ata, requires the capacitation of individuals from the community, to fully engage within all the phases of managing the health system (1). Various legislative processes are in place, to ensure community participation in health. Despite these, there remain a considerable mismatch between policy and implementation, especially with regards to appropriately capacitating the community to fulfil their required roles (8). In order for the community to participate in health, the strengthening of capacity building initiatives are required. These are to include, both community members and health workers, for the facilitation of trust and collaboration between the community and the health system (15).

A number of positive examples emerged from countries, as to the value of capacity building of clinic committees. A study conducted in Nepal, showed that governance challenges in the PHC system, can be addressed through an improvement in capacity building around learning areas and skills on how to; co-manage health facilities, deal with issues relating to human resources, dealing with performance issues and granting the community access to information relating to health and financial data (15).

The Zambia Integrated Health Programme (ZIHP), a community mobilising training programme, has been recognised as an effective means of training community level health workers, community agents and neighbourhood health committees (NHCs), in Zambia (16). The training is presented as a distance learning course that utilises a trainer of trainer approach. The training has produced

significant health outcomes and an improvement in health worker performance including that of NHCs. However, following an assessment of ZIHP, a number of concerns were foregrounded; a misalignment with regards to resources and programs between ZIHP and the district health management team (DHMT), issues with sustainability of the intervention, concerns around cost effectiveness, not providing members with the necessary equipment, and lack of follow-up and supportive supervision (16). Issues around sustainability have however been addressed through; '(1) the policy, planning and system support component as a key element of ZIHP, and (2) ZIHP's emphasis on NGOs and the private sector' (16).

Other forms of formal training programmes developed in the South African context, are the 'Health Committee Training' by the Learning Network and the 'PHC Facility Governance Structures Trainer-of-Facilitator Learning Programme' which is the focus of this assessment. In 2014, the Learning Network developed a health committee training programme and produced participant manuals. The overall aim of the manuals was the capacitation of clinic committees; those already established and those still to be established. The manual is the product of the assessment of training needs and challenges facing health committees in the Western Cape, as well as experiences with training health committees in the Eastern Cape (17). Training is meant to take place over three days, in a workshop setting, facilitated by a skilled facilitator or trainer. A number of new and established clinic committees have since been trained.

Similarly there are also organisations who have made considerable strides towards capacitating health facility committees. The Community Practitioners on Accountability and Social Action in Health (COPASAH) has a strong community monitoring approach in LMIC health systems and prioritises capacitating communities participating in health and health facility committees (18). The Regional Network for Equity in Heath in East and Southern Africa (EQUINET) has been integral advocating for the establishment and capacitating health clinic committees. To this end, EQUINET has made recommendations to various LMICs to prioritise health clinic committees and together

with the Training and Research Support Centre (TARSC) and the Learning Network has developed considerable documentation around community training for citizens and community representatives (19). EQUINET is a network of professionals, civil society members, policy makers, state officials and others within East and Southern Africa who serves as an equity catalyst that promotes and realises the shared values of equity and social justice in health (19).

7. Training of trainer courses

This section focuses on literature of the different types of trainer of trainer courses available in disciplines other than health, such as Human Resources and Education. Even though these are not directed at health clinic committees specifically, there are a number of aspects that can be learned from them and be generalised to a clinic committee setting.

Trainer of trainer courses have proven to be highly effective, yields positive outcomes and influences attitudes and behaviours amongst other things, yet it can also pose challenging if certain aspects such as resources, training environment, clear purpose of training and criteria for participants, amongst others, are not taken into account (20-22).

Using a trainer of trainers approach to conduct a voluntary counselling and testing (VCT) program in the Caribbean, has shown to be highly effective (20). The approach comprises a combination of competency based and mastery learning techniques, aimed at developing trainers who will go on to train others, as well as be integral to the development of a curricula for further training initiatives (20). This approach has four different phases, with theoretical and practical components, and participants are required to show sound knowledge as well as master all the components in each phase before continuing to the next phase (20). An assessment of the VCT program has shown the trainer of trainers approach to be highly successful, if used in collaboration with other stakeholders and is able to be conducted within a four day period without impeding on participants busy schedules, but that limited resources can impair the process (20). Trainer of trainers courses are also

beneficial in that they tend to: (a) be more cost effective than employing professional trainers (b) develops local capacity (c) maintain cultural significance and adaptation necessary for learning and is thus appropriate in settings where large numbers of people require training bearing in mind the quality of the training material (20). The sustainability of trainer of trainer's courses is partly dependent on the measures of follow-up on trainings put in place, as this determines future training and curriculum developments (20).

In comparing a trainer of trainer approach with training conducted by an expert trainer approach – in order to determine whether there is a difference between the two approaches – no substantial difference was found (22). The study, which focused on capacitating participants on the usage of hearing protection devices, could not determine whether the change in users behaviour could be ascribed to the training material itself or to either one of the two approaches, and concluded that neither approach will make much difference on the effectiveness of the training (22). The authors suggests that focus should rather be given to laying a firm foundation in understanding the training program itself, as well as the theory that guides it.

In reflecting on a study conducted by Fleishman in 1953 Saks, Salas and Lewis (2014) noted that there is a positive link between consideration attitudes and behaviours during training, which can be ascribed to atmospheres existing in a classroom setup and in a work station, as well personal attitudes rather than the attendance of a training programme. Fleishman recommended a change in both the work and social environment to be key in the successful transfer of training (21).

Building onto Fleishman's ideas, Baldwin and Ford, in 1988, indicated that the problem with transfer lies within the process of transfer and that these were due to various factors (21). Blume and others, would later, in 2010, identify these factors as characteristics of the trainee such as their ability to learn, the extent to which they are guided by their conscience, their choice in participating in the training voluntarily and the atmosphere in which they work (21). Programme design, the participant's ability or readiness to learn, the trainers ability to train, lack of accountability

mechanisms, through which all parties involved (trainers, trainee's and management) amongst others, are reasons given for why transfer of training programmes are not sustained in the workplace (23). Accountability mechanisms, forms a vital part of an organisations standard working procedures and thus, should be prioritised and could take the form of performance reviews, and intentional follow-up (23).

Whilst much focus have been given to the role of training participants and managers involved in the transfer of training process in the workplace, the role and perceptions of training professionals, the experts in the field, have been overlooked in the process of transfer (24). The experts are of the opinion that successful transfer is dependent on a combination of factors; the trainers ability to conduct the training, and the trainers participation in the design, implementation and evaluation of the training process (24). It is thus critical for trainers to have a concrete understanding of the underlying philosophy, the skill sets to transfer this understanding in creative ways, to have a clear understanding of the desired outcomes of the training and to conduct training in a manner that will yield these outcomes (22, 24). From these examples of training of trainer courses it is clear that trainer of trainer courses and especially those directed at clinic committees should to take into account issues such as resources, a curriculum that is transferable, skilled facilitators, clear purpose and outcomes and efforts to promote sustainability.

8. Conceptual framework

The Illuminative Evaluation Framework

The Illuminative Evaluation Framework was used as an evaluative conceptual framework in this study. The rationale and design for the framework was introduced by editors, Parlett and Dearden, in 1977, and looks at a learning programme's educational processes or the instruction system (course material), programme outcomes or the learning milieu (through qualitative collection of data) and the consequences of the programme (25, 26). The instruction system also refers to the

context within which learning takes place, highlighting the roles of the various actors, which enhances aspects of the programme outcomes and its consequences.

The aims of the Illuminative Evaluation Framework (26), are to study an innovative programme;

- How it operates;
- How it is influenced by the various situations in which it is applied;
- What those directly concerned think are its advantages and how students' intellectual tasks and academic experiences are most affected

It enables researchers to:

1. Explore the educational process
2. Explore programme outcomes
3. Explore its consequences

It seeks to document and discover what it is like to be;

- Participating in the scheme, whether as student or teacher and
- It looks for the most significant features and critical processes of the innovation (in this case, a trainer-of-facilitator approach to learning for clinic committees)

Other evaluation frameworks have also been considered; 'Evaluating Training Programmes' (27) and the 'HRD Evaluation Research and Measurement Model' (28), which is a revised version of the Kirkpatrick and Kirkpatrick framework. A fourth framework considered for this assessment was the 'Health Policy Analysis' (29), because it is centred within a health system and its complexities. This study was however interested in evaluating the content, context and process of the training programme and not the power dynamics of stakeholders or the outcomes of the training at facility level. A stakeholder's analysis may in fact become applicable at a later stage of the study.

Since its design and introduction, the Illuminative Evaluation Framework, continues to be used to evaluate various educational training programmes, as well as to inform training and implementation policies. When the Australian government introduced changes in its higher education sector, it had an impact on all sectors including staff and students (30). The framework was helpful in assessing the process and consequences of the policy changes and allowed investigators to review both the intended and unintended consequences of the intervention (30). Embedded within a social anthropological paradigm and paying attention to contexts, the framework has been used across various disciplines (31, 32).

Shapiro et al (1983) described the usage of illuminative evaluation in assessing the transferability of a management training program for women in higher education. The training program itself was highly complex and required an evaluation framework that was both diverse and flexible. The adaptability of the framework was key to the outcomes of the evaluation. The training programme was designed in three parts, which allowed for the framework to be employed at the end of each part, making the results more salient. The methods included various forms of information gathering such as observations, interviews, review of documents, questionnaires and quantifiable measures as required (31). The evaluation illuminated intended and unintended consequences and afforded the evaluator the freedom to properly describe the obvious results of the training program (31). The authors do not however clarify what the framework entails and how it is used.

As part of a broader evaluation of institutional guidelines, the framework has shown to be useful as an evaluation methodology, due to its ability to gather information and to reveal intended and unintended consequences (33). The framework can thus be used in collaboration with other evaluative measures. In comparing the quality of a new online educational course with an existing hybrid course, the framework was key in determining that no significant differences exists in the quality of the different educational methods (32). Illuminative evaluation has also shown to be effective in facilitation processes connecting research and practice. When used to explore how an

email communication service can be used in an evidence based health care setting, it revealed that social processes can be used to inform evidence based health care settings (34). Further to this, the framework has also been used to evaluate relational interactions between various levels of staff within the work place. Sloan and Watson explored the interpersonal interactions between clinical supervisors and their supervisees (35). The framework was found to be instrumental in exploring the supervisory process and the relational dynamics within this process.

In another context, the illuminative framework was used to assess the Royal College of General Practitioners' Quality Team Development (QTD) programme. The aim of the QTD was to develop primary health care teams and their services (36). The assessment revealed that QTD can have positive benefits for participants and suggests further enquiry involving quality improvement programmes. The framework was used to determine whether secondary education curriculum operated as intended. In evaluating the 'Challenges in the teaching of Botswana General Certificate of Secondary Education Art and Design Curriculum' (37), found that even though the curriculum was in place, it still did not reflect the ideology intended for the programme.

The Illuminative Evaluation Framework is designed to conduct assessments of both quantitative and qualitative enquiries. The design allows for the illumination and synergy of both qualitative and quantitative data, as well as various documents. It is also conducive to observational enquiries. This was a retrospective study and the researcher relied on informant accounts and a document review. The framework was suitable as it enabled the researcher to answer objectives one – five of the study. The specific objectives of this study were to:

1. Describe the context in which the training occurred
2. Describe the PHC Facility Governance Structures Trainer-of-Facilitator Learning Programme
3. Examine whether the training was done according to the intentions of the PHC Facility Governance Structures Trainer-of-Facilitator Learning Programme

4. Examine whether the master trainers understood the training and whether they were able to transfer the training
5. Describe the role of the DoH support (senior) staff
6. Make recommendations for future training

9. Conclusion

This review focussed on available literature on training of clinic committees and approaches used to train clinic committees. The literature shows that clinic committees, as a vehicle for community participation, are complex and require approaches that are context specific. There has been widespread agreement on the value of functional clinic committees. There has however not yet been agreement on the functions, roles and responsibilities of governance structures in relation to the health system. It has also not been overly clear as to what is meant by governance structures, which may contribute to the current disjoint between the health system and governance structures. In order for governance structures to operate as intended by policy, intentional collaboration between the health system and governance structures is needed. This will require a clarification of what governance structures are and then an integration of governance structures into the health system.

In the broader LMIC context, clinic committees have proven to be beneficial to the health system. It has contributed positively to health outcomes. Better health outcomes are further associated with support from the health system. This contribution and their functionality are however limited by the way they are perceived by the health system and the level of authority granted to them. Training or capacity building has been positively linked to this authority and empowerment. Integration into the health system is further emphasised.

Within the South African context, there remains the need for; the capacitation of clinic committees, sustainability, integration into the health system, support and prioritisation of funds and a collaboration between governance structures and the health system.

Examples from other trainer of trainer courses highlighted a number of areas key to the success of trainer of trainer programmes. These include, but are not exclusive to; adequate resources, cost effectiveness of training programmes, sustainability, participants readiness to learn, trainers ability to train, atmospheres that are conducive to learning, accountability mechanisms such as follow-up plans and the perceptions of training professionals.

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PART C: Journal Article

PLOS ONE

(Full title)

An assessment of the 'PHC Facility Governance Structures Trainer-of-Facilitator Learning Programme' in Nkangala District, Mpumalanga Province

(Short title)

Assessing the training of PHC facility governance structures in Nkangala, Mpumalanga

Natasha Esau

Supervised by: Dr Maylene Shung King and Dr René English

Abbreviations

AET	Adult Education Theory
CHC	Community Health Centre
DoH	Department of Health
FGD	Focus Group discussion
HST	Health Systems Trust
IEF	Illuminative Evaluation Framework
KII	Key Informant Interview
LMIC	Low-and-Middle-Income-Country
NDoH	National Department of Health
NGO	Non-Government Organisation
NHA	National Health Act
PHC	Primary Health Care
ToF	Training of Facilitator
WHO	World Health Organisation

Abstract

Background

In South Africa, as part of specified governance requirements, clinic committees were established to provide management oversight at Primary Health Care facilities. In order for them to better understand their roles they needed training. Facilitators in the district were selected to participate in the 'PHC Facility Governance Structures Trainer-of-Facilitator (ToF) Learning Programme' in order to train the clinic committees. This study assessed the training of facilitators.

Methods

This retrospective single case study used qualitative methods and was guided by the Illuminative Evaluation Framework. It assessed whether the aims, objectives and methodology of the training programme was clearly conveyed by the trainers, whether this was understood by the participants and whether the participants were able to transfer the training programme as intended to the clinic committees. Qualitative data were collected through key informant interviews and focus group discussions, face to face and telephonically. These were complimented by a document and literature review. Study participants were purposively selected based on their involvement in the development, facilitation or training of the programme. Interviews were conducted in English, with semi-structured open ended questions pertaining to participants' perceptions and understanding of the training, and whether the ToF Learning Programme was delivered to the clinic committees. After participants signed consent forms interviews were audio recorded and transcribed verbatim. Data analysis was done manually and guided by the methodology presented by Ritchie and Lewis.

Results

A total of 13 participants participated in the study and 23 (national, provincial and partner) documents were reviewed. Despite the different perceptions and understandings of the ToF Learning Programme its overall goal was achieved. Participants' capacity was strengthened and they

trained the clinic committees. The document review showed inconsistency across legislations with regards to clinic committees.

