

## Case Study: Commissioning of Du Noon Community Health Centre in the City of Cape Town Health District

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A story of internal capacity development and external partnership in Primary Health Care service delivery (2008 to 2017)

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There is limited formal documentation of success stories in the Metro District Health System (MDHS) and its contribution towards strengthening the broader health system through increased access and quality of primary health care (PHC) in the City of Cape Town Health District. This case study explains how a cohesive, decentralized DHS team commissioned the largest new PHC facility in Western Cape as a tangible milestone of success of learning by doing, through improved internal district capabilities and external alliances.

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## Abbreviations

AG	Auditor-General
AIDS	Acquired Immune Deficiency Syndrome
ASGISA	Accelerated Shared Growth Initiative of South Africa
BMTT	Bi-Ministerial Task Team
BOD	Burden of Disease
CBS	Community-Based Services
CCW	Community Care Workers
CDC	Community Day Centre
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CHC	Community Health Centre
COO	Chief of Operations
CSP	Comprehensive Service Plan
CDM	Chronic Disease Management
CNP	Clinical Nurse Practitioner
DDG	Deputy-Director General
DDG: DHS & HP	Deputy-Director General: District Health Services and Health Programmes
DDG: SPES	Deputy-Director General: Specialized and Emergency Services
DOH	Department of Health (Western Cape)
DHC	District Health Council
DHP	District Health Plan
DHS	District Health System
EMS	Emergency Medical Services
FPS	Forensic Pathology Services
GENSES	General Specialist and Emergency Services
GSA	Geographic Service Area
GSH	Groote Schuur Hospital
HBC	Home-Based Care
HCBC	Home and Community Based Care
HIV	Human Immune-deficiency Virus
HOD	Head of Department (Health)
HSG	Health Systems Governance
HPSR	Health Policy and Systems Research
IDP	Integrated Development Plan
IGR	Inter-Governmental Relations
MDG	Millennium Development Goals
MDHS	Metro District Health Services
MEC	Member of Executive Committee
MinMEC	Minister of Health (National) and Member of Executive Committee (Provincial Health Ministers)
NSDG	Negotiated Service Delivery Goals
COCT	City of Cape Town (Municipal Authorities)
NCS	National Core Standards
NDOH	National Department of Health
NGO	Non-Governmental Organization
NHA	National Health Act
NPO	Non-Profit Organization

OHS	Occupational Health and Safety
OHSC	Office of Health Standards Compliance
PGDS	Provincial Growth and Development Strategy
PHC	Primary Health Care
PMTCT	Prevention of Mother-to-Child Transmission
PHC	Primary Health Care
PPHC	Personal Primary Health Care
PT	Provincial Treasury
RCWMCH	Red Cross War Memorial Children's Hospital
SCWG	Service Co-ordinating Work Groups
SDG	Sustainable Development Goals
SPES	Specialized and Emergency Services
SSA	Statistics South Africa
TBH	Tygerberg Hospital
UNDP	United Nations Development Programme
VBH	Valkenberg Hospital
WCG	Western Cape Government
WCG: H	Western Cape Government : Health
WHO	World Health Organization

## Chapter 1

There is limited formal documentation of success stories in the Metro District Health System (MDHS) and its contribution towards strengthening the broader health system through increased access to quality primary health care (PHC) in the City of Cape Town Health District. The goal of this dissertation is to explain how a cohesive, de-centralized team commissioned the largest new PHC facility in Western Cape as a tangible milestone of accomplishment, through improved internal district capabilities and external alliances. Learning-by-doing, which has resonance in economics, education, and psychology became a cornerstone principle of this team's modus operandi. (Arrow, 1962) (Schank, 1995) Chapter One outlines the case study rationale and roadmap, introduces the conceptual framework, and offers a synopsis of all chapters.

Since 2007, a de-centralized district health system (DHS) was implemented in Western Cape Government: Health (WCG: Health) as central pillar of Healthcare 2010 strategy. (Health Western Cape, 2003) The DHS is responsible for 90 per cent of all patient contacts in the health system, with a headcount of 14 150 180 in the Primary Health Care (PHC) services in 2015 /16 (Health Western Cape , 2016) from a baseline of 1.6 million in 1994/95. (Western Cape Health, 2017) Mid-year population estimates for Western Cape in 2016 gauged the provincial population at 6 510 312, signifying annual growth of 1.9 per cent since 2011 estimates of 5 822 734. (Statistics South Africa, 2017) Sixty-four per cent of the provincial population, estimated to be 4 140 565 in 2018, reside in City of Cape Town district, serviced by the Metro District Health Services (MDHS) and 77.5 per cent of city residents are dependent upon this system to access PHC services. (Western Cape : Health, 2018)

Evidence of progress in DHS and PHC service delivery is inadequately recorded beyond official annual operational and performance plans, with limited specific evaluation of MDHS contribution towards health system strengthening, service access and overall health outcomes embedded in a practice context. Without longitudinal or in-depth case studies evaluating PHC service delivery, there are missed opportunities to harvest lessons from rich experiences of system role-players proficient in frontline policy practice. Carefully-made central plans often do not always get implemented as expected, and managing unintended consequences and unpredicted outcomes in complex environments tests all stakeholders to problem-solve and adapt in order to achieve set objectives. Iterative processes of successful learning-by-doing incrementally build team capacity and confidence, and reciprocally enhance organizational trust in the team as goals are progressively attained. "Learning is the product of experience. Learning can only take place through the attempt to solve a problem and therefore only takes place during activity." (Schank, 1995)

Sharing achievements and learning from DHS change is crucial, especially when WCG: Health undergoes further transformation with its Healthcare 2030 strategy (Western Cape Government: Health, 2013), aspiring towards wellness and quality patient-centred care grounded in PHC philosophy. (World Health Organisation, 1978)

Tracing one pathway of MDHS development, this case-study narrates the journey of commissioning Du Noon CHC, the largest new PHC facility constructed in Western Cape over the past decade, located in the Cape Town Health District. The mission was to commission comprehensive PHC services to a community with socio-economic deprivation after chronic poor health service access in dilapidated infrastructure. Analysis of this account offers layered lessons in navigating complexity, uncertainty, and iterative learning by a district team working with many stakeholders who do not always share similar objectives. It embodies processes of developing an index of memories and scripts during experiential learning from problem identification, solution-seeking, discovering failure and success through testing, reflecting and adapting. (Schank, 1995)

Chapter Two details the hypothesis, research methodology and literature review. The primary hypothesis postulates that an inexperienced, newly-formed de-centralized district health team successfully commissioned Du Noon CHC through continuous application of practice-based knowledge to build team capability and external partnerships to overcome multiple challenges. As a second hypothesis, the learning-through-doing approach of the team was supported by a cohesive, performance orientation that consistently focused on accountability which was inspired by a shared social commitment to transformational change.

Seminal work tracing the evolution and interlinkages of organizational capacity, strengthened reputation and exercise of bureaucratic autonomy grounds the case study. These themes are expanded upon in Chapter Two. (Carpenter, 2001) Phased realization of de-centralized "decision-space" proportionately achieved after proven accountability, maturing organizational capacity, and evolving authorization and trust from central departmental structures will be discussed as a specific organizational capacity development approach. (Bossert & Mitchell, 2011)

Chapter Three discusses service and system indicators to describe project growth and achievement over time. Improvement in health outcomes cannot be solely and directly attributed to specific interventions such as the commissioning of a new PHC facility, however from a health system strengthening perspective, Du Noon CHC has undeniably provided comprehensive PHC access measured by national sentinel indicators, and notionally to overall health outcomes in the geographic area. Measures of service outputs, access and effectiveness are presented. The extent to which Du Noon has enhanced outcomes and impact of individual health programmes is beyond the scope of this paper.

Chapter Four maps the delivery of Du Noon in a three-part discussion: (I) de-centralized team formation (II) depiction of critical junctures that drive team and institutional capacitation, enhanced reputation and external alliances, and (III) Team transformation from baseline capacity to a post-Du Noon commissioning state, focused upon the learning-by-doing experience to add public value. A frame of “problem-driven learning”, which argues for context-specific understanding, dialogue and agency by relevant involved actors can “stimulate a process of de-institutionalization, where dominant incumbent institutions are questioned” is explored. (Andrews, 2013) Critical junctures during project inception and implementation are traced, illustrating difficulties in traversing byzantine public sector processes at local, provincial and national levels. Multiple perspectives of different actors document team development and partnerships involved in successfully delivering a modern health facility that opened in December 2014. A learning-by-doing approach in seeking solutions to impediments, often via unlikely partnerships, and enhanced confidence in taking on greater challenges is discussed. The case study shall demonstrate an unwavering team vision to add public value to the Du Noon community by commissioning comprehensive PHC services and building effective alliances, and in doing so, fulfilled a social compact for redress and human dignity.

Chapter Five reflects on key findings related to organizational capacity development and coalition-building offer credence to the research hypotheses. The case study offers a context-specific evaluation of a component of Metro DHS development over the past decade, and proposes some concluding recommendations for policy makers.

## **Chapter 2: Hypothesis, research methodology and literature review**

Chapter Two outlines the motivation for the research question, formulation of the hypothesis and framing it within Carpenter's theoretical construct of bureaucratic autonomy. The literature review expands the core ideas of de-centralized decision-making as part of developing internal capability.