Conclusion

The ToF Learning Programme has reached its overall goal despite the deviation in the process of delivery and can be recommended for implementation. [305 words]

Key words: governance structures, clinic committees, training, trainer of facilitator, South Africa

1. Introduction and background

The Alma Ata Declaration, following the international conference on Primary Health Care (PHC) in 1978, foregrounded the importance of community participation in health and health authorities' responsibility to capacitate individuals to this end (1). PHC is intended to be essential, accessible, and cost effective, allow for community participation, is fundamental to a country's health system and economic development and is the first level of contact that societies have with the health system (2)). Since the conference there has been an increase in active community engagement in decision making, planning and execution processes of the health system that has become foundational to the establishment of PHC systems, especially in Low-and-Middle-Income Countries (LMICs) (1). South Africa is one such LMIC.

Following the 1994 change in the South African Government leadership, the Ministry of Health released its *White paper for the transformation of the health system in South Africa* in 1997 (3). The White Paper introduced a policy reform for a decentralized health system that would meet the needs of all citizens, amidst limited resources (3). In this decentralised system, provinces were granted greater legislative autonomy and were tasked to ensure that clinic committees are established, have their functions clarified and that these are outlined in the respective provincial legislations (4). The White Paper, like the Alma Ata Declaration, advocated for community participation in health governance and the establishment of governance structures that would enable communities to engage in governance roles at health facilities (3). In South Africa, clinic committees is centred upon the principle of community participation in health and governance structures such as clinic committees, hospital boards and district health councils are meant to express this principle at both local and district levels (5). Governance and leadership are essential parts of any health system. One aspect of health system governance concerns the formal structures put in place by government. An essential dimension of health system governance is the participation and contribution of communities and formal structures, such as hospital boards and facility

committees have been put in place globally to provide a vehicle for community participation in how facilities execute their health service mandates (6-8).

As a key World Health Organisation (WHO) system building block, governance refers to the measures put in place by governments to ensure improvement in the health of populations, equal access to services, quality services and the rights of patients (9). According to Levendal et al the concept of health governance has always been both referred to and used to mean 'clinic committees, community health-centre committees, hospital boards and district health councils' in South Africa (10). In PHC, a clinic provides a range of services during normal working hours and a community health centre (CHC) is open 24 hours including weekends (11).

Community participation in health; a LMIC context

Community participation in health is not unique to the South African context. Clinic committees enables community participation in health, and contributes to health systems strengthening (HSS) and improved health (12). Greater care should be given to contextual, social, economic, cultural and political factors of each community during policy drafting and implementation. Community participation in health is a complex process, and evolves differently in differing contexts (12, 13). Nonetheless, adequate collaboration between the community and the health system accompanied by specific and clear roles, which is dependent on community readiness and adequate dialogue, can lead to a rewarding process (14, 15). Two examples from Kenya and Tanzania showed that, despite collaboration, inadequate authority granted to health facility committees result in their ineffective management and function (15, 16).

Studies conducted in Peru, Zimbabwe, Kenya and Uganda showed that clinic committees have the ability to contribute positively towards health outcomes (12). It showed that facilities with committees had better results with regards to increase in utilisation, user satisfaction and creating access to health care for the poor, improvement in health workers' performance despite restricted

functioning in a governance capacity and the negative perceptions of officials and health professionals towards them (12).

Studies conducted in Nigeria and Tanzania showed that clinic committees functioning has also largely been impacted by limited roles and responsibilities and a lack of training (17, 18). McCoy et al is of the opinion that a new framework should be designed that outlines the differing roles and functions of clinic committees that is to include governance, co-management, resource generator, community outreach, advocacy, intelligence and social leveller (12). Across the LMIC countries the common thread is that clinic committees are not fully empowered and capacitated.

Training of clinic committees

Given the mismatch between policy and the appropriate capacitation of community health committees in fulfilling their roles, capacity building initiatives are required for both community members and health workers, to facilitate trust and collaboration between the community and the health system, as demonstrated in a number of country initiatives (19).

In Nepal, governance challenges in the PHC system were addressed through improving capacity building around learning areas and skills on how to co-manage health facilities, deal with issues relating to human resources, deal with performance issues and granting the community access to information relating to health and financial data (19).

In Zambia, an Integrated Health Programme (ZIHP), with a trainer-of-trainer approach, has produced significant health outcomes and an improvement in health workers performance, including that of neighbourhood health committees (NHCs) (20). An assessment of the ZIHP has however raised a number of concerns around misalignment of resources and programs between ZIHP and the district health management team (DHMT), issues with sustainability, concerns around cost-effectiveness, lack of necessary equipment and lack of follow-up and supportive supervision (20).

Overall, the literature makes very little mention of training of clinic committees. In Kenya, health facility management committees were expected to engage in financial management tasks, but a study showed that less than 18% of committees – and only certain individuals – reportedly received facility and or financial management training (21).

There are also organisations who have made considerable strides towards capacitating health facility committees. The Community Practitioners on Accountability and Social Action in Health (COPASAH) has a strong community monitoring approach in LMIC health systems and prioritises capacitating communities participating in health and health facility committees (22). The Regional Network for Equity in Heath in East and Southern Africa (EQUINET) has been integral advocating for the establishment and capacitating health clinic committees (23). To this end, EQUINET has made recommendations to various LMICs to prioritise health clinic committees and together with the Training and Research Support Centre (TARSC) and the Learning Network has developed considerable documentation around community training for citizens and community representatives (23).

Trainer of trainer courses and especially those directed at clinic committees should to take into account issues such as resources, a curriculum that is transferable, skilled facilitators, clear purpose and outcomes and efforts to promote sustainability (24-28).

South African context

In South Africa, community members appointed to health governance structures are expected to know what they are required to do upon appointment (10). They are meant to function within a governing role (i.e. overseeing facility management processes) alongside facility managers at facility level. A recent study conducted in Mpumalanga, which included interviews with members of clinic committees showed that these committees generally do not perform governance functions. Instead they often function as nurses' aides, queue marshals and are put in charge of receiving various

complaints from the public (29). It also became apparent that many clinic committee members do not have high school certificates and struggle with literacy and numeracy skills, which makes reading, writing and communication difficult, which are required for their day-to-day functioning as committee members.

Despite some policy guidelines a number of factors impede the effective functioning of clinic committees (5). These impediments refer to the structural make-up of committees and the fact that existing policy guidelines are not always adhered to; members do not always operate according to the stipulated functions; member election processes are not always transparent; there are no clear linkages to the broader governance structures or other government sectors; and inadequate financial and technical input and lack of training amongst others (5).

Trainings that are conducted on an ad hoc basis, with no systematic plan or direction, cannot be sustainable or effective for clinic committees (30). Further to this, a study conducted in the Eastern Cape argued that clinic committees should be platforms for capacity building and personal development of its members who can have an impact beyond the committees' responsibilities (30).

An assessment on the status of clinic committees revealed that despite widespread agreement on the importance of integrating training with community participation, training of clinic committees still remains neglected (5). The assessment also revealed that when training occurred, it often did not meet the requirements for capacitation that enhanced members' functionality. Training would often be a once-off occurrence and exclude vital committee members, such as health facility staff (5). The assessment has advocated for on-going sustainable training programmes that will serve as a means of continuous capacitation of committee members (5). It has also called for a more collaborative partnership between the health system and governance structures through the provision of deliberate support from all levels of the health system (5). This collaboration should involve trust and an investment in training, as well as resources and development, in order for clinic committees to function effectively (30).

There is, however, very little evidence to suggest that the health system is in fact providing the necessary resources to enable the capacitation of clinic committees to fulfil their roles (10). Building the capacity of clinic committees alone will not be sufficient if not considered in relation to clarity of their roles and the capacity building of service providers and managers (10). Ultimately, not capacitating clinic committees to perform their roles as governance structures, interferes with the delivery of effective health governance and building of the health system (10).

Study rationale

South Africa has nine provinces that have made progress towards meeting the requirements for community participation in health in different ways. Some provinces have formally trained their clinic committees through external contractors. One of these external agencies, a well-established Non-Governmental Organisation (NGO) called Health Systems Trust (HST), was contracted by one of the nine provinces, Mpumalanga, to do such training in one of its districts called Nkangala. Nkangala has six sub-districts. In order for clinic committees in this district to understand their role better and to be adequately capacitated, they were earmarked to undergo training. The Nkangala Department of Health (DoH) identified potential district level trainers, who in turn would train the committee members. Towards the end of 2015, the DoH requested of HST to train the district's master trainers, in order for them to train the districts health clinic committees. Due to the districts' time and budgetary constraints it was decided that a trainer of trainer approach would best serve the district.

Variants in the name of the training exists, thus for the purpose of this assessment the training is called 'Primary Health Care (PHC) Facility Governance Structures Trainer-of-Facilitator (ToF) Learning Programme'. The training consists of three modules (described in the next section), which were meant to be facilitated by the HST facilitators. The facilitators however, only completed module one and left the newly trained facilitators behind in the district to complete modules two and three. HST has since requested that an assessment be done to see whether the model of leaving newly trained

trainers behind works as opposed to having the trainers facilitate the process through modules one to three.

This study aimed to assess the ToF Learning Programme in Nkangala district, Mpumalanga Province. The specific objectives of this assessment were to describe the context in which the training occurred, describe the ToF Learning Programme, examine whether the training was done according to the intentions of the ToF Learning Programme, examine whether the master trainers understood the training and whether they were able to transfer the training, and to describe the role of the DoH support (senior) staff and make recommendations for future training.

Researchers' reflexivity

As a staff member of HST the researcher had some knowledge about clinic committees and the ToF Learning Programme, but had no direct involvement in the Programme. The researcher is aware that this may have posed a limitation to the study and may have influenced how truthfully participants would answer questions asked of them. The researcher did however make participants aware of her relationship with HST and the study at the start of the study. Participants were again given the option to participate in the study or not. Prior to the study the researcher had concerns around whether the clinic committees would be able to grasp the training, but these concerns were addressed during discussions with the study participants.

2. ToF Learning Programme

In 2014, HST in consultation with the National Department of Health (NDoH) developed the 'PHC Facility Governance Structures ToF Learning Programme', the structure and training materials of which are outlined in Table 1. The programme has four overall learning outcomes (see table 1). There are three modules and each module has a specific set of training material serving a specific purpose (see table 1).

Table 1 ToF Learning Programme Training Material

Overall learning outcomes	Module 1	Module 2	Module 3
• Understand the legislative and administrative framework and organisational structure of the NHS • Participate in and contribute to the planning, M&E, and quality assurance of health establishments • Understand health paradigm • Use and apply relevant information, knowledge skills and values to fulfil the governance role in the health system	**Purpose and participants:** Training of facilitators	**Purpose and participants:** Training of clinic committees	**Purpose and participants:** Follow-up sessions and on-going mentoring of clinic committees
	Material: Facilitation guide for capacity strengthening of health governance structures	**Material:** Learning resources for PHC facility governance structure members	**Material:** a) A set of 16 Posters b) Pocket Handbook
	Purpose of material: • Provides background knowledge of health governance, facilitation and adult education • Introduces the ToF Learning Programme to facilitators • Provides guidance on how to use the guide and how to facilitate the ToF Learning Programme	**Purpose of material:** • To be used together with the facilitators guide to train governance structure members	**Purpose of material:** a) Used for reflection of the training, highlighting areas needing clarification To be displayed in health facilities for easy access and reference to governance structure members and health facility staff b) An easy reference guide of roles and responsibilities for clinic committees, health managers and facility staff To be used during follow-up sessions

Training approach and implementation

The overall aim of the ToF Learning Programme is to strengthen the facilitator's capacity to deliver the PHC facility governance structure capacity strengthening learning programme, to the clinic

committees (31). The ToF Learning Programme is based on the principles of Adult Education Theory (AET). AET is transformative and autonomous as it facilitates critical thinking and the assessment of knowledge in order to derive at one's own conclusions regarding a particular area of interest (32). It is the art of facilitating learning to adult learners, through specifically crafted activities (33).

The HST facilitators were meant to facilitate module one and to oversee the facilitation of modules two and three, whilst the districts newly trained facilitators facilitated modules two and three. The programme was first piloted in uMzinyathi district, in KwaZulu-Natal, in 2015 by HST. A short evaluation at the end of the training sessions revealed areas in the programme that needed revision. The HST team had subsequently incorporated these changes. The pilot in uMzinyathi implemented the training programme as it was intended: from the training of facilitators to the training of governance structures to the three follow-up sessions with the HST team overseeing the facilitation process throughout.

3. Methods

3.1 Study design

This was a retrospective qualitative single case study with key informant interviews (KIIs), focus group discussions (FGDs) and a document review. In this qualitative descriptive assessment the outcomes of the training for the clinic committees have not been assessed, nor has the perspectives of the clinic committee members been elicited. This study has elicited the perspectives of the trainers and how they perceived the clinic committees had experienced the training. The validation of the trainer's perspectives and the clinic committee's perspectives will be considered at a later stage as part of another study. The study was guided by the Illuminative Evaluation Framework (IEF) as referred to below.

3.2 Conceptual framework

The conceptual framework drawn upon for this assessment was the Illuminative Evaluation Framework (IEF), as shown in Table 2 and discussed below.

Table 2 Illuminative Evaluation Framework

The Illuminative Evaluation Framework	
Enables researches to →	1. Explore the educational process 2. Explore programme outcomes 3. Explore its consequences
The aims of illuminative evaluation are to study an innovatory programme →	1. How it operates 2. How it is influences by the various situations in which it is applied 3. What those directly concerned think are its advantages and how students' intellectual tasks and academic experiences are most affected
It seeks to document and discover what it is like to be →	1. Participating in the scheme, whether as student or teacher 2. It looks for the most significant features and critical processes of the innovation (in this case, the ToF Learning Programme)

Source 1 Taken from Smith, Masterson & Lask, 1995; 246

Other conceptual frameworks considered were the Kirkpatrick and Kirkpatrick's 'Evaluating Training Programmes' (34), Holton's 'HRD Evaluation Research and Measurement Model' (35) and the Buse et al's 'Health Policy Analysis' (36). These were however not suitable as it was either too focussed on the learning experiences of the participants in the training with not enough emphasis on the context, content, and the process undertaken or the power dynamics of stakeholders.

The rationale and design for the IEF was introduced by editors Parlett and Dearden in 1977 and looks at a learning programme's educational processes or the instruction system (course material), programme outcomes or the learning milieu (through qualitative collection of data) and the consequences of the programme (37, 38). The instruction system also refers to the context within which learning takes place, highlighting the roles of the various actors which enhance aspects of the programme outcomes and its consequences. The IEF continues to be used to evaluate various educational training programmes as well as to inform training and implementation policies (39).

In response to the research questions; how did the training approach adopted in Nkangala work? Was the training approach sufficient or comprehensive enough for the newly trained facilitators to train the clinic committees without the assistance of external trainers? The IEF enabled the

assessment of the ToF Learning Programme by checking whether the aims, objectives and methodology of the training programme was clearly conveyed by the facilitators, whether this was understood by the participants and whether the participants were able to transfer the training programme as intended to the clinic committee members. It also enabled the documentation of participants' perceptions and experiences of the training.

Study setting

The study was conducted in Nkangala district, Mpumalanga Province, South Africa. The district is strategically situated on the Maputo Development Corridor and borders Gauteng Province which has contributed to it being the economic hub of Mpumalanga. Nkangala District has a total population of 1,308,129 and 115 health facilities (fixed clinics, community health centres, mobile clinics, hospitals) across the six sub-districts. Of its 279 facilities in the province, the province has established a total of 188 functioning clinic committees (40). Nkangala has a total of 90 PHC fixed clinics, community health centres, with an established clinic committee, consisting of ten members each.