### **Problem statement**

Health system accomplishments in Metro District Health System (MDHS) are poorly researched and evaluated, consequently leading to its unacknowledged contribution towards strengthening the broader health system and improving population health outcomes. There are many missed opportunities to understand how people work in complex adaptive systems (Page & Millar, 2007) within the health context and navigate their circumstances to achieve milestones and become more resilient despite the prevailing odds. This case study conducted detailed inquiry into the processes, context, interactions and experiences of people who were set the task to commission the largest new PHC facility despite its omission from Healthcare 2010, the WCG: Health strategy that drove system restructuring at the time. A project of this magnitude had multiple role-players across many sections of different governmental departments, however the primary perspective of "mezzo-level actors" who have a niched situation in organizational echelons to both innovate and the "political capacity to build coalitions behind new ideas" was explored in seeking explanations for observed success. (Carpenter, 2001, p. 22)

### **Research question and hypothesis**

Du Noon CHC was conceptualized through a primary act of public entrepreneurship (Carpenter, 2001) (Levy, 2014) when the previous Head: Health decided to construct a new facility as a priority above many other pressing health needs in Western Cape despite initial policy silence on its existence. It is argued that the eventual realization of commissioning this facility came about through multiple inter-dependent processes of "organizational evolution and bureaucratic entrepreneurship" at local and district team levels. (Carpenter, 2001) More explicitly, success resulted out of connections between different agents and their growing capabilities, their respective roles and positions in the organizational network to build institutional entrepreneurship. (Andrews, 2013)

The prevalent WCG: Health organizational context between 2007 and 2016 to establish and expand de-centralized district management capacity facilitated and actively encouraged accountability, performance, internal governance and innovation. (Grammer, 2016) Commissioning Du Noon became the proving ground for extending team performance, exhibited through more competent de-centralized decision-

making and problem-solving. Both conventional operational and strategic planning, as well as responding to the unanticipated critical junctures, enhanced team capabilities to seek solutions through alliances, more efficient administration and negotiation, resulting in greater confidence and trust in abilities. Organizational capacity grew incrementally at district level that was further customized at de-centralized level to improve productivity.

Bureaucratic autonomy is recognized when organizations “can change the agendas or preferences of the politicians or organized public” as a positive influence rather than summarily disregard political or service mandates. (Carpenter, 2001) (Balla, 2003)

Carpenter holds that three pre-conditions are crucial to autonomous bureaucracies:

1. Political differentiation from the politicians and organized interests seeking control of these organizations;
2. Demonstration of unique organizational capabilities inclusive of critical analysis, planning, problem-solving, efficient programme administration and innovation, and willingness and capacity to prevent corruption;
3. Political legitimacy or an immutable reputation networked into an independent power base. (Carpenter, 2001)

Successful coalition-building and alliances in turn cultivate political and organizational currency, which theoretically grows public recognition of reputational credibility and trust to innovate policy. In Carpenter’s treatise on American bureaucratic development he explains that:

*“The advance of the policy state is a narrative of organizational evolution and bureaucratic entrepreneurship. Operating within the rigid confines of the American institutional order – the primacy of elected officials, the constraints of American political culture, and the dominance of parties – administrative leaders in USDA and the Post Office department slowly carved out pockets of limited discretion by starting small experimental programs. By nurturing local constituencies and by using their multiple network affiliations to build broad support coalitions among professionals, agrarians, women’s groups, moral crusaders, congressional and partisan elites, they won for their young programs both political currency and administrative legitimacy. Fledgling experiments with dubious survival prospects at the turn of the century became, by the close of the 1920s, established policies. At almost every step in the development of these programs, the institutional authorities of the American order – Congress, the president, the parties, the courts, and organized interests – assented to greater and greater administrative innovation. Through reputation building, federal agencies won the capacity to innovate. In American political development, bureaucratic autonomy was not captured but earned.”*  
(Carpenter, 2001)

Against this expansive framework positing how bureaucracies develop, mature and flourish, evolving organizational capacity and alliance formation are primary pillars that

are being explored in this case study. Specific emphasis on decisions, actions and processes undertaken by the de-centralized district team actors who make up the “mezzo-level administrators” will be investigated as optimally located actors with their deep understanding and connection with operations and programmes as well as their sufficient authority to nimbly make changes. Carpenter holds that it is this set of organizational functionaries that have both the local authority to innovate through “experimental doing” by testing, observing, analyzing, failing or succeeding, and thus subsequently engaging in “inferential learning” and adapting plans to achieve set objectives. Middle-management actors are once again seen to be ideally placed to motivate, permit and facilitate innovation through intrinsic capacity derived from long-standing career expertise and networks of resources and alliances. (Carpenter, 2001)

Hypothesis I: *“A decentralized district health team's success in commissioning Du Noon CHC was embedded in persistent, iterative and experiential team-based learning by doing – resulting in ongoing, mutually-reinforcing strengthening of (i) **internal organizational capacity**; and (ii) **external partnerships**.*

*Achievement of (i) and/or (ii) along all points of the journey towards Du Noon project implementation created the foundation for the team to successfully deliver the critically-needed PHC services to the Du Noon community after overcoming multiple obstacles during the course of the project.*

Hypothesis II argues the importance of intrinsic de-centralized organizational culture, and a strong focus on a developmental approach as core contributors towards successfully attaining observed outcomes.

Hypothesis II: *“The efforts laid out in H1 were facilitated by a district team which from the outset was cohesive, performance-driven, accountable and socially committed.”*

The milieu in which the Du Noon project was commenced included multiple factors that mitigated against its successful completion. These included:

- i) Omission from Healthcare 2010 DOH Strategic Plan;
- ii) Untested capabilities within MDHS and De-centralized District teams;
- iii) Perceived lack of leadership and competencies required for large project delivery;
- iv) Some mistrust and organizational rigidity and limited decision-space due to relative “youth” of DHS itself;
- v) Opposition and poor collaboration from specific stakeholders;
- vi) Financial uncertainty for full implementation of services;
- vii) Technical delays in infrastructure delivery via the Implementing Agent;
- viii) Unforeseen events impacting commissioning team capacity

The research aims to:

- Use an analytic narrative and process tracing to identify and explain how a decentralized team built internal capacity through learning-by-doing, expanded decision-space, and external coalitions in its path to successfully commission Du Noon CHC (Bossert, et al., 2007) (Carpenter, 2001)
- Provide evidence to confirm or refute the tabled Hypotheses
- Map mechanisms as tangible demonstration of how systems change really happens through a learning-by-doing process rather than through top-down command-and-control planning methods
- Illustrate how improved internal district capabilities and external governance relationships and alliances drove the project forward
- Explore the “human attributes (choices, needs, preferences, interests, power, values)” (Sheik, et al., 2014) of role-players in the Metro District Health System

### **Study Design**

A Case Study design is being used to explore health system contextual complexity through research by uncovering and reviewing evidence that would explain and evaluate events, processes and lived experience of the actors and entities under investigation. An empirical methodology of process tracing to understand causal mechanisms as “unobservable physical, social or psychological processes” (George & Bennett, 2005) or “events, activities, and intermediate outcomes” (Punton & Welle, 2015) in support or refutation of the hypothesis shall be utilized. Criticisms of case-studies include being “vulnerable to inferential errors” making theory-testing and development difficult and having an “indeterminate research design” and no diagnostic tests and remedial procedures.” (Waldner, 2012) Unusual or extreme situations that are not representative or have non-generalizable findings until multiple cases demonstrate a more “quantitative” characteristic are further concerns. (Tarrow, 2010) Alternatively, they provide density of detail, illustrative description, and scrutiny of evidence that either support or reject explanatory theories, and uncover causal mechanisms through process tracing. Case study methods such as “within-case analysis such as process tracing” assist with adjudicating “competing explanatory claims in social science research” and allow “inferences about which alternative explanations are more convincing, in what ways, and to what degree”. (Bennett, 2010)

### **Methodology**

A Mixed methods approach was employed, with both Quantitative and Qualitative components to the case study.

## **Qualitative research component**

### ***Sampling***

Purposive sampling of the participants closest to the actual process of planning, commissioning and implementation of the project shall be done after detailed stakeholder mapping process. Seven participants were interviewed for approximately two hours each.

### ***Method of qualitative data collection and tool***

Semi-structured interviews were conducted with participants using a directive enquiry method. Interviews were transcribed onto the Directive Inquiry questionnaire for ease of thematic analysis. Documentary review was also utilized to illustrate an analytic macro-level narrative.

### **Quantitative data**

Relevant primary service performance data was obtained from Sinjani, the official repository of DOH data, and secondary data from audited Annual Health Department Reports and other formal sources. Primary financial data was sourced from the Basic Accounting System (BAS) and secondary data from official audited Annual Financial Statements.

### **Ethics Process for Research**

The researcher has direct or indirect links with most participants who form part of the expanded district management team she leads. She was fully cognizant of potential for professional relationship and conflict of interest impacts in her dual leadership and researcher role, however declared her intentions and interests as both an actor in the health system as a manager, and a researcher. These include documenting perspectives and processes from a people-centred and values-driven philosophy to enhance different voices through open discourse, promote reflection and re-framing of challenges, generate, collate and analyze knowledge, and inform policy from a reality-based and practice-embedded context in a dialogic manner. (Sheik, et al., 2014)

“Change occurs at many layers of a health system, shaped by social, political, and economic forces, and brought about by different groups of people who make up the system, including service users and communities. The seeds of transformative practice in Health Policy and Systems Research (HPSR) (Bennett, 2007) lie in amplifying the breadth and depth of dialogue across health system actors in the conduct of research – recognizing that these actors are all generators, sources, and users of knowledge about the system.”