3.3 Sampling

Participants were purposively selected based on their involvement in the ToF Learning Programme, their availability and consent given to participate in the study. Participants were initially identified as master trainers and DoH (senior) staff. This was later changed as it became apparent that the district does not have master trainers per se and due to the volume of sub-districts and clinic committee members the DoH availed its available staff to participate in the training. Of the fifty-three trainees who participated in the training, eleven agreed to participate in this study. Seven of the eleven trainees agreed to participate in two focus group discussions. These two groups were separated into (1) DoH sub-district managers and (2) health facility supervisors. Despite the small number of participants who agreed to participate in FGDs the researcher is of the opinion that no further information would have been received in a KII setting and that these two groups enhanced individual participation due to the safe space created for participation. Further to this, FGDs also worked

better logistically. Four participants participated in key informant interviews. These included the two HST training facilitators, the PHC director and a sub-district manager. Snowballing allowed for a further two participants (HST and NDoH) to be identified and participate as key informants. (See table 3). The PHC director also served as a gatekeeper for the district and made the purposive selection of the DoH participants based on the criteria provided by the researcher. Using both FGDs and KIIs combined with the literature and document review ensures credibility and rigour of findings. HST in collaboration with NDoH developed the training material and HST facilitated the training in Nkangala District.

Table 3 Sampling

Interviews	Department	Description	Number of participants	Method of interview
Key informant interviews	NDoH	Informal conversation	1	Telephonic
	Nkangala DoH	Director of PHC Sub-district manager	1 1	Face to face Face to face
	HST	Director of Research Training facilitators	1 2	Face to face Telephonic
Total participants			***6***	
Focus group discussions	Group 1	Sub-district managers	3	Face to face
	Group 2	Health facility supervisors	4	Face to face
Total participants			***7***	

3.4 Data collection

Data collection encompassed primarily of qualitative data collection from key informants and a document review.

Qualitative data

Data collection incorporated mainly two forms of qualitative data collection: KIIs and FGDs (see Table 3). After ensuring that the participants read and understood the information sheet and signed the informed consent form, the interviews and discussions were conducted in the English language and were audio recorded and transcribed verbatim. The interview process was semi-structured, with

open ended and clarifying questions pertaining to participants' perceptions and understanding of the training, and whether the learning programme was delivered to the clinic committees. Qualitative data collection further included a literature review and a documentary review.

Document review

In this study the document review enables analysis of relevant documentation as a way to identify consistency between a country's national level policies and documents (41). In qualitative studies document reviews are useful means of data triangulation, and cost-effective (42). To gain an understanding of the policy and legislative requirements for clinic committees and the subsequent practical application of these in South Africa, relevant available published and unpublished policies, legislative and appropriate training guidelines were searched for and reviewed. Inclusion and exclusion criteria are presented in Table 4 below.

Table 4 Inclusion and exclusion criteria for the documentary review

Inclusion criteria	Exclusion criteria
1. South African documents: a. policies, laws and training guidelines b. that say something about clinic committees' role, position and training South African documents or policies 2. Speak to clinic committees specifically: a. Role, position and training 3. Policies and or documents dated between 1996 and 2017	1. Documents: a. not from South Africa b. speaks to hospital boards or other forms of community participation 2. Policies and or documents outside of the 1996 and 2017 timeframe

Sources of information consisted of publicly available national and provincial government websites, academic institutions and HST that supports the development of government departments (see Appendix M for list of documents reviewed).

A data extraction template was developed using an Excel spread sheet to chart relevant data (see Appendix N for list of variables). Shown in Table 5 below are the search terms used.

Table 5 Search terms

Search terms
“health” AND “policy”
“clinic committees” AND “South Africa”
“health policy”
“South African health policies”
“national” AND “policies” AND “clinic committees”
“clinic committees” AND “training” AND “policy”
“South Africa” AND “clinic committees”
“South Africa” AND “guidelines”
“South Africa” AND “strategic objectives”

3.5 Data analysis

Due to the small sample size of participants the data were manually analysed, using the methodology presented by Ritchie and Lewis (2003). This iterative form of analysis consisted of three phases: data management, descriptive accounts and explanatory accounts (43).

Phase 1: Data management

The transcripts were anonymised by assigning unique codes to participants. The transcripts for the FGDs were kept in two separate groups, namely for (1) the sub-district managers, and (2) the health facility supervisors. The KIIs were individually analysed and stored. A coding framework was designed using an Excel spreadsheet (see results section). Deductive themes were the initial set of themes derived from the questionnaires as informed by the literature review. In both the transcripts and spreadsheets various parts of the texts were assigned to the various codes and each code assigned a number and were then further analysed until sub-themes and sub-sub-themes emerged. Text was assigned to the subsequent themes in the same manner as for the initial themes, and repeated until new sets of themes emerged. An inductive or new theme, not part of the study’s initial deductive enquiry, also emerged. The analysis for the inductive theme followed the same

procedure as the deductive themes. The Illuminative Evaluation Framework was instrumental in clarifying the deductive themes.

Phase 2: Descriptive accounts

All themes were collated into one spreadsheet and the content of each theme was categorised and classified into sub-themes (43). Data were examined for participants' responses to the themes and sub-themes and how different participants responded to specific themes thus eliciting the variants, similarities, and interesting elements within the different responses. This led to a new set of themes and sub-themes which then led to further classification, and gave rise to new interpretations and understandings of the themes, which highlighted the interconnectedness between various themes. These themes were merged together.

Phase 3: Explanatory accounts

During this phase a thematic chart containing summarised versions of the managed and described data was used to provide explanations for the identified patterns and associations (43). After checking the number of times these patterns and associations appeared across the dataset, data were clustered together and explanations were assigned to the patterns. These explanations resulted from the researchers theoretical perspective, inference of an underlying logic, the use of explicit reasoning and using common sense (43).

3.6 Documentary data analysis

Excel spreadsheets were created for deductive themes that arose from within the text. The development of themes was an iterative process and followed the same procedure presented above. The data were then triangulated with the objectives of the study, the qualitative results and the literature review.

4. Ethics approval and support

Approval of this study was received from the University of Cape Town, Faculty of Sciences' Human Research Ethics Committee (FHS HREC, REF 194/2017, and Appendix O). Support for this study was received from the Mpumalanga Provincial Department of Health (Appendix P).

5. Results

The themes that emerged from the analysis of the document review and interviews are listed in Table 6 and are referred to below.

Table 6 Emerging themes

Source	Themes	Sub-themes
Document review	Legislative perceptions of clinic committees	The establishment of clinic committees; a national priority
		Training of clinic committees; a lesser priority
		Stipend as legislated
Interviews	Perceptions	Participants' perceptions of the training
		Participants' perceptions of themselves
		Participants' perceptions of clinic committees
		Participants' perceptions of training clinic committees
	Understandings of the training	Capacity building of the trainers
		Empowerment of participants and clinic committees
		Ownership of positions as committee members
	Stipend as motivator	

5.1 Document review

Legislative perceptions of clinic committees

The establishment of clinic committees; a national priority

From as early as 1997, community participation in health, through the establishment of governance structures, has been a department of health priority (3). This priority is reflected in all 23 documents reviewed (policies, guidelines, reports and training material). The first province to have legislated clinic committees, in 1999, was the Eastern Cape (44). The South African Health Act, of 2003 (NHA),

mandated the establishment of clinic committees and offered limited guidance with regards to the how and left this up to the provinces. As a result, clinic committees differ across South Africa in terms of its composition, eligibility for membership criteria, roles and responsibilities, powers and functions. At least three provincial documents, including the earlier versions of these documents, have not been explicit about the composition of their committees (44-46).

With regards to the composition of committees, some provinces followed the NHA guide: one or more local government councillors, one or more members of the community, and the head of the facility and added a ward councillor and/or municipal councillors (47-50). Other provinces followed a more intersectoral approach (51). Some provinces like Mpumalanga, in their guideline, included organized labour, traditional authorities and people representing disabled groups amongst others (47, 52, 53). These too differ across the provinces.

A National Colloquium held in Cape Town in 2014 provided an opportunity for stakeholders working on community participation in health to share research findings and experiences (51). It concurred that the roles, responsibilities, powers and functions of committees are generally understood to mean oversight, governance, advocacy, social mobilization and representing the needs of the community (51). These are however not similar across provinces. Some provinces require of their committees to ensure sustainability and collaboration between all levels of the health system (46, 54).

Training of clinic committees; a lesser priority

Training of clinic committees are not prioritized across the provinces. Certain provinces (46-49) have legislated some form of induction, training or capacity building, but it is not clear what these entail. The *Ideal Clinic Manual*, a reference guide for managers to enable them to determine the status of the Ideal Clinic dashboard elements in a facility, infers training to be the responsibility of the district (55).

In 2014, the Learning Network for Health and Human Rights developed training material called *Health Committee Training: Participant Manuals*. The Learning Network aims to use human rights to advance health issues through collective action and reflection, in order to identify best practices with regard to using human rights to advance health issues. The training manual, accompanied by a Facilitators Guide and skilled facilitators, is an on-going training and capacity building programme for clinic committees (56). It provides a platform referred to as learning circles for committee members to share their experiences, consolidate new capacities and explore new topics (56). The training is scheduled over three days and intended to be adaptable to different contexts, particularly with regards to legislation and needs of the participants (56). This material has been in use since 2014, in the Western Cape and Eastern Cape provinces (51).

The *ToF Learning Programme*, the focus of this study and discussed elsewhere, had been commissioned by the NDoH and was meant to be a standardized training programme that can easily be adapted within the different contexts (31, 57). In referring to the ToF Learning Programme the *NDoH Annual Report for 2016/17* stated that 'a Handbook with training material has been developed to institutionalise a uniform approach with regard to the establishment and sustainability of governance structures for PHC facilities' (58). According to the NDoH key informant, the department's overall plan is a national standardized dissemination of the training programme, by hosting one training session for representatives of the nine provinces and for these representatives to train facilitators within their respective provinces and districts so that they in turn can train their clinic committee members (KI_5).

Stipend as legislated

Three of the documents reviewed (44, 48, 54) referred to some form of reimbursement for meetings attended, or hours spent on committee work, or travel reimbursement for meetings attended. Stipends are not standardized across the three provinces and the rest of the provinces are silent on

the topic. The Colloquium concluded that support in the form of reimbursement is a government responsibility and should be considered (51). This was also a sentiment from the study participants.

These results served to complement results from the participant interview process which is the focus of the next section of the results.

5.2 Interviews

In this section a few interesting quotations linked to the perceptions and the understandings of the training are referred to in Table 7 below.

Table 7 Table of quotations

Perceptions	
Quote 1	*"FG2_P1: the first training… the exercises were good. So the training was very much good because of the equipment, material and also the facilitators"*
Quote 2	*"FG2_P4: well it was very, very good according to me because…it was very informative… The material the scenarios everything was practical during training so it was easier for us to deliver to the clinic committee members and the nurse in our facilities"*
Quote 3	*"KI_4: I would have loved to increase the time…the time was very much limited"*
Quote 4	*"KI_4: we never had a chance of giving feedback to HST…with the follow-up training we could have been able to do that"*
Quote 5	*"KI_2: they (previous participants) also asked for more time for simulation and the adult education theory and that we did in Nkangala"*
Quote 6	*"FG1_P3: whilst you are actually here to make sure that you impart knowledge to others but you end up gaining yourself"*
Quote 7	*"FG1_P1: I mean I didn't find anywhere where it was bad or difficult depending on your level of understanding so to me it was exciting"*
Quote 8	*"KI_3: I know that there was a bit of concern as well from the national department of health in terms of the content, but…as a district we just felt let's empower people to the best of our ability using the material that we have. Because in essence how then do you break it down further than it actually is? What do you say? I mean policy is policy…"*
Quote 9	*"FG1_P2: Yah we were really empowered to such an extent that I was worried saying, if the content is challenging to some of us what was going to happen to the governance structures down there?"*
Quote 10	*"FG1_P1: when we looked into the material we thought this is higher grade but when we actually start training…we could deduct that people understand. People know what is happening around their community…they could relate nicely"* *"FG1_P3: you might have elected them from ordinary community members by show of hand but you must never underestimate their capabilities and their comprehension levels"*
Quote 11	*"FG1_P3: we went to sub-districts…I also wanted to overemphasize on the issue of the knowledge and the skills of the clinic committees it's not that low…you may think that these are just ordinary community members but when you get there you*

	find very knowledgeable people. Though I admit that somewhere you find an elderly person one or two but the majority of them are young people and they can engage"
Quote 12	*"FG1_P2: it was tough…and you knew you were going to train people that did not go to school…you read and you translate in the language that they understand…it depends on an area because I'm from the deep rural areas and most of the governance structures members are older people. English is not easy to them so we need to translate in their local language"*
Quote 13	*"FG2_P4: the difficulty that I experienced was when I was capacitating the clinic committee members. The different languages…was exhausting because I had to change many times to all this languages"*
Understandings of the training	
Quote 14	*"FG1_P1: as managers…we also understood better on how we can deal with conflict that arise at a cold face and also issues that affect our staff"* *"FG1_P2: really it polished our skills like presentation skills for some of us who did not know how to present"* *"FG2_P1: we gained knowledge and skills to be able to train the clinic committees"*
Quote 15	*"KI_3: So it is in our interest as a department of health to ensure that these clinic committees are optimally utilized and that they are efficient and effective in their duties. So it becomes important that we ensure that they count"*
Quote 16	*"FG1_P1: so in terms of what we've received and also cascaded to our governance structures I think we felt empowered"*
Quote 17	*"FG1_P3: You will not feel that you've appointed clinic committees, until the training. After the training you realize…they know their important roles…in facilities. The training…really changed how they see themselves and their authority. Now they started knowing that they're heavy weights and they started punching on that level of weight that they carry…you can see the knowledge that they have and it changes your own perception"*
Quote 18	*"KI_6: we get side-tracked by a nice glossy book, but does it actually work? Because if it doesn't work then de-invest in it. Find another way to empower the committees."*
Quote 19	*"KI_4: …in some indicators especially ANC bookings before 20 weeks, coupled with protection rate, there has been improvement…and the testing rate also improved. I would say, because of the training that was imparted to them, because they could be empowered and could influence their communities"*
Quote 20	*"KI_3: So that they are able to empower the community and in empowering the community we want that ownership where they can call the clinic their own"*
Quote 21	*"FG1_P1: they approach you to say please advise us on your recruitment process and some of them will even insist to say as a chairperson I want a sit in the interviews. I want to sit there and make sure that you get a good cadre there. I don't want someone who's going to…wake up sick and it's going to affect my population there."*
Quote 22	*"KI_3: if they have that passion and there's that ownership whatever challenges that the facility is having…they step in. And when it comes to the queue marshaling and so forth that's part of the Ideal Clinic and with the shortage of staff… They become very passionate and we do not discourage that…they are…assisting in addressing the gaps that are there at that point in time"*
Quote 23	*"KI_4: (if) there's a conflict the governance structures are there to buffer…like a shock absorber…they act on our behalf as well because they are assisting the facility functions"*

Perceptions

Participants' perceptions of the training

The participants' from the two focus groups as well as the two DoH key informants perceived the training as good. Managers perceived the training as good, yet challenging for the most part, and of a very high standard. It was considered to be on par with tertiary level training. The supervisors did not perceive the training to be challenging, and found the material and training process to be of a very high yet acceptable standard. In making reference to this standard, one participant listed their own criteria that made for an acceptable standard (Table 7, quote 1). Added to this the participants perceived the training tools and process to have facilitated the learning and transfer process (Table 7, quote 2).