The researcher conducted her research in an autonomous manner and with integrity to support health systems transformation through the agency of people.

## Literature Review

### *Institutions, Organizations, Bureaucratic autonomy and public entrepreneurship*

"Institutions are the rules of the game in a society, or more formally, the humanly derived constraints that shape human interaction," whereas organizations are differentiated as "groups of individuals bound by some common purpose to achieve objectives" and occupy social, state, political, economic and educational spaces. (North, 1990) Iterative interactions result in institutional evolution when agents of change or organizational entrepreneurs, influence transformative practice and performance. "Institutions reduce uncertainty by introducing a structure to everyday life," and form "a guide to human interaction" through use of a "combination of skills, strategy and coordination" to achieve victory in the game of societal performance. (North, 1990)

The South African public sector is not regarded as a stronghold of innovative problem-solving, convincing institutional reform, good governance and leadership, with National Treasury and South African Revenue Services (SARS) as notable exceptions. (Public Affairs Research Institute, University of Witwatersrand, 2016) (Pillay, et al., 2016) Public bureaucracy stereotypes abound: bloated structures with poorly-trained, under-performing and corrupt officials who do not create public value. Failures in ethical leadership, governance and institutional capacity have eroded the developmental state at local, provincial and national levels across multiple sectors. (Daily Maverick, 2017) Citizens often assume that all public servants, institutions and organizations are incompetent, unresponsive, inflexible to change or captured given the yawning trust deficit. (Stazyk & Goerdel, 2011) Little appreciation exists of contextual complexity, and the ambiguity that agents need to navigate to deliver on key mandates, let alone be pioneers in problem-solving in a learning-by-doing paradigm. Proposed variables which determine organizational performance include "availability of financial resources, the extent to which organizations receive support and guidance from external sources, the autonomy organizations are able to exert in the decision-making process, and the relative clarity of organizational goals." (Stazyk & Goerdel, 2011)

It is difficult to imagine that there are examples of "islands of effectiveness" in many parts of our public sector (Levy, 2014) where teams coalesced around shared vision and mission make slow yet steady progress through strategy design, task execution, reflection on and consolidation of small wins. Confidence gained from early success begets capacity and self-belief to take on greater awaiting challenges.

Researching bureaucratic organizations offers intrinsic value to understand their "administrative outcomes" in order to differentiate "institutional transformation" from "institutional creation" which is oft heralded as the primary political development milestone rather than evaluation of policy efficacy for its citizenry. (Carpenter, 2001) Bureaucratic autonomy describes the condition of "agencies taking sustained patterns

of action consistent with their own wishes, patterns that will not be checked or reversed by elected authorities, organized interests, or courts" and is attained through political differentiation from principals, unique organizational capacity, and political legitimacy. (Carpenter, 2001)

Western Cape: Government: Health (WC: G: H) had features of bureaucratic autonomy by 2008 after its first phase of post-democratic transformation. It had steadily grown its national and provincial reputation for good governance, unqualified financial audits, emerging innovation and improving service delivery as measured by multiple health outcomes, yet adopting certain health policy positions not always aligned with the politically-dominant views at the time. A notable example was a proposal to commence antiretroviral treatment (ART) for pregnant women by one of the Metro District Health Services (MDHS) pioneers, a Chief Medical officer (CMO) to his then Divisional Head, on recognizing the high HIV prevalence in Khayelitsha, and supported by the HOD despite rampant national AIDS denialism. Pregnant women living with HIV in Khayelitsha were the first in SA to access ART at Michael Mapongwana CDC in 2000 through a responsive DHS to local health priorities. In-house capacity improvements and greater alliance-building with certain Non-Profit Organisations (NPOs) from this unique success subsequently paved the way for up-scaling the Provincial Prevention of maternal to child transmission (PMTCT) programme. Now provincially and nationally institutionalized, PMTCT has reduced paediatric mortality from HIV / AIDS / TB and contributed towards making Western Cape life-expectancy consistently the highest in SA. (Statistics South Africa, 2016) (Statistics South Africa, 2017)