There were however some participants that found the training schedule to be taxing due to the content, but the general sense were that it worked well. Only one participant felt that more time should have been given to the training (Table 7, quote 3). This participant felt that a follow-up session would have been helpful (Table 7, quote 4). One of the training facilitators had indicated that the timeframe had already been increased from three days to five days, based on input and recommendations from a previous pilot (Table 7, quote 5).

Despite this, the participants from the two focus groups as well as the two DoH key informants perceived the training to have met its overall objective. Further to this, managers in particular felt that their public speaking, presentation and facilitation skills had been developed. The managers also felt that since the training their own management roles were enhanced. The training exceeded their expectations. They learned how to train clinic committees and were surprised at gaining knowledge themselves. One of the participants mentioned how this was unexpected (Table 7, quote 6).

Participants' perceptions of themselves

At the same time the participants were challenged by their perceptions of themselves, their level of education and their abilities as managers. On the other hand the training was also challenging in that

participants from FG1 found the content in general to be difficult or parts of the content to be difficult whereas the participants from FG2 did not find any part of the training to be difficult (Table 7, quote 7).

Participants' perceptions of clinic committees

The ToF Learning Programme initially sparked some debate between different stakeholders. Some stakeholders were concerned that the level of the information would be too difficult for the committee members to grasp. Others were however, of the opinion that the intellect of committee members was being underestimated. One of the managers shared the stakeholders concerns prior to the training of the committee members. He concluded that the ToF Learning Programme proved to be a source of empowerment for the committee members.

These were NDoH concerns as well, but the Nkangala District DoH decided to use the material to train the clinic committees, regardless, as pointed out by one of the key informants (Table 7, quote 8). The participants initially perceived clinic committee members to be less educated, old and slow to learn. They too, were concerned that clinic committees would not be able to grasp the content and that the training would be too high level for them. In light of this they were not sure whether and how the committee members would benefit from the training as pointed out by one participant (Table 7, quote 9).

Participants' perceptions of training clinic committees

According to all the focus group participants, their previously held perceptions of the clinic committees and the training had changed after training the committee members. From FG1, two participants were particularly surprised that the committee members were able to understand and relate what they had learned to their daily activities (Table 7, quote 10).

There was however a number of factors that impeded the delivery of the training programme. Structural differences (e.g. rural versus urban) marking the South African context yielded different

perceptions. Participants were of the opinion that urban meant younger and more educated members whilst rural meant older and less educated members. Those who conducted the training in urban areas experienced the training of clinic committees to be good. According to one participant most clinic committees were younger and could grasp quicker. There were however some committee members that struggled. One of the participants emphasized this (Table 7, quote 11). Other reported impediments were language, education levels, and the time allocation, which impacted on the delivery of the training. The participants who trained in the rural areas found that they had to translate the material from English into the local languages and found this particularly hard as mentioned by one of the participants (Table 7, quote 12).

The supervisors did not perceive the initial training as challenging, but as some of the managers they found training the clinic committee members to be very challenging. Training in the rural areas meant having to translate the training from English into the local languages, and thus more time was required to accommodate for the translations. Some participants also struggled with the actual translations as they could not translate some of the concepts into the different languages. One participant shared that language in particular was a major difficulty during the training (Table 7, quote 13).

Understandings of the training

Capacity building of the trainers

Based on the participant's from the two focus groups as well as one of the DoH key informants own understandings of the training they felt that they had been capacitated with the necessary knowledge and skills to train the clinic committees. They trained the clinic committees using the knowledge and skills received during the training. All the participants from FGD one thought the training better equipped them to fulfil their management roles and responsibilities. One of the training facilitators was not entirely sure as to whether capacity strengthening took place during the

training and if it did, to what degree. The participants from both FGDs and two key informants however agreed that the strengthening of facilitator's capacity to deliver the ToF Learning Programme had taken place during the training. Three of the participants from FGDs one and two shared how they were capacitated (Table 7, quote 14). A key informant felt it was the duty of the DoH to fully capacitate clinic committees as this would communicate acknowledgment of their value (Table 7, quote 15).

Empowerment of participants and clinic committees

Apart from being capacitated, a sense of empowerment resonated throughout, but this sense was more prominent in relation to the clinic committees. Only the participants from FGD one articulated that they had personally been empowered by the training. The knowledge they received during the training and the fact that they could pass this knowledge on to the clinic committees. Based on their interaction with the clinic committees after their training, it had become clear to them that empowerment had taken place. Another area in which participants felt empowered by the training was knowing the roles of the governance structures at facility level. Prior to the training it was not clear to all the participants what the roles of the clinic committees were. One participant shared how he was able to share this newfound knowledge with the clinic committees (Table 7, quote 16).

According to the study participants the empowerment of clinic committees has meant different things. It has meant: (a) members now had confidence to do what was required of them, (b) members' functionality could lead to better health outcomes, (c) greater ownership of the health facility and communities, (d) better understanding of their roles and responsibilities as well as reporting lines, and (e) understanding management functions and administrative procedures . These came as a result of the participants' interaction with the clinic committees since the training. One of the sub-district managers described the empowerment of clinic committees (Table 7, quote 17).

Participants from FGD two did not contribute to the conversation on their own empowerment or that of clinic committees. Empowerment was one of the underlying aims of the ToF Facilitators guide. Ultimately the training is about empowering people. This means that stakeholders may need to make drastic changes should this tool no longer be capable of producing empowerment within people. One of the key informants felt the empowerment of clinic committees to be the key factor (Table 7, quote 18).

Whilst the study did not set out to determine the impact of the training, some participants volunteered their perspectives on possible outcomes that they perceived were influenced by the training of the clinic committees. One participant indicated that the training led to a change in certain indicators (Table 7, quote 19). This could however not be corroborated as there were a number of factors could have influenced this outcome and according to the correlation had not yet been tested.

Ownership of positions as committee members

With the empowerment of clinic committees the DoH had somehow hoped that this would lead to a sense of ownership of health facilities. The key informant mentioned this to have been the case (Table 7, quote 20). Based on discussions with participants, the act of empowering clinic committees has in fact led to a sense of ownership of health facilities and the community amongst committee members. One of the participants relayed how the chairperson of a committee requested more involvement in decision making in his facility as this may impact on his population (Table 7, quote 21).

The notion of ownership of the facility has also been linked to participants fulfilling roles other than that of governance at facilities. One participant explained how community members take ownership of their facilities through doing what needs to be done at a particular time (Table 7, quote 22).

Another participant likened ownership to the act of becoming shock absorbers between the health professionals and the committee (Table 7, quote 23).

Stipend as motivator

Whilst not part of the studies initial enquiry, stipends, an inductive theme recurred throughout interactions with participants. As the document review indicated a lack of stipends within legislation across provinces, so too did the empirical data confirm the impact this has had with regards to the functioning of clinic committees. Stipends were perceived as a motivating factor for joining and leaving clinic committees, despite the fact that stipends had not been offered (KI_3). This has led to continuous discussions, re-nomination processes and re-training of members. According to the participants, the drive for stipends was more from younger members and those with political orientations. Older members, pensioners in particular, expressed less of a concern for stipends. Participants believed this to be due to them receiving monthly pensions (KI_3, FG2_P2). The majority of clinic committee members are unemployed and sees serving on committees as a means to career advancement. Stipends are given to hospital boards and not clinic committees, despite both being governance structures. The absence of stipends, in particular, has served as a barrier to functionality, longevity and sustainability of active clinic committees (FG1_P3, FG2_P4 and KI_6).

From a government perspective, stipends have not been an easy topic as it has funding, governance and accountability implications (KI_6). The DoH has expressed an awareness of the issues around stipends and is in the process of formalising it through having a unified approach (KI_5). To this end the department has conducted a short study aimed at assessing the status of stipends in two provinces. On the other hand, the participants from the FGDs also questioned the volunteerism approach and felt that it leads to members with low educational levels and no prospects of career development (FG1_P3).

6. Discussion and conclusions

Guided by the IEF, this study set out to assess the PHC Facility Governance Structures ToF Learning Programme conducted in Nkangala District, Mpumalanga. The IEF enabled the researcher to determine whether the aims, objectives and methodology of the training programme were clearly conveyed by the facilitators, whether this was understood by the participants and whether the participants were able to transfer the training programme as intended to the clinic committees. It set out to describe the context in which the training occurred, describe the ToF Learning Programme, examine whether the training was done according to the intentions of the ToF Learning Programme, examine whether the master trainers understood the training and whether they were able to transfer the training, describe the role of the DoH support (senior) staff and to make recommendations for future training. The study used qualitative data collection methods.

Despite the deviation in the training process, the significance of the ToF Learning Programme is that it was still delivered as intended. The training fulfilled its overall purpose in that the facilitators' capacity was strengthened and they were able to deliver the ToF Learning Programme to the clinic committees. The literature emphasises the importance and need for training clinic committees, yet without enough focus on the actual training of clinic committees. In reference to the results section and the particularly the views of the focus group participants and the key informants, this study suggests that despite this, committee members seem receptive to and values training and that functioning at facility level can be enhanced as a result of training. As shown in the results section, based on the views of the focus groups and key informant participants in the study, the ToF Learning Programme can thus be seen as beneficial and can be recommended for implementation. The results also suggest that the Programme is feasible, potentially sustainable and could be adapted to different contexts. Feasible in that large numbers of clinic committee members can be trained, including follow-up trainings, within a short period of time. The training of facilitators within and from the same districts speaks to its ability to be sustainable. Capacitating individuals from within

the same districts and or areas have the ability to foster sustainability. A number of factors contributed to the successful outcome of the training process.

Trainer of trainer approach

Trainer of trainer courses are beneficial, highly effective, yield positive outcomes and influences attitudes and behaviours in that they tend to (1) be more cost effective than employing professional trainers (2) develops local capacity (3) maintain cultural significance and adaptation necessary for learning (25). It is appropriate in settings where large numbers of people require training, bearing in mind the quality of the training material (25). Trabeau et al, however, found no substantial difference between a trainer of trainer approach and training by an expert approach and suggests focus be directed to understanding the training program and the theory that guides it instead (28).

The sustainability of trainer of trainer courses is partly dependent on the measures of follow-up on trainings put in place as this determines future training and curriculum developments (25). The ToF Learning Programme made provision for three follow-up sessions and in Nkangala the DoH has continuous training done by facility managers. Sustainability is further impacted by programme design, the participant's ability or readiness to learn, the trainers ability to train and accountability mechanisms through which all parties involved (trainers, trainees and management) adheres to (24)). It can also pose challenges if certain aspects such as resources, training environment, clear purpose of training and criteria for participants amongst others are not taken into account (25, 27, 28).

Factors enabling transfer are dependent on the process and characteristics of trainees; such as their ability to learn, the extent to which they are guided by their conscience, their choice in voluntary participation and the atmosphere in which they work (27). Successful transfer is dependent on a combination of factors, namely, the trainers' ability to conduct the training, and the trainers participation in the design, implementation and evaluation of the training process (26). It is thus

critical for trainers to have a concrete understanding of the underlying philosophy, the skill sets to transfer this understanding in creative ways, to have a clear understanding of the desired outcomes of the training and to conduct training in a manner that yields these outcomes (26, 28).

From the participants' perspective and based on their interaction with governance structures the latter were capacitated, empowered and have shown the ability integrate this new knowledge into their day to day activities. With regards to sustainability and continuous capacitation this approach may need to be considered as an alternative to the policy intent. This confirms that training programmes with a systematic plan and direction can be sustainable and effective for clinic committees (30). On-going sustainable training programmes can serve as a means of continuous capacitation (5).

Adult Education Theory

The process of adults learning is often referred to and seen as being transformative and transformational (33, 59, 60). Apart from acquiring various sets of knowledge and skills, it enables a deeper understanding of self and one's being in the world (61). This understanding is reached through the learning experience that encourages the engagement of one's own views, experiences and understandings of the world (61). The differing pre and post perceptions of the training that participants have of themselves and others are indicative of the power of adult education to be both transformative and transformational. At the same time, adult education remains complex, ever changing and requires attention to the context within which learning takes place (33).

Training of managers

Studies have shown the value-add of capacitating health managers and how it can contribute to better health outcomes and organisational change (62, 63). The participants indicated that the training improved their knowledge about clinic committees and their understanding of the roles and functions of clinic committees. Their skills, facilitation and public speaking, improved and they are

able to better perform their managerial tasks. Further to this, capacity building efforts that have government support and positive management attitudes, can contribute to the success of these efforts (64). Contextual factors (65, 66) including local as oppose to external trainers can impact training successes significantly.

Policy

In South Africa, the establishment of clinic committees are a national priority, as indicated by its national and provincial legislatures. These legislatures however do not prioritise capacitating members of these committees. Policies are essential, but often inadequate when it does not address all that is required for transformation (67). Hence deliberate policy changes, including the development of skill sets, are required for the achievement and sustainability of health goals (68-70). Lack of clear national level guidelines indicates a gap in policy development, interferes with and can lead to inconsistent implementation (71, 72). Policies thus have to adequately reflect and prioritise desired health outcomes. These have to be in place for successful role out of national strategies.

Stipend

Volunteerism, a vehicle through which PHC is delivered requires a change at health systems level that promotes community participation in health (73). In the South African context, in particular, the concept of volunteering has evolved into a service associated with some form of remuneration (74). Volunteerism was envisioned as a form of job creation and alleviating poverty (74). The lack of stipends or other forms of reimbursement demotivates community participation in health and often leads to high attrition rates (75). The role of stipends cannot be underestimated in volunteerism. It serves as a major motivator for involvement and the lack thereof impacts on the functioning, sustainability and stability of clinic committees. It also has negative implications for training. The policies reviewed showed an inconsistency with regards to stipends for clinic committee members.

Perceptions of community members

The IEF was instrumental in drawing out intended and unintended consequences (39, 76). The perceptions revealed towards the community members is one such unintended consequence as it points to prejudice of professionals which leads to them underestimating community members abilities and intellect. The IEF was useful in that it allowed participants the opportunity to reflect on their experiences as participants at first and later as facilitators. A limitation particularly pertaining to the IEF was that this was a retrospective study, which did not allow for direct observation and documentation of the processes as it unfolded.

Limitations and opportunities of the study

The successful transfer of training could however not be tested as the clinic committees did not form part of this study. This lends the opportunity to further enquiry that will include clinic committees. Perceptions of participants will have to be corroborated with clinic committees at a later stage in another study. Document reviews have limitations. These include by nature of its design, limitations to required information, challenges with accessing documents and it may be biased in the way documents are selected (42). As is the nature of qualitative research, the initial methods set out for this study did not unfold quite as expected. In qualitative research, a change of plans can always be anticipated and as a researcher one need to be flexible, bearing the original research design in mind (77).

6.1 Recommendations

6.1.1 Policy recommendations

This study set out to assess whether the training model presented in Nkangala works and to make recommendations for future training. Based on the results of this study; the documentary review and the interviews, a few implications for policy emerged.

Legislative prioritisation

The current inconsistent legislation and application of training suggest that standardised legislative guidelines for the ToF Learning Programme are required. The development of a standardized national guideline for governance structures is critical. This will further communicate clinic committees as a national prerogative and give a unified direction with regards to clinic committees. It will also aid the process of monitoring and evaluation of the committees.

Standardisation of the training

Large scale uptake of the ToF Learning Programme will require a standardisation of the training programme, but this must be accompanied by flexibility so as to allow for differences in district contexts.

Training availability and accessibility

In order to enable the wide dissemination of the ToF Learning Programme the necessary processes and resources should be in place to make training available and accessible to all committee members across the nine provinces.

Stipend

Based on the concerns about stipends, a national position on stipends is required and must be fast-tracked considering the impact of lack of stipends clinic committees' functionality.

6.1.2 Practice recommendations

Based on the results of the study and how this may imply for policy the following recommendations on the length and format of training through use of train the trainer approach are advised to aid future training.

Language

Training material should be translated into the different languages which represent the South African population to foster inclusiveness and encourage learning.

Greater inclusivity

Based on the results from the Nkangala training, in particular, it would be highly advisable to extend the ToF Learning Programme to all levels of health system (national, provincial, district, sub-district and facility) and the clinic committees. This has the potential to bridge the gap currently existing between the department of health and the community and serve to familiarise all levels of the health system with the roles of clinic committees.

Training material

In order to make the training more effective and sustainable it would be advisable to print only the 16 Posters and the Pocket Handbook for training participants. This will allow for greater access to the material and for the DoH to make this possible.

6.2 Competing interests

None declared

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6.4 Author's contributions

The author is responsible for the development of the study design, data collection, management, analysis and write-up of findings.

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PART D: APPENDICES

An assessment of the 'PHC Facility Governance Structures Trainer-of-Facilitator Learning Programme' in Nkangala District, Mpumalanga Province

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S1 Appendix A: Data collection tool – KII (District DoH)

For the interviewer to complete
Name of researcher: ……..
Name of supervisor: ……
Name of co-supervisor: ……
Name of organisation: ……
Date of interview: ……
Venue of interview: ……

Introduction
Hello my name is…… I am a Master in Public Health (MPH) student at the University of Cape Town (UCT). My mini dissertation, for the purpose of completing my MPH, focuses on training of clinic committees. I am specifically looking at a training methodology called 'PHC Facility Governance Structures Trainer-of-Facilitator (ToF) Learning Programme', used to train the master trainers and clinic committees in Nkangala District, Mpumalanga Province, and am assessing the effectiveness of this training.
Purpose of the study
As per our previous communication, the purpose of this study is to assess the effectiveness of the 'PHC Facility Governance Structures Trainer-of-Facilitator (ToF) Learning Programme', conducted for the Primary Health Care (PHC) facility governance structures (clinic committees) in Nkangala district, Mpumalanga province.
You have been selected to participate in this study because of your experience and role in the training. I would like to ask you a few questions that will contribute to my understanding of the ToF Learning Programme. The interview will take about 60 – 90 minutes. I would like to spend a brief moment going through the consent form.
Do you have any questions that you would like me to clarify before we begin [confirm that the participant has consented and the form is signed by both parties]?
[*Press record on voice recorder*]
Thank you for agreeing to take part in this study [*ensure statement acknowledging consent is recorded*].

1. Can you please share a little bit about yourself; the position you hold and what you do in this position?
    a) What is your job title?
    b) How long have you been in this position?
    c) How does this relate to governance structures in the district?

2. Can you please tell me why the district DoH decided to conduct training for its master trainers?
    a) Can you please tell me why the district DoH decided to conduct training for its master trainers? What were the external factors that influenced the decision?
    b) What were the internal factors that influenced the decision?

3. What macro and micro factors played a role in the commissioning of the training?
    a) Societal and political pressures and interests
    b) Historical and socio-cultural context
    c) International context
    d) Economic conditions and policy
    e) The organisational climate and culture
    f) Other policies and experiences
    g) Organisational capacity

4. What is the department of Health's overall plan for training clinic committees in the district?
   a) Was this training a short-term plan?
   b) Are there long-term plans for training of clinic committees and master trainers?
   c) Are there any plans of scaling up to the rest of the Province?

5. Is training of clinic committees prioritised in the district's budget?
   a) Is there an allocation of funds for training of clinic committees?
   b) Who is responsible for managing the funds?
   c) How is funding to clinic committees allocated?

6. Please tell me about your understanding of clinic committees
   a) What are clinic committees; what function, if any do they fulfil?
   b) How does clinic committees relate to what you do?
   c) Why clinic committees?
   d) Who are its members?

7. How do clinic committees function in this district?
   a) What do they do?
   b) Is there a work plan that outlines day to day tasks and responsibilities?
   c) Who oversees them?
   d) Who do they report to/what are their reporting lines?
   e) How many clinic committees do you have in the district?
   f) Is every facility represented by a clinic committee?

8. Please tell me about your general understanding regarding the training of clinic committees.
   a) Why are clinic committees trained?
   b) Is training a priority?
   c) How often are clinic committees trained?
   d) What is the district's plan for training of clinic committees?

9. Why did you decide to do a trainer of trainers' model or type of training?
   a) What training model did you use before?
   b) Why did you not employ that model again for this training?
   c) Why did you decide on this specific training and material?
   d) Why did you choose HST as a service provider?

10. Has the training process been monitored since the initial training? Please explain.
    a) What has been monitored?
    b) Who has been doing the monitoring?
    c) What are the monitoring criteria?

11. How were candidates selected to attend the training?
    a) What criteria for selection were used?
    b) Who attended the training?
    c) Why were these initial attendees selected to attend?

12. How did you find the training itself?
    a) What was your overall impression with; trainers, material (content), timeframes?

Conclusion

1. Do you have any questions that you would like to ask me?
2. Is there anything that I failed to mention and you feel is important to discuss regarding the training?

Thank You!

[*Stop the recording*]

S2 Appendix B: Data collection tool – KII (training facilitators)

For the interviewer to complete
Name of researcher: …….
Name of supervisor: …….
Name of co-supervisor: ……
Name of organisation: ……..
Date of interview: ……
Venue of interview: …….

Hello my name is…… I am a Master in Public Health (MPH) student at the University of Cape Town (UCT). My mini dissertation, for the purpose of completing my MPH, focuses on training of clinic committees. I am specifically looking at a training methodology called 'PHC Facility Governance Structures Trainer-of-Facilitator (ToF) Learning Programme', used to train the master trainers and clinic committees in Nkangala District, Mpumalanga Province, and am assessing the effectiveness of this training.

Purpose of the study

As per our previous communication, the purpose of this study is to assess the effectiveness of the 'PHC Facility Governance Structures Trainer-of-Facilitator (ToF) Learning Programme', conducted for the Primary Health Care (PHC) facility governance structures (clinic committees) in Nkangala district, Mpumalanga province.

You have been selected to participate in this study because of your experience and role in the training. I would like to ask you a few questions that will contribute to my understanding of the ToF Learning Programme. The interview will take about 60 – 90 minutes. I would like to spend a brief moment going through the consent form.

Do you have any questions that you would like me to clarify before we begin [confirm that the participant has consented and the form is signed by both parties]?

[*Press record on voice recorder*]

Thank you for agreeing to take part in this study [*ensure statement acknowledging consent is recorded*].

1. Can you please share a little bit about yourself; type of work you do, your qualifications and the position you currently hold?
   a) What is your job title?
   b) Were you in this position at the time of the training?
   c) How long were you in this position?

2. Have you conducted a Trainer-of-Trainer/Facilitator Learning Programme before? Please explain.
   a) When and where did you conduct this training?
   b) How was that different or similar to this training?

3. How were you selected to conduct the Trainer-of-Trainer/Facilitator Learning Programme in Nkangala district?
   a) What was the process of selection of facilitators for the training in Nkangala district?

4. Please tell me about the training.
   a) What are the aims and objectives of the training?
   b) What does the training material consist of?
   c) How was the training material compiled?
   d) Why were the specific topics selected to form part of the training?
   e) What language was used?

5. Can you please tell me about the name of the training programme?
   a) Why this name?
   b) How was the name decided upon?
   c) Why the variations of the name; trainer/facilitator/capacitating, etc.
   d) Were these meant to mean different things?

6. How were the participants selected?
   a) Did you have selection criteria? What was this?
   b) Did you advertise the training? Did people have to apply for the training?
   c) Was the training limited to a specific amount of people?

7. What were your observations of the participants during the training?
   a) Do you think that you had the correct selection of people?
   b) Were the trainees attentive?
   c) Do you think the trainees grasped the aims and objectives of the training? Please explain.

8. Did you feel that the participants were ready to transfer the training?
   a) What made you think so?
   b) How did you assess their readiness?
   c) Did they have a 'plan' that they could work from?

9. Did the participants transfer the training?
   a) How did they go about doing this?
   b) How many clinic committees were trained?
   c) How many sub-districts were trained?
   d) Were all attendees clinic committee members?

10. Which aspects of the training itself did you find easy to compile and teach? Why?
    a) Which aspects of the training were difficult to do? Why?

11. What aspects of this training would you do differently or better in the future?
    a) Are there aspects of the training that you would leave out?
    b) What would you add to the training?
    c) Which aspects of the training did you find essential?
    d) What was your overall impression of the training?

Conclusion

1. Do you have any questions that you would like to ask me?

2. Is there anything that I failed to mention and you feel is important to discuss regarding the training?

Thank You!

[Stop the recording]

S3 Appendix C: Data collection tool – KII (sub-district manager)

For the interviewer to complete
Name of researcher: ……..
Name of supervisor: ……
Name of co-supervisor: ……
Name of organisation: ……..
Date of interview: ……
Venue of interview: ……..

Hello my name is…… I am a Master in Public Health (MPH) student at the University of Cape Town (UCT). My mini dissertation, for the purpose of completing my MPH, focuses on training of clinic committees. I am specifically looking at a training methodology called 'PHC Facility Governance Structures Trainer-of-Facilitator (ToF) Learning Programme', used to train the master trainers and clinic committees in Nkangala District, Mpumalanga Province, and am assessing the effectiveness of this training.

Purpose of the study

As per our previous communication, the purpose of this study is to assess the effectiveness of the 'PHC Facility Governance Structures Trainer-of-Facilitator (ToF) Learning Programme', conducted for the Primary Health Care (PHC) facility governance structures (clinic committees) in Nkangala district, Mpumalanga province.

You have been selected to participate in this study because of your experience and role in the training. I would like to ask you a few questions that will contribute to my understanding of the ToF Learning Programme. The interview will take about 60 – 90 minutes. I would like to spend a brief moment going through the consent form.

Do you have any questions that you would like me to clarify before we begin [confirm that the participant has consented and the form is signed by both parties]?

[*Press record on voice recorder*]

Thank you for agreeing to take part in this study [*ensure statement acknowledging consent is recorded*].

1. Can you please share a little bit about yourself; type of work you do, position you hold and how were you selected to attend the training?
   a) What is your job title?
   b) How long were you in this position at the time of the training?
   c) What was the selection process for attendees?

2. Please tell me about the training.
   a) Have you been part of this type of training before?
   b) How did you find the timeframe of the training?
   c) How did you find the way in which the training was conducted?
   d) How did you find the facilitators?
   e) What were the aims and objectives?

3. What are your thoughts on the name of the training programme?
   a) Was this easily understood?

4. Did the training change your knowledge about clinic committees in any way? If so, how?
   a) What was your understanding of clinic committees before the training?
   b) Is there anything you learned during the training that you did not know before?

5. What about the training did you find easy and what did you find difficult?

a) Please explain easy.
b) Please explain difficult.

6. How did you find the training material?
   a) Was it easy to understand?
   b) Was the language easy?
   c) Was the methodology easy?
   d) Did you find the material sufficient for what you needed to know in order to transfer the training?
   e) What was missing?

7. Since your training have you trained clinic committees?
   a) How many clinic committees have you trained?
   b) From which sub-district were these committees?
   c) Did you conduct separate trainings for separate sub-districts?
   d) Which methodology did you employ?
   e) Did you find it easy to transfer the training?

8. How many people attended the training?
   a) How many people were invited to the training?
   b) Of those invited how many attended?
   c) Were all attendees clinic committee members?
   d) What were the selection criteria for participants?

9. Which aspects of the training were easy to transfer? Why?
   a) Which aspects of the training were difficult to transfer? Why?

10. Do you have any written or oral feedback from clinic committees on their experience of the training?
    a) Which aspects of the training would you leave out?
    b) Which aspects of the training did you find essential?
    c) What was your overall impression of the training?

11. Do you have any suggestions about how this training can be done differently or better in the future?
    a) Which aspects of the training would you leave out?
    b) Which aspects of the training did you find essential?
    c) What was your overall impression of the training?

Conclusion

3. Do you have any questions that you would like to ask me?

4. Is there anything that I failed to mention and you feel is important to discuss regarding the training?

Thank You!

[Stop the recording]

S4 Appendix D: Data collection tool – FGD 1 (sub-district managers)

For the interviewer to complete
Name of researcher: ……..
Name of supervisor: ……
Name of co-supervisor: ……
Name of organisation: ……..
Date of interview: ……
Venue of interview: ……..

Hello my name is…… I am a Master in Public Health (MPH) student at the University of Cape Town (UCT). My mini dissertation, for the purpose of completing my MPH, focuses on training of clinic committees. I am specifically looking at a training methodology called 'PHC Facility Governance Structures Trainer-of-Facilitator (ToF) Learning Programme', used to train the master trainers and clinic committees in Nkangala District, Mpumalanga Province, and am assessing the effectiveness of this training.

Purpose of the study

As per our previous communication, the purpose of this study is to assess the effectiveness of the 'PHC Facility Governance Structures Trainer-of-Facilitator (ToF) Learning Programme', conducted for the Primary Health Care (PHC) facility governance structures (clinic committees) in Nkangala district, Mpumalanga province.

You have been selected to participate in this study because of your experience and role in the training. I would like to ask you a few questions that will contribute to my understanding of the ToF Learning Programme. The interview will take about 60 – 90 minutes. I would like to spend a brief moment going through the consent form.

Do you have any questions that you would like me to clarify before we begin [confirm that the participant has consented and the form is signed by both parties]?

[*Press record on voice recorder*]

Thank you for agreeing to take part in this study [*ensure statement acknowledging consent is recorded*].

1. Can you please share a little bit about yourself; type of work you do, position you hold and how were you selected to attend the training?
   a) What is your job title?
   b) How long were you in this position at the time of the training?
   c) What was the selection process for attendees?

2. Please tell me about the training.
   a) Have you been part of this type of training before?
   b) How did you find the timeframe of the training?
   c) How did you find the way in which the training was conducted?
   d) How did you find the facilitators?
   e) What were the aims and objectives?

3. What are your thoughts on the name of the training programme?
   a) Was this easily understood?

4. Did the training change your knowledge about clinic committees in any way? If so, how?
   a) What was your understanding of clinic committees before the training?
   b) Is there anything you learned during the training that you did not know before?

5. What about the training did you find easy and what did you find difficult?
   a) Please explain easy.

b) Please explain difficult.

6. How did you find the training material?
   a) Was it easy to understand?
   b) Was the language easy?
   c) Was the methodology easy?
   d) Did you find the material sufficient for what you needed to know in order to transfer the training?
   e) What was missing?