Examples of service-driven public entrepreneurship in WCG: Health can be cited over past years, even within an immense bureaucracy with exhaustive health-specific and financial legislative and policy frameworks. (Western Cape Health, 2017) There is continuous tension between the vision for person-centred health service delivery, innovation and transformation and stifling central pressure for compliance and corporate governance reputation management that can choke ingenuity, innovation and enterprise. These sentiments have been expressed by staff in formal organizational surveys with limiting organizational values of "red tape" and "control" recorded, however improved alignment of personal and organizational values have been reported over the past six years. Courageous public health entrepreneurship resulted from non-conformist thinking and learning-by-doing, as well as critical partnerships with civil society organizations, thereby enhancing departmental reputation, building programmatic and political legitimacy, and taking early incremental steps towards improving community health. Inter-sectoral coalitions that functioned via the Provincial Aids Council speak to a politically diverse array of stakeholders united around a shared mission to tackle HIV /AIDS. The DHS and Health Programmes (DHS and HP) delivered technical and organizational capacity through strong central business planning and advocacy which mobilized donor funding to rapidly upscale PHC ART access. Effective

resource utilization through programme implementation by capacitated de-centralized district management teams delivered steadily improved outputs and outcomes over time, thus setting up a virtuous cycle of enhanced relationships between all partners. Relationships were built between the nascent local District team management role-players and the central authorizing role of DHS and HP senior managers with positive development of the HIV / AIDS care platform that has contributed towards increasing life expectancy in Western Cape.

This tradition of acting in the best interests of patient care, has continued at multiple levels within different parts of the organization over the years, notwithstanding its strong compliance culture to invest in its reputation with Provincial Treasury, invoking the sentiment that bureaucratic autonomy is “not captured but earned.” (Carpenter, 2001) “Reputations that were embedded in multiple networks gave agency officials an independence from politicians, allowing them to build manifold coalitions around their favored programs and innovations.” (Carpenter, 2001)

Projects that were originally unfunded mandates, such as the Primary Health Care Information System (PHCIS) initiated by public entrepreneurial figures within senior DHS management, won international awards and have modernized health service delivery. A famed maxim in the District management cadre was to “do the right thing for the patient and ask forgiveness afterwards.”

### *Learning-by-doing*

“Modeling organizations is analyzing governance structures, skills, and how learning by doing will determine the organization's success over time.” (North, 1990) District health system policy developers and practitioners recognized early that PHC implementation could not follow a “conventional blueprint approach to development in which all components of a strategy are planned in detail and then followed rigidly during implementation.” (World Health Organisation, 1988) Experimentation and learning are overtly called for, with “willingness and ability of health systems to learn from experience” and to “explore innovative strategies and to analyze what lessons are emerging as these strategies are being implemented.” (World Health Organisation, 1988) It is reiterated that:

“the planning of interventions needs to become an ongoing process in which there is plenty of room for revising, adapting and refining the plans as implementation progresses. It is becoming increasingly evident that the most innovative and successful initiatives have been developed in the spirit of experimentation and learning over extended periods of time.” (World Health Organisation, 1988)

Sustainability is attained through institutionalization of capabilities essential for implementation by capacitated teams and managers, and effective systems for developing and retaining people are key components in a DHS seeking performance, longevity and self-reliance. Health systems are organizations functioning within institutional constraints with the fundamental purpose to improve population outcomes

and performance. They transform over time by whole systems change, multi-dimensional alliances and partnerships, where “a relationship between actors outside the health system and those working within it: health workers, facility teams, supervisors, district management teams and so on” that are further influenced and affected by a myriad “dynamic, multi-layered contexts,” including preceding socio-political history, organizational and policy reform agendas and end-user expectations. (Gilson, 2013)

An approach of “problem-driven learning,” where contextually relevant and responsive solutions to challenges, often results in the most meaningful institutional reform. (Andrews, 2013) Agents who transform institutions through unconventional sensibilities and approaches, yet are part of the establishment to effect authority and harness resources, are regarded as “institutional entrepreneurs”, especially when de-centralized from prevailing loci of power in social networks. (Andrews, 2013) Incumbent arrangements are easier critiqued and higher amenability to change is present when agents are located further from central positions of influence, which arguably empowered de-centralized district teams to innovate more through practice. When lower power yet high creativity agents interact meaningfully with agents with greater authorizing power or resources, it sparks potential for enhanced institutional capacity. Andrews argues that “change comes out of their connections, not from these isolated capabilities,” which makes the case for “institutional entrepreneurship” rather than individual entrepreneurs. Multi-agent leadership is more likely to underpin and deepen sustainable institutional transformation. (Andrews, 2013) Opportunity to give effect to greater freedom of planning and action within broader organizational strategic frameworks of governance, programmes and aspirational outcomes, is ideally located in the context of de-centralized DHS management and service implementation. A recurrent motif was the centrally-located policy and programmatic “navigators” who set course towards true-north for governance and improving health outcomes, and the de-centralized “drivers” who implemented and delivered health services at the coal-face within their discretionary decision-space.

A learning-by-doing approach in seeking solutions to impediments, often via unlikely partnerships, and enhanced confidence in taking on greater challenges characterizes much of the DHS context due to its array of actors, multiplicity of health programmes, large health platform and manifold strategic partnerships. An iterative cycle of development through implementation-driven learning, oftentimes stumbling and then adapting from temporary setbacks, leads to enhanced understanding and organizational aptitude, and ultimately improved health service delivery and system strengthening. Multiple small wins enhance the broader District and WCG: Health reputation over time, thus improving overall system legitimacy. Institutions are built with libraries of corporate and service practice memories housed within its teams of human capital, indexed for recall to solve new, yet familiar challenges based on experiential learning.

### **Internal capacity, institutional development, governance and leadership**

In the post-Ebola outbreak analysis in Guinea, Sierra Leone and Liberia, the key recommendation to improve institutional capacity of District Health Management Teams (DHMT) was to focus upon “sustainable, continuous improvement in governance, leadership and management competencies to permit decentralization of authority, resources and a support system for all districts.” (World Health Organisation, 2016) Building partnerships and recognition of “increased leadership responsibilities in the health sector” at a “time when the communities no longer have much trust in the national health system” was emphasized.

Capacity development was directly linked to accountability, co-ordination mechanisms, quality and performance management through integrated planning, monitoring and evaluation “to allow adaptation of solutions to the local context and monitor these activities over time.” (World Health Organisation, 2016) Reliable health information available in real time for more informed decision-making and exercise of accountability. Contextual problem-solving would be more likely, with the consequence of growing trust and greater legitimacy. An enhanced bureaucratic capability can potentially spark a virtuous developmental cycle. (Levy, 2014) (Bossert & Mitchell, 2011) This motif is echoed by Carpenter’s fundamental premise is that systematic accomplishment through technical expertise and demonstrated capacity permits organizations with trustworthy reputations and public recognition to leverage their “reputational uniqueness” and build legitimacy across a spectrum of diverse role-players and sectors, allowing bureaucratic autonomy in execution of their mandate via greater innovation, “cohesion and efficiency”. (Carpenter, 2001)

Successful delivery of the Du Noon project despite its myriad challenges represents a public good on multiple levels; at a systems level providing Du Noon community access to quality PHC services denied historically, evidence of DHS functionality and governance, effectiveness of managerial de-centralization, meeting core health mandates and contributing towards improving health system outputs and outcomes. At team and institutional capacity level it supports the premise of organizational evolution and reputational enhancement.

Social agents occupy a dynamic, connected system where choices, decisions, actions and adaptation lead to complexity when interacting with others who are similarly thinking, predicting and reacting to them. (Page & Millar, 2007) To cope in such demanding environments, to manage external shocks and uncertainty, health system resilience is critical, defined as “the capacity of health actors, institutions, and populations to prepare for and effectively respond to crises; maintain core functions when a crisis hits; and, informed by lessons learned during the crisis, reorganize if conditions require it.” (Kruk, et al., 2015)

## **Governance and De-centralization**

It is contended that “good governance is not simply a function of the structure of intergovernmental relationships” but rather the “consequence of new opportunities and resources, the impact of leadership, motivation and choices, the influence of civic history, and the effect of institutions that constrain and facilitate innovation.” (Grindle, 2007) Health system governance has journeyed from founding Alma Ata Declaration citing community participation and accountability, (World Health Organisation, 1978) to the centrality of stewardship (governance) within functional health systems where its essence incorporates effective oversight of strategic policy frameworks, provision of appropriate regulations and incentives, system-design, accountability and coalition-building. (WHO, 2007) De-centralized health systems management of regions, provinces or districts has been implemented in many settings, however successful implementation “depends critically on the people in the district who are charged with the management and implementation of PHC strategies. It is in the district where top down and bottom up meet, if they are to meet at all.” (World Health Organisation, 1988)

“The district provides an excellent organizational framework within which to introduce changes in the health system. At this level, policies, plans and practical realities can meet, and feasible solutions can be developed, provided that human and material resources are made available and sufficient authority is delegated.” (World Health Organisation, 1988)

Recent iterations of governance frameworks call for greater flexibility and relevance to the complex adaptive nature of health systems, and have evolved from more developmental origins as Health System Governance (HSG) is challenging to objectively measure and evaluate, and remains under-researched and contested. (Sididiqi, et al., 2009) (Joumard, et al., 2010) A comprehensive, values-based HSG framework to support capacity development of role-players and institutions within civil society, government and health sector in Eastern Mediterranean developing countries proposes ten principles critical for good stewardship or practice of HSG. These include strategic vision, participation and consensus orientation, rule of law, transparency, equity and inclusiveness, accountability, intelligence and Information, ethics, responsiveness, and efficiency and effectiveness. (Sididiqi, et al., 2009) Health systems evaluation utilizing composite indicators entails risk in over-simplification and masking significant under-performance. (Joumard, et al., 2010)

Grindle defined de-centralization as the “formal and informal mechanisms and rules that allocate authority and resources downward among different levels of government” which is a process unfolding over time in a non-linear manner and does not necessarily result in comparable outcomes. Research on the Mexican de-centralization experience depicted everyday challenges of ordinary public service employees and the citizens they serve “as they adjusted to complex new roles and realities that were simultaneously political, technical and historical.” This aptly described the reality of the new MDHS team in 2008, and describes the innate learning-by-doing

reality which meant that any blueprint plans did not exist when the team assembled, and had to deliver the day-to-day business of DHS management.