7. Since your training have you trained clinic committees?
   a) How many clinic committees have you trained?
   b) From which sub-district were these committees?
   c) Did you conduct separate trainings for separate sub-districts?
   d) Which methodology did you employ?
   e) Did you find it easy to transfer the training?

8. How many people attended the training?
   a) How many people were invited to the training?
   b) Of those invited how many attended?
   c) Were all attendees clinic committee members?
   d) What were the selection criteria for participants?

9. Which aspects of the training were easy to transfer? Why?
   a) Which aspects of the training were difficult to transfer? Why?

10. Do you have any written or oral feedback from clinic committees on their experience of the training?
    a) Which aspects of the training would you leave out?
    b) Which aspects of the training did you find essential?
    c) What was your overall impression of the training?

11. Do you have any suggestions about how this training can be done differently or better in the future?
12. Which aspects of the training would you leave out?
13. Which aspects of the training did you find essential?
14. What was your overall impression of the training?

Conclusion

1. Do you have any questions that you would like to ask me?

2. Is there anything that I failed to mention and you feel is important to discuss regarding the training?

Thank You!

[Stop the recording]

S5 Appendix E: Data collection tool – FGD 2 (facility supervisors)

For the interviewer to complete
Name of researcher: …….
Name of supervisor: …….
Name of co-supervisor: ……
Name of organisation: ……..
Date of interview: ……
Venue of interview: …….

Hello my name is…… I am a Master in Public Health (MPH) student at the University of Cape Town (UCT). My mini dissertation, for the purpose of completing my MPH, focuses on training of clinic committees. I am specifically looking at a training methodology called 'PHC Facility Governance Structures Trainer-of-Facilitator (ToF) Learning Programme', used to train the master trainers and clinic committees in Nkangala District, Mpumalanga Province, and am assessing the effectiveness of this training.

Purpose of the study

As per our previous communication, the purpose of this study is to assess the effectiveness of the 'PHC Facility Governance Structures Trainer-of-Facilitator (ToF) Learning Programme', conducted for the Primary Health Care (PHC) facility governance structures (clinic committees) in Nkangala district, Mpumalanga province.

You have been selected to participate in this study because of your experience and role in the training. I would like to ask you a few questions that will contribute to my understanding of the ToF Learning Programme. The interview will take about 60 – 90 minutes. I would like to spend a brief moment going through the consent form.

Do you have any questions that you would like me to clarify before we begin [confirm that the participant has consented and the form is signed by both parties]?

[*Press record on voice recorder*]

Thank you for agreeing to take part in this study [*ensure statement acknowledging consent is recorded*].

1. Can you please share a little bit about yourself; type of work you do, position you hold and how were you selected to attend the training?
    a) What is your job title?
    b) How long were you in this position at the time of the training?
    c) What was the selection process for attendees?

2. Please tell me about your understanding of clinic committees.
    a) What is their function?
    b) Have you worked with clinic committees before?
    c) How do clinic committees fit into the structure/organogram of the district?

3. Please explain your role with regards to clinic committees.
    a) Do you have any function that relates to clinic committees?
    b) Do you provide any support to clinic committees?
    c) If so, please explain what this role entails.

4. Please tell me about the training.
    a) Have you been part of this type of training before?
    b) How did you find the timeframe of the training?
    c) How did you find the way in which the training was conducted?
    d) How did you find the facilitators?
    e) What were the aims and objectives?

5. What are your thoughts on the name of the training programme?
   a) Was this easily understood?

6. Did the training change your knowledge about clinic committees in any way? If so, how?
   a) What was your understanding of clinic committees before the training?
   b) Is there anything you learned during the training that you did not know before?

7. What about the training did you find easy and what did you find difficult?
   a) Please explain easy.
   b) Please explain difficult.

8. How did you find the training material?
   a) Was it easy to understand?
   b) Was the language easy?
   c) Was the methodology easy?
   d) Did you find the material sufficient for what you needed to know in order to transfer the training?
   e) What was missing?

9. Do you have any suggestions about how this training can be done differently or better in the future?
   a) Which aspects of the training would you leave out?
   b) Which aspects of the training did you find essential?
   c) What was your overall impression of the training?

Conclusion

1. Do you have any questions that you would like to ask me?

2. Is there anything that I failed to mention and you feel is important to discuss regarding the training?

Thank You!

[Stop the recording]

S6 Appendix F: Data collection tool – KII (NDoH)

For the interviewer to complete
Name of researcher: ……..
Name of supervisor: ……
Name of co-supervisor: ……
Name of organisation: ……..
Date of interview: ……
Venue of interview: ……..

Hello my name is…… I am a Master in Public Health (MPH) student at the University of Cape Town (UCT). My mini dissertation, for the purpose of completing my MPH, focuses on training of clinic committees. I am specifically looking at a training methodology called 'PHC Facility Governance Structures Trainer-of-Facilitator (ToF) Learning Programme', used to train the master trainers and clinic committees in Nkangala District, Mpumalanga Province, and am assessing the effectiveness of this training.

Purpose of the study

As per our previous communication, the purpose of this study is to assess the effectiveness of the 'PHC Facility Governance Structures Trainer-of-Facilitator (ToF) Learning Programme', conducted for the Primary Health Care (PHC) facility governance structures (clinic committees) in Nkangala district, Mpumalanga province.

You have been selected to participate in this study because of your experience and role in the training. I would like to ask you a few questions that will contribute to my understanding of the ToF Learning Programme. The interview will take about 60 – 90 minutes. I would like to spend a brief moment going through the consent form.

Do you have any questions that you would like me to clarify before we begin [confirm that the participant has consented and the form is signed by both parties]?

[*Press record on voice recorder*]

Thank you for agreeing to take part in this study [*ensure statement acknowledging consent is recorded*].

1. Can you please share a little bit about yourself; the position you hold and what you do in this position?
    a) What is your job title?
    b) How long have you been in this position?
    c) How does this relate to governance structures in the district?

2. Can you please provide me with background information about the training and training material?
    a) Development, purpose, aims and objectives
    b) What were the external factors that influenced the development of training?
    c) What were the internal factors that influenced the development of training?

3. What macro and micro factors played a role in the commissioning of the training?
    a) Societal and political pressures and interests
    b) Historical and socio-cultural context
    c) International context
    d) Economic conditions and policy
    e) The organisational climate and culture
    f) Other policies and experiences
    g) Organisational capacity

4. What is the Department of Health's overall plan for training clinic committees?

a) Was this training a short-term plan?
b) Are there long-term plans for training of clinic committees and master trainers?
c) Are there any plans of scaling up to the rest of the Provinces?
d) Does the plan include master trainers?

5. Is training of clinic committees prioritised in the NDoH's budget?
   a) Is there an allocation of funds for training of clinic committees?
   b) Who is responsible for managing the funds?
   c) How is funding to clinic committees allocated?

6. Please tell me about your understanding of clinic committees.
   a) What are clinic committees;
   b) What function, if any do they fulfil?
   c) How does clinic committees relate to what you do?
   d) Why clinic committees?
   e) Who are its members?

7. Do clinic committees currently function in this way?
   a) What do they do?
   b) Is there a work plan that outlines day to day tasks and responsibilities?
   c) Who oversees them?
   d) Who do they report to/what are their reporting lines?
   e) How many clinic committees do you have in the district?
   f) Is every facility represented by a clinic committee?

8. Please tell me about the overall plan for the training of clinic committees. Why are clinic committees trained?
   a) Is training a priority?
   b) How often are clinic committees trained?
   c) What is the NDoH's plan for training of clinic committees?

9. Why did you decide to do a trainer-of-trainers' model or type of training?
   a) What training model did you use before?
   b) Why did you not employ that model again for this training?
   c) Why did you decide on this specific training and material?
   d) Why did you choose HST as a service provider?

10. Has the training process been monitored since the initial training? Please explain.
    a) What has been monitored?
    b) Who has been doing the monitoring?
    c) What are the monitoring criteria?

Conclusion

3. Do you have any questions that you would like to ask me?

4. Is there anything that I failed to mention and you feel is important to discuss regarding the training, especially the background and its initial stages?

Thank You!

[*Stop the recording*]

S7 Appendix G: Data collection tool – KII (HST_HSR)

For the interviewer to complete
Name of researcher: ……..
Name of supervisor: ……
Name of co-supervisor: ……
Name of organisation: ……..
Date of interview: ……
Venue of interview: ……..

Hello my name is…… I am a Master in Public Health (MPH) student at the University of Cape Town (UCT). My mini dissertation, for the purpose of completing my MPH, focuses on training of clinic committees. I am specifically looking at a training methodology called 'PHC Facility Governance Structures Trainer-of-Facilitator (ToF) Learning Programme', used to train the master trainers and clinic committees in Nkangala District, Mpumalanga Province, and am assessing the effectiveness of this training.

Purpose of the study

As per our previous communication, the purpose of this study is to assess the effectiveness of the 'PHC Facility Governance Structures Trainer-of-Facilitator (ToF) Learning Programme', conducted for the Primary Health Care (PHC) facility governance structures (clinic committees) in Nkangala district, Mpumalanga province.

You have been selected to participate in this study because of your experience and role in the training. I would like to ask you a few questions that will contribute to my understanding of the ToF Learning Programme. The interview will take about 60 – 90 minutes. I would like to spend a brief moment going through the consent form.

Do you have any questions that you would like me to clarify before we begin [confirm that the participant has consented and the form is signed by both parties]?

[*Press record on voice recorder*]

Thank you for agreeing to take part in this study [*ensure statement acknowledging consent is recorded*].

1. Can you please share a little bit about yourself; the position you hold and what you do in this position?
    a) What is your job title?
    b) How long have you been in this position?
    c) How does this relate to governance structures in the district?

2. Please tell me about your understanding of clinic committees.
    a) How are clinic committees meant to function?
    b) Please tell me about your general understanding regarding the training of clinic committees.

Health Systems Trust

3. Please tell me about HST's overall involvement in clinic committees in (South Africa)
4. Previous published material (Padarath and Friedman, 2008) indicates that HST conducted training for clinic committees prior to 2008. Please tell me about this.
5. Please tell me about HST's involvement in the development of the TOF Learning Programme

Nkangala District

6. In February 2016 HST conducted the TOF Learning programme in Nkangala. Please tell me about the TOF Learning programme (background, aims, objectives, rationale).
7. *The TOF learning programme was developed by HST as a specific model and piloted in KwaZulu-Natal previously. It was then piloted again in Nkangala. The second pilot did not however follow the intended model.*

Please tell me why there was a second pilot of the ToF Learning programme in Nkangala and why the deviation of/in the model.

8. It has been almost two years since the pilot, can you please tell me why the learning programme has not yet been scaled up to the rest of the province?

Department of Health

9. What is the Department of Health's overall plan for training clinic committees?
10. Is the training of clinic committees a Department of Health priority and is it reflected in its budget?
11. Why was a 'trainer-of-trainers' model or type of training decided upon?
    a) Who made this decision?
12. Has the learning programme been monitored and or evaluated since the initial training?
13. What is the Department of Health's plan with regards to monitoring and evaluation of the programme?

General

14. What macro and micro factors played a role in the commissioning of the training? This refers to but are not restricted to:
    a. Societal and political pressures and interests
    b. Historical and socio-cultural context
    c. International context
    d. Economic conditions and policy
    e. The organisational climate and culture
    f. Other policies and experiences
    g. Organisational capacity
15. What are your thoughts on the learning programme/training itself?

Conclusion

1. Do you have any questions that you would like to ask me?

2. Is there anything that I failed to mention and you feel is important to discuss regarding the training?

Thank You!

[*Stop the recording*]

S8 Appendix H: Informed consent letter (FGD)

Department of Health

Nkangala District Office

Piet Koornhof Building

Justice Street

Emalahleni

1039

October, 2017

Dear

Study Title: An assessment of the 'PHC facility governance structures trainer-of-facilitator learning programme' in Nkangala district, Mpumalanga Province

Re: Information sheet and informed consent

My name is Natasha Esau. I am a Master in Public Health (MPH) student at the University of Cape Town (UCT). I am in the process of doing a mini dissertation, for the purpose of completing my MPH. My dissertation focuses on training of clinic committees and I am specifically looking at a training methodology 'PHC Facility Governance Structures Trainer-of-Trainer/Facilitator Learning Programme', used to train the master trainers and clinic committees in Nkangala District, Mpumalanga Province in order to assess the training.

This letter consists of two sections which you will find attached:

1. An information sheet to share information about the study with you
2. A consent form for you to sign if you decide to participate in the study

Kindly read through the information sheet provided and complete the consent form, should you agree to participate in the study. Once the consent form is completed you may then return the consent form to me using the following email address: natasha.cptsa@gmail.com

Should you have any further queries regarding the study, please feel free to contact me on (cell) 074 142 0031 or my supervisor Dr Maylene Shung King on (office number) 021 406 6580 or my co-supervisor Dr René English on (office number) 021 762 0700.

Yours sincerely,

Ms Natasha Esau

Master of Public Health (MPH) Student

University of Cape Town School of Public Health and Family Medicine

S9 Appendix I: Informed consent letter (KII)

Department of Health

Nkangala District Office

Piet Koornhof Building

Justice Street

Emalahleni

1039

September, 2017

Dear

Study Title: An assessment of the 'PHC facility governance structures trainer-of-facilitator learning programme' in Nkangala district, Mpumalanga Province

Re: Information sheet and informed consent

My name is Natasha Esau. I am a Master in Public Health (MPH) student at the University of Cape Town (UCT). I am in the process of doing a mini dissertation, for the purpose of completing my MPH. My dissertation focuses on training of clinic committees and I am specifically looking at a training methodology 'PHC Facility Governance Structures Trainer-of-Trainer/Facilitator Learning Programme', used to train the master trainers and clinic committees in Nkangala District, Mpumalanga Province in order to assess the training.

This letter consists of two sections which you will find attached:

1. An information sheet to share information about the study with you
2. A consent form for you to sign if you decide to participate in the study

Kindly read through the information sheet provided and complete the consent form, should you agree to participate in the study. Once the consent form is completed you may then return the consent form to me using the following email address: natasha.cptsa@gmail.com

Should you have any further queries regarding the study, please feel free to contact me on (cell) 074 142 0031 or my supervisor Dr Maylene Shung-King on (office number) 021 406 6580 or my co-supervisor Dr René English on (office number) 021 762 0700.

Yours sincerely,

Ms Natasha Esau

Master of Public Health (MPH) Student

University of Cape Town School of Public Health and Family Medicine

S10 Appendix J: Section 1 Information sheet (FGD)

Purpose of the research

Towards the end of 2015, the Nkangala district department of health, Mpumalanga province, requested of Health Systems Trust (HST), to conduct a trainer of trainers programme for the districts health clinic committees. Following this request, a five day training took place in February 2016, in Nkangala district. The aim of the training was to strengthen the facilitator's capacity to deliver the PHC facility governance structures trainer-of-facilitator learning programme to the clinic committees. This meant that after the training participants of the training had to conduct the same training programme with the existing clinic committees in the Nkangala district and sub-districts.

Due to the districts time and budget constraints, it was decided that a trainer of the trainer approach would best serve the districts purpose for training clinic committees. Since the training in February 2016, no assessment has been done to assess the training; whether participants were appropriately capacitated, whether the training programme had been transferred and clinic committees trained and also what the effect of this training has been at facility level. This study is mainly aimed at assessing the training, participant capacitation and whether the training programme had been transferred. Due to the timeframe between the initial training and this assessment, as well as the scope of this study, it will not be possible to assess what effect this training has had at facility level. Interviews are mainly being conducted with Department of Health (DoH) staff that was involved in the training as well as the facilitators of the training.

Participant selection

You have been selected to participate in this study because of your experience and involvement in the 'PHC Facility Governance Structures Trainer-of-Trainer/Facilitator Learning Programme' in Nkangala District, Mpumalanga Province.

Voluntary participation

Your participation in this research is entirely voluntarily. It is your choice to participate or not. You should not feel forced to participate. Your participation, or refusal to participate, will not affect your job or your work related evaluations or reports. During the interview you are free to stop at any time or refuse to answer any questions you do not want to answer. You are free to stop participating, even though you have agreed to participate.

Procedures

I would like to invite you to take part in this study. This will involve taking part in a group discussion with other participants of the training based on their availability who also shares knowledge of the programme. The group discussion will be guided by me *[Natasha]*. The group discussion will start with the facilitator making sure that you are comfortable. I will answer any questions that you may have. The discussions will take place at *[tbc]*. During the interview, I will ask a few questions from a list that was prepared relating to the Training of Facilitators for Facility Governance Structures Training and questions that may arise from your responses. This interview will be recorded on a digital recorder in order to transcribe (write it out in full) later. The information from this interview is confidential and only core research team members will have access to the recordings or transcripts.

All research material will be kept under the custodianship of the Principal Investigator and Project Manager in a secure manner.

Risks

The questions that I will be asking are related to your knowledge and experiences of the 'PHC Facility Governance Structures Trainer-of-Trainer/Facilitator Learning Programme', and the training in Nkangala District. I do not foresee any personal risk, through the information that you will provide me with. However there is the risk that you may accidentally share confidential information or feel uncomfortable answering certain questions. I do not wish for this to happen. You do not have to answer any question(s) or take part in the interview/discussion if the question(s) make you feel uncomfortable.

Benefits and reimbursements

You will not be reimbursed for your participation in this study. The information you provide will be used to gain a deeper understanding of the 'PHC Facility Governance Structures Trainer-of-Trainer/Facilitator Learning Programme' and help the department with their future decisions regarding this programme; how to improve the PHC Facility Governance Structures Trainer-of-Trainer/Facilitator Learning Programme and how the training can be expanded in the district.

Confidentiality

The information that you provide will be used strictly for the objectives of this study. Your details and all the study information will be kept strictly confidential and will only be accessible to the core research team. Your name and affiliation will be deleted from the questionnaires and will not be revealed in any report or publication that may arise from this study. All your responses will remain anonymous outside of the core research team. We are however, unable to ensure complete confidentiality and anonymity within a focus group setting, as the rest of the members of the focus group will know what was said during the discussion. We will thus request of you to sign a confidentiality statement, in which you are asked to keep the information of the focus group discussions confidential. But we are able to guarantee that anonymity will be secured at a reporting and publishing level by not including any identifying information like the name of the sub-districts, clinics and participants. The transcripts and records will be destroyed after a period of five years.

Ethics

This proposal have been reviewed and approval have been received from the University of Cape Town (UCT), Human Research and Ethics Committee (HREC), which is a committee whose task it is to make sure that research participants are protected from harm.

Who to contact

If you have any concerns about your rights as a research participant or the ethical conduct of this study, you should contact the principal investigator, Dr. Maylene Shung King, at office number 021-4066580, or the University of Cape Town, Human Research Ethics Committee at office number 021-6501236. Physical contact details as follows:

HUMAN RESEARCH ETHICS COMMITTEE

Journal article

Old Main Building of Groote Schuur Hospital

Floor E53

Room 46

Observatory

7925

Tel: 021-6501236

If, at any time you have questions or concerns about this study, you can ask them now or later. If you wish to ask questions later, you should contact the lead of the research team (Principal Investigator), Dr Maylene Shung King at, office number 021-4066580.

S11 Appendix K: Section 1 Information sheet (KII)

Purpose of the research

Towards the end of 2015, the Nkangala district department of health, Mpumalanga province, requested of Health Systems Trust (HST), to conduct a trainer of trainers programme for the districts health clinic committees. Following this request, a five day training took place in February 2016, in Nkangala district. The aim of the training was to strengthen the facilitator's capacity to deliver the PHC facility governance structures trainer-of-facilitator learning programme to the clinic committees. This meant that after the training participants of the training had to conduct the same training programme with the existing clinic committees in the Nkangala district and sub-districts.

Due to the districts time and budget constraints, it was decided that a trainer of the trainer approach would best serve the districts purpose for training clinic committees. Since the training in February 2016, no assessment has been done to assess the training; whether participants were appropriately capacitated, whether the training programme had been transferred and clinic committees trained and also what the effect of this training has been at facility level. This study is mainly aimed at assessing the training, participant capacitation and whether the training programme had been transferred. Due to the timeframe between the initial training and this assessment, as well as the scope of this study, it will not be possible to assess what effect this training has had at facility level. Interviews are mainly being conducted with Department of Health (DoH) staff that was involved in the training as well as the facilitators of the training.

Participant selection

You have been selected to participate in this study because of your experience and involvement in the 'PHC Facility Governance Structures Trainer-of-Trainer/Facilitator Learning Programme' in Nkangala District, Mpumalanga Province.

Voluntary participation

Your participation in this research is entirely voluntarily. It is your choice to participate or not. You should not feel forced to participate. Your participation, or refusal to participate, will not affect your job or your work related evaluations or reports. During the interview you are free to stop at any time or refuse to answer any questions you do not want to answer. You are free to stop participating, even though you have agreed to participate.

Procedures

I would like to invite you to take part in this study. This will involve taking part in a one on one key informant interview. The interview will be guided by me, *[Natasha].* The interview will start with me making sure that you are comfortable. I will answer any questions that you may have. The interview will take place at the Nkangala District Department of Health. During the interview, I will ask a few questions from a list that was prepared relating to the Training of Facilitators for Facility Governance Structures Training and questions that may arise from your responses. This interview will be recorded on a digital recorder in order to transcribe (write it out in full) later. The information from this interview is confidential and only core research team members will have access to the

recordings or transcripts. All research material will be kept under the custodianship of the Principal Investigator and Project Manager in a secure manner.

Risks

The questions that I will be asking are related to your knowledge and experiences of the 'PHC Facility Governance Structures Trainer-of-Trainer/Facilitator Learning Programme', and the training in Nkangala District. I do not foresee any personal risk through the information that you will provide me with. However there is the risk that you may accidentally share confidential information or feel uncomfortable answering certain questions. I do not wish for this to happen. You do not have to answer any question(s) or take part in the interview/discussion if the question(s) make you feel uncomfortable.

Benefits and reimbursements

You will not be reimbursed for your participation in this study. The information you provide will be used to gain a deeper understanding of the 'PHC Facility Governance Structures Trainer-of-Trainer/Facilitator Learning Programme' and help the department with their future decisions regarding this programme; how to improve the PHC Facility Governance Structures Trainer-of-Trainer/Facilitator Learning Programme and how the training can be expanded in the district.

Confidentiality

The information that you provide will be used strictly for the objectives of this study. Your details and all the study information will be kept strictly confidential and will only be accessible to the core research team. Your name and affiliation will be deleted from the questionnaires and will not be revealed in any report or publication that may arise from this study. All your responses will remain anonymous outside of the core research team. The transcripts and records will be destroyed after a period of five years.

Ethics

This proposal have been reviewed and approval have been received from the University of Cape Town (UCT), Human Research and Ethics Committee (HREC), which is a committee whose task it is to make sure that research participants are protected from harm.

Who to contact

If you have any concerns about your rights as a research participant or the ethical conduct of this study, you should contact the principal investigator, Dr. Maylene Shung King at office number 021-4066580, or the University of Cape Town, Human Research Ethics Committee at office number 021-6501236. Physical contact details as follows:

HUMAN RESEARCH ETHICS COMMITTEE

Old Main Building of Groote Schuur Hospital

Floor E53

Room 46

Journal article

Observatory

7925

Tel: 021-6501236

If, at any time you have questions or concerns about this study you can ask them now or later. If you wish to ask questions later, you should contact the lead of the research team (Principal Investigator), Dr Maylene Shung King at, office number 021-4066580.

S12 Appendix L: Section 2 consent form

Statement made by participant giving consent

I have been invited to participate in the research study 'An assessment of the 'PHC Facility Governance Structures Trainer-of-Trainer/Facilitator Learning Programme' a capacity building approach, in Nkangala District, Mpumalanga Province'.

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study.

I hereby provide further consent to:

Audio-record my interview YES / NO

Print Name of Participant: …….
Signature of Participant: ……
Date (Day/Month/Year): …….

Statement made by researcher requesting consent

I have read out the information sheet to the potential participant and to the best of my ability made sure that the participant understands that the following will be done.

1. That they will be asked questions relating to the 'PHC Facility Governance Structures Trainer-of-Trainer/Facilitator Learning Programme';
2. That the discussion will be recorded;
3. That the report that will be generated from this study will not include any personally identifiable information;
4. That they are entering into the study voluntarily but they are free to stop participating at any stage during the interview process.

I confirm that the participant was given an opportunity to ask questions about the study and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent and that the consent has been given freely and voluntarily.

I declare that I have no conflict of interest ☐

A copy of this Informed Consent Form has been provided to the participant

Print Name of Researcher: ……..
Signature of Researcher: ……..
Date (Day/Month/Year):……

S13 Appendix M: List of documents reviewed

Document	Year	Source/Author	Document	Purpose of document
White Paper for the Transformation of the Health System in South Africa	1997	South African Department of Health	National document	To present a set of policy objectives and principles upon which the Unified National Health System of South Africa will be based
Eastern Cape Provincial Health Act, No. 10 of 1999	2000	Eastern Cape Department of Health	Provincial document	Not stated
National Health Act, No. 61 of 2003	2004	South African Department of Health	National document	To provide a framework for a structured uniform health system within the Republic and to provide for matters connected therewith
KwaZulu-Natal Health Act No. 01 of 2009, Section 42	2009	KwaZulu-Natal Department of Health	Provincial document	To advise relevant managers that Community Health Centre and Clinic Committees are to be appointed in terms of the promulgated legislation
Free State Department of Health 2009. Provincial Health Act No. 3 of 2009	2009	Free State Department of Health	Provincial document	To provide for the establishment of a health system that is compatible with the structured uniform national standards; to establish health governance structures
Policy on the establishment and functioning of clinic and community health centre committees, Final Draft	2009	Eastern Cape Department of Health	Provincial draft bill	To regulate the establishment and functioning of clinic and community health centre committees in the Eastern Cape
Policy guidelines for the establishment and operation of Primary Health Care facility committees, Draft 1	2009	Gauteng Department of Health	Provincial draft guideline	Not stated
KwaZulu-Natal Health Act No. 123 of 2012	2012	KwaZulu-Natal Department of Health	Provincial document	To regulate Clinic and Health Centre Committees
Policy on Hospital Boards, Community Health Care Centres and Clinic Committees, V01	2013	Northern Cape Department of Health	Provincial draft bill	To increase public accountability in health establishments by establishing and maintaining hospital boards and clinic/community health centre committees
Report of a National Colloquium on Health Committees in South Africa. Health Committees as Vehicles for Community Participation: A National Colloquium on Health Committees in South Africa.	2014	Haricharan H, Boulle T, London L. (2014)	Partner report	To provide an opportunity to share research findings and experience from the project and other partners working on community participation in health
Health Committee Training: Participant Manuals	2014	The South African Learning Network	Training manual	Training of established and new health committees and to promote

				a human rights culture at all health facilities
Strategic Plan 2014/15 - 2018/19	2014	National Department of Health	National document	Not stated
Draft Western Cape Health Facility Boards and Committees Bill, 2015	2015	Western Cape Department of Health	Provincial draft bill	To provide for the establishment, functions and procedures of hospital boards and primary health care facility committees
Guidelines for Primary Health Care Facilities Committees, September 2015. Review date: September 2018 or when there is a need.	2015	Mpumalanga Department of Health	Provincial guideline	To regulate the establishment, appointment and functioning of primary health care facility committees in the Mpumalanga Province
Capacity Strengthening Learning Programme	2015	Health Systems Trust	Training manual	To strengthen health governance structures in South Africa's capacity by empowering them with the skills, knowledge, attitudes and values they need in order to fulfil their health governance roles and responsibilities
National Health Insurance for South Africa Towards Universal Health Care V40	2015	National Department of Health	National document	Not stated
Western Cape Health Facility Boards and Committees Act, 2016	2016	Western Cape Department of Health	Provincial document	To provide for the establishment, functions and procedures of hospitals boards and primary health care facility committees
Guidelines for establishment of health governance structures: District Health Councils (DHCs), hospital boards and Primary Health Care (PHC) facilities committees	Not dated	National Department of Health	National guideline draft	To assist health governance structures to address the health needs of the community, to ensure that facility management and staff are accountable and responsive to the community
uMzinyathi report: An Evaluation of the Primary Health Care Facility Governance Structure Capacity-strengthening Learning Programme	2016	Health Systems Trust	Partner report	To evaluate the Primary Health Care Facility Governance Structure Capacity-strengthening Learning Programme that was conducted in uMzinyathi, KwaZulu-Natal.
Ideal Clinic Manual	2016	National Department of Health	National document	To assist managers at various levels of healthcare service provision to correctly interpret and understand the requirement for achieving the elements depicted in the Ideal Clinic dashboard and serves as a useful tool to ensure progressive discipline of those reporting to them

ANNEXURE A: Ideal Clinic Realisation and Maintenance; The Primary Health Care Package; The District Hospital Service Package; The Patient Referral System	2016	National Department of Health	National document annexure	Not stated
Annual Report 2016/17	2016	National Department of Health	National document	Not stated

S14 Appendix N: List of variables

Number	Variables
1.	Name of document
2.	Year published (or developed)
3.	Source or author
4.	Purpose of document
5.	Appointment/Establishment of Committees/members
6.	Composition of the Committee
7.	Eligibility Criteria for member selection
8.	Roles and responsibilities/powers/functions of Clinic committees
9.	Training of clinic committees
10.	Training guidelines
11.	Training material
12.	Training programme
13.	Remuneration
14.	Department's responsibility towards clinic committees

S15 Appendix O: UCT HREC approval letter

UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee

Room E53-46 Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 406 6492
Email: sumaya.h.ariefdien@uct.ac.za
Website: www.health.uct.ac.za/fhs/research/humanethics/forms

06 July 2017

HREC REF: 194/2017

Dr M Shung King
School If Public Health & Family Medicine
Falmouth Building-FHS

Dear DR Shung King

PROJECT TITLE: AN ASSESSMENT OF THE PHC FACILITY GOVERNANCE TRAINER-OF-TRAINER PROGRAMME' IN NKANGALA DISTRICT, MPUMALANGA PROVINCE (MPH-candidate-N Esau)

Thank you for your response letter dated 30 May 2017, addressing the issues raised by the Human Research Ethics Committee (HREC).

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

Approval is granted for one year until the 30 July 2018.

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.
(Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

We acknowledge that the student, N Esau will also be involved in this study.

Please quote the HREC REF in all your correspondence.

Please note that the ongoing ethical conduct of the study remains the **responsibility** of the principal investigator.

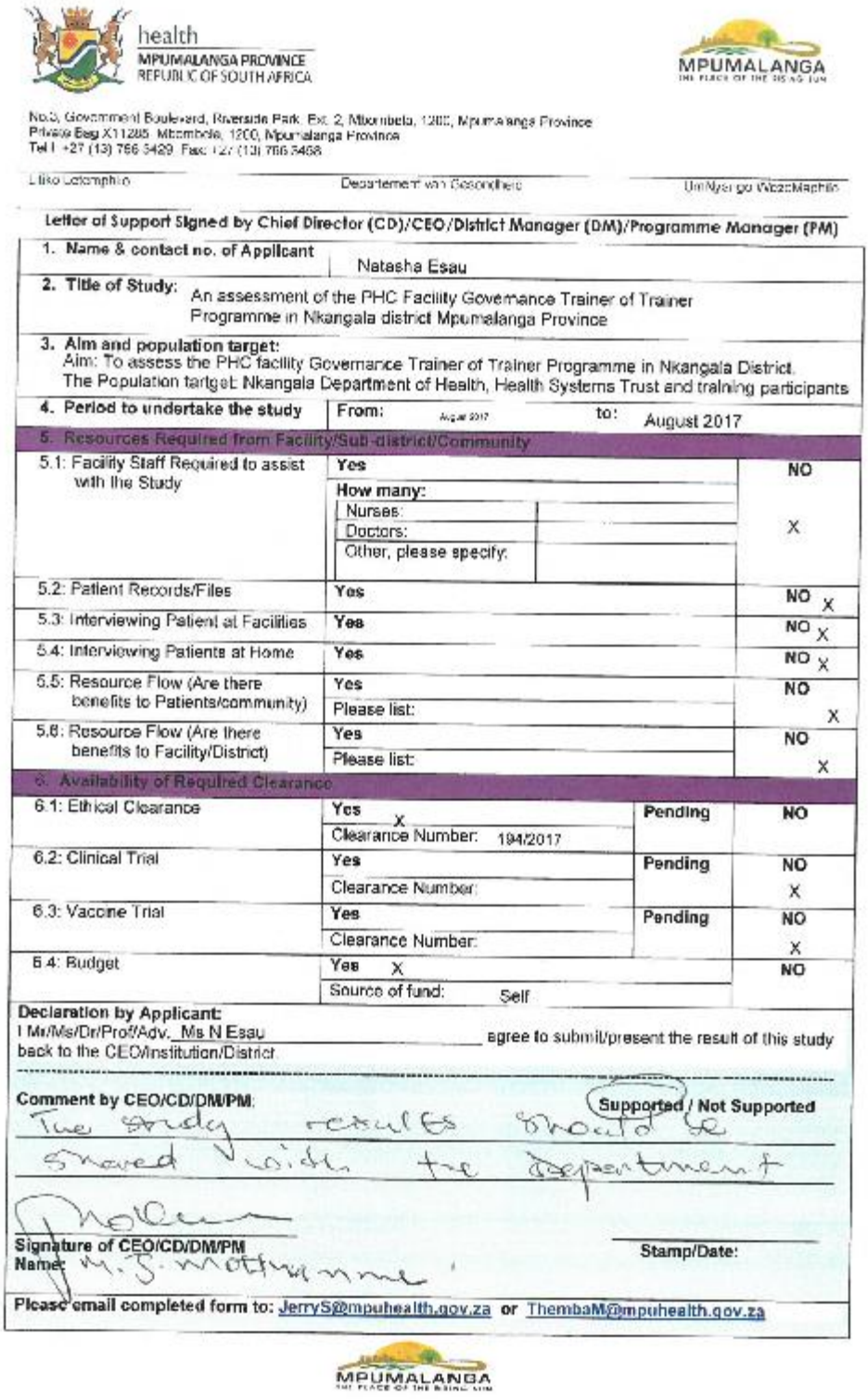
Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate institutional approval before the research may occur.

Yours sincerely

PROFESSOR M BLOCKMAN
CHAIRPERSON, FHS HUMAN RESEARCH ETHICS COMMITTEE

Federal Wide Assurance Number: FWA00001637,
Institutional Review Board (IRB) number: IRB00001938

S16 Appendix P: Provincial approval letter



health
MPUMALANGA PROVINCE
REPUBLIC OF SOUTH AFRICA

MPUMALANGA
THE PLACE OF THE RISING SUN

No.3, Government Boulevard, Riverside Park, Ext. 2, Mbombela, 1200, Mpumalanga Province
Private Bag X11285, Mbombela, 1200, Mpumalanga Province
Tel: +27 (13) 766 5429 Fax: +27 (13) 766 5468

Lisiko Letsoalo | Departement van Gesondheid | UmNyango WezeMpilo

Letter of Support Signed by Chief Director (CD)/CEO/District Manager (DM)/Programme Manager (PM)

1. Name & contact no. of Applicant	Natasha Esau		
2. Title of Study:	An assessment of the PHC Facility Governance Trainer of Trainer Programme in Nkangala district Mpumalanga Province		
3. Aim and population target:	Aim: To assess the PHC facility Governance Trainer of Trainer Programme in Nkangala District. The Population target: Nkangala Department of Health, Health Systems Trust and training participants		
4. Period to undertake the study	**From:** August 2017	**to:** August 2017	
5. Resources Required from Facility/Sub-district/Community			
5.1: Facility Staff Required to assist with the Study	**Yes** **How many:** Nurses: Doctors: Other, please specify:		**NO** X
5.2: Patient Records/Files	**Yes**		**NO** X
5.3: Interviewing Patient at Facilities	**Yes**		**NO** X
5.4: Interviewing Patients at Home	**Yes**		**NO** X
5.5: Resource Flow (Are there benefits to Patients/community)	**Yes** Please list:		**NO** X
5.6: Resource Flow (Are there benefits to Facility/District)	**Yes** Please list:		**NO** X
6. Availability of Required Clearance			
6.1: Ethical Clearance	**Yes** X Clearance Number: 194/2017	**Pending**	**NO**
6.2: Clinical Trial	**Yes** Clearance Number:	**Pending**	**NO** X
6.3: Vaccine Trial	**Yes** Clearance Number:	**Pending**	**NO** X
6.4: Budget	**Yes** X Source of fund: Self		**NO**

Declaration by Applicant:
I Mr/Ms/Dr/Prof/Adv. Ms N Esau agree to submit/present the result of this study back to the CEO/Institution/District

Comment by CEO/CD/DM/PM: **Supported / Not Supported**

The study results should be shared with the Department

Signature of CEO/CD/DM/PM **Stamp/Date:**
Name: M. S. Mothimme

Please email completed form to: JerryS@mpuhealth.gov.za **or** ThembaM@mpuhealth.gov.za

MPUMALANGA
THE PLACE OF THE RISING SUN

S17 Appendix P: Submission guidelines – PLOS ONE

Related information for authors

- Submission system
- Journal scope and publication criteria
- Getting started guide
- Guidelines for revisions
- Publication fees

Style and Format

File format	Manuscript files can be in the following formats: DOC, DOCX, or RTF. Microsoft Word documents should not be locked or protected. LaTeX manuscripts must be submitted as PDFs. Read the LaTeX guidelines.
Length	Manuscripts can be any length. There are no restrictions on word count, number of figures, or amount of supporting information. We encourage you to present and discuss your findings concisely.
Font	Use a standard font size and any standard font, except for the font named "Symbol". To add symbols to the manuscript, use the Insert → Symbol function in your word processor or paste in the appropriate Unicode character.
Headings	Limit manuscript sections and sub-sections to 3 heading levels. Make sure heading levels are clearly indicated in the manuscript text.
Layout and spacing	Manuscript text should be double-spaced. Do not format text in multiple columns.
Page and line numbers	Include page numbers and line numbers in the manuscript file. Use continuous line numbers (do not restart the numbering on each page).
Footnotes	Footnotes are not permitted. If your manuscript contains footnotes, move the information into the main text or the reference list, depending on the content.
Language	Manuscripts must be submitted in English. You may submit translations of the manuscript or abstract as supporting information. Read the supporting information guidelines.
Abbreviations	Define abbreviations upon first appearance in the text. Do not use non-standard abbreviations unless they appear at least three times in the text. Keep abbreviations to a minimum.
Reference style	PLOS uses "Vancouver" style, as outlined in the ICMJE sample references. See reference formatting examples and additional instructions below.
Equations	We recommend using MathType for display and inline equations, as it will provide the most reliable outcome. If this is not possible, Equation Editor or Microsoft's Insert→Equation function is acceptable.

	Avoid using MathType, Equation Editor, or the Insert→Equation function to insert single variables (e.g., "$a^2 + b^2 = c^2$"), Greek or other symbols (e.g., β, Δ, or ′ [prime]), or mathematical operators (e.g., x, ≥, or ±) in running text. Wherever possible, insert single symbols as normal text with the correct Unicode (hex) values. Do not use MathType, Equation Editor, or the Insert→Equation function for only a portion of an equation. Rather, ensure that the entire equation is included. Equations should not contain a mix of different equation tools. Avoid "hybrid" inline or display equations, in which part is text and part is MathType, or part is MathType and part is Equation Editor.
Nomenclature	Use correct and established nomenclature wherever possible.

Units of measurement	Use SI units. If you do not use these exclusively, provide the SI value in parentheses after each value. Read more about SI units.
Drugs	Provide the Recommended International Non-Proprietary Name (rINN).
Species names	Write in italics (e.g., *Homo sapiens*). Write out in full the genus and species, both in the title of the manuscript and at the first mention of an organism in a paper. After first mention, the first letter of the genus name followed by the full species name may be used (e.g., *H. sapiens*).
Genes, mutations, genotypes, and alleles	Write in italics. Use the recommended name by consulting the appropriate genetic nomenclature database (e.g., HUGO for human genes). It is sometimes advisable to indicate the synonyms for the gene the first time it appears in the text. Gene prefixes such as those used for oncogenes or cellular localization should be shown in roman typeface (e.g., v-fes, c-MYC).
Allergens	The systematic allergen nomenclature of the World Health Organization/International Union of Immunological Societies (WHO/IUIS) Allergen Nomenclature Sub-committee should be used for manuscripts that include the description or use of allergenic proteins. For manuscripts describing new allergens, the systematic name of the allergen should be approved by the WHO/IUIS Allergen Nomenclature Sub-Committee prior to manuscript publication. Examples of the systematic allergen nomenclature can be found at the WHO/IUIS Allergen Nomenclature site.

Copyediting manuscripts

Prior to submission, authors who believe their manuscripts would benefit from professional editing are encouraged to use language-editing and copyediting services. Obtaining this service is the responsibility of the author, and should be done before initial submission. These services can be found on the web using search terms like "scientific editing service" or "manuscript editing service."

Submissions are not copyedited before publication.

Submissions that do not meet the *PLOS ONE* publication criterion for language standards may be rejected.

Manuscript Organization

Manuscripts should be organized as follows. Instructions for each element appear below the list.

Beginning section	*The following elements are required, in order:* • Title page: List title, authors, and affiliations as first page of manuscript • Abstract • Introduction
Middle section	*The following elements can be renamed as needed and presented in any order:* • Materials and Methods • Results • Discussion • Conclusions (optional)
Ending section	*The following elements are required, in order:* • Acknowledgments • References • Supporting information captions (if applicable)
Other elements	• Figure captions are inserted immediately after the first paragraph in which the figure is cited. Figure files are uploaded separately. • Tables are inserted immediately after the first paragraph in which they are cited. • Supporting information files are uploaded separately.

Please refer to our downloadable sample files to ensure that your submission meets our formatting requirements:

- Download sample title, author list, and affiliations page (PDF)
- Download sample manuscript body (PDF)

Viewing Figures and Supporting Information in the compiled submission PDF
The compiled submission PDF includes low-resolution preview images of the figures after the reference list. The function of these previews is to allow you to download the entire submission as quickly as possible. Click the link at the top of each preview page to download a high-resolution version of each figure. Links to download Supporting Information files are also available after the reference list.

Parts of a Submission

Title

Include a full title and a short title for the manuscript.

Title	Length	Guidelines	Examples
Full title	250 characters	Specific, descriptive, concise, and comprehensible to readers outside the field	Impact of cigarette smoke exposure on innate immunity: A *Caenorhabditis elegans* model Solar drinking water disinfection (SODIS) to reduce childhood diarrhoea in rural Bolivia: A cluster-randomized, controlled trial
Short title	100 characters	State the topic of the study	Cigarette smoke exposure and innate immunity SODIS and childhood diarrhoea

Titles should be written in sentence case (only the first word of the text, proper nouns, and genus names are capitalized). Avoid specialist abbreviations if possible. For clinical trials, systematic reviews, or meta-analyses, the subtitle should include the study design.

Author list

Authorship requirements

All authors must meet the criteria for authorship as outlined in the authorship policy. Those who contributed to the work but do not meet the criteria for authorship can be mentioned in the Acknowledgments. Read more about Acknowledgments.

The corresponding author must provide an ORCID iD at the time of submission by entering it in the user profile in the submission system. Read more about ORCID.

Author names and affiliations

Enter author names on the title page of the manuscript and in the online submission system.

On the title page, write author names in the following order:

- First name (or initials, if used)
- Middle name (or initials, if used)
- Last name (surname, family name)

Appendices

Each author on the list must have an affiliation. The affiliation includes department, university, or organizational affiliation and its location, including city, state/province (if applicable), and country. Authors have the option to include a current address in addition to the address of their affiliation at the time of the study. The current address should be listed in the byline and clearly labeled "current address." At a minimum, the address must include the author's current institution, city, and country.

If an author has multiple affiliations, enter all affiliations on the title page only. In the submission system, enter only the preferred or primary affiliation. Author affiliations will be listed in the typeset PDF article in the same order that authors are listed in the submission.

Author names will be published exactly as they appear in the manuscript file. Please double-check the information carefully to make sure it is correct.

Corresponding author

The submitting author is automatically designated as the corresponding author in the submission system. The corresponding author is the primary contact for the journal office and the only author able to view or change the manuscript while it is under editorial consideration.

The corresponding author role may be transferred to another coauthor. However, note that transferring the corresponding author role also transfers access to the manuscript. (To designate a new corresponding author while the manuscript is still under consideration, watch the video tutorial below.)

Only one corresponding author can be designated in the submission system, but this does not restrict the number of corresponding authors that may be listed on the article in the event of publication. Whoever is designated as a corresponding author on the title page of the manuscript file will be listed as such upon publication. Include an email address for each corresponding author listed on the title page of the manuscript.

Title page

The title, authors, and affiliations should all be included on a title page as the first page of the manuscript file.

 Download our sample title, author list, and affiliations page (PDF)

Abstract

The Abstract comes after the title page in the manuscript file. The abstract text is also entered in a separate field in the submission system.

The Abstract should:

- Describe the main objective(s) of the study
- Explain how the study was done, including any model organisms used, without methodological detail
- Summarize the most important results and their significance
- Not exceed 300 words

Abstracts should not include:

- Citations
- Abbreviations, if possible

Introduction

The introduction should:

- Provide background that puts the manuscript into context and allows readers outside the field to understand the purpose and significance of the study
- Define the problem addressed and why it is important
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Appendices

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