De-centralization could advance stronger governance or cause local regression of service delivery and accountability, or could increase overall health gains as well as contribute to increased inequalities in health care. (Jimenez Rubio & Smith, 2005) Contextual factors cited that offer some causal explanation in disparate findings on evaluation of de-centralization include public entrepreneurship, political competition, civil society administrative modernization, all of which either support or hamper good governance. (Grindle, 2007) Duplication, poor expenditure control, appropriate use of scales of economy, unnecessary bureaucracy, and role-confusion of different levels become risks of de-centralization. In certain health sub-systems such as logistics, more centralized functions were associated with improved performance in tasks such as inventory control and information systems, while more choice through more decentralization over planning and budgeting was associated with stronger performance in Ghana and Guatemala. (Bossert, et al., 2007) A Brazilian study refuted decentralization as a variable improving health system functionality, arguing that it was contingent upon informal management and political culture. (Atkinson & Haran, 2004)

De-centralization theorem, where efficient resource utilization to provide public goods and services at sub-national or lower tiers of government to improve outcomes based upon deeper knowledge of local context and community needs, was tested in the Canadian health system. (Jimenez Rubio & Smith, 2005) Exploring the empiric relationship between proportional de-centralized health expenditures (and thus local decision-making) compared to total national health costs, it was estimated that a 1 per cent increase in provincial expenditure stimulated roughly a 3.8 percent reduction in infant mortality, thus enhancing population health outcomes and efficiency. Its limitation was that only fiscal federalism, exclusive of other dimensions of de-centralization, such as service models, health programmes, social determinants, political, institutional and administrative factors (governance) were considered.

Health sector de-centralization supporters cite improved local responsiveness to health needs, better service delivery quality and efficiency as primary gains of the system, whereas detractors are concerned about inequity and potentially contrarian outcomes for the health system. (Bossert & Mitchell, 2011) An empiric analysis of OECD health system typologies and governance frameworks revealed de-centralization as an oft-overlooked parameter, finding in the Swedish experience it improved system flexibility and innovation, and had potential to increase responsiveness to local health needs, encourage competitive performance and experimentation. (Joumard, et al., 2010)

Effective DHS implementation falters with lack of conceptual and legal clarity on PHC by stakeholders, and multiple operational short-comings. Weak governance, “insufficient de-centralization, inadequate resource mobilization, poor managerial and

leadership skills, resulting in weak district health management teams (which leads to poor quality of care and multiple risks related to patient safety)" are core challenges. (Making Health Systems Work for Africa, 2016) Failure of services integration and co-ordination, whether on inter-sectoral basis or transforming vertical health programmes, low community trust and participation further contribute to system failures. More alignment is reached regarding implementation, where "local-level authority, institutional capacities and mechanisms of accountability mediate relationships between de-centralization and health sector performance." (Bossert & Mitchell, 2011)

Thailand's decade-long de-centralization called for learning from experience, with policy clarity, better co-ordination and capacity-building of local government health teams when uneven implementation resulted from differential capacities and understanding of responsibilities. (Jongudomsuk & Srisasalux, 2012) Analysis of Ghana's de-centralization and DHS decision-making showed that successes could be easily reversed via centralized decision-making, and that "lack of coherence in district financing, mandated managerial responsibilities and strong vertical accountabilities negatively influenced the authority of district managers." (Kwamie, et al., 2016)

A Pakistan-based study exploring inter-relationships of these three dimensions of decentralization found that despite functioning within a single de-centralized dispensation, practices and exercise of decision-making and local capacity to get things done varied depending on knowledge of wider authority and translation into initiative. (Bossert & Mitchell, 2011) A second finding highlighted synergies between different functions, where decision-space or institutional capacities in one of four core health system functions such as strategic and operational planning, health service organization and delivery, budgeting and human resources management, echoed strong capacities in other functions. It proposes a mechanism of "learning and taking more responsibility and authority in one function that leads to the understanding of the range of choice allowed for other functions" by key officials, who in turn become more "entrepreneurial" and undertake more calculated risks. There is an interplay between institutional capacity, accountability and de-centralized authority in health systems as depicted in Figure 1 and serves as explanatory connections within the learning-by-doing framework. A virtuous circle is established between the triad, mediated by mechanisms of taking initiative, learning-by-doing, enhanced responsiveness to local health needs, informed decision-making and choices, improved effectiveness and performance, and driving motivation for capacity-building. Multiple linkages contribute towards improved service delivery.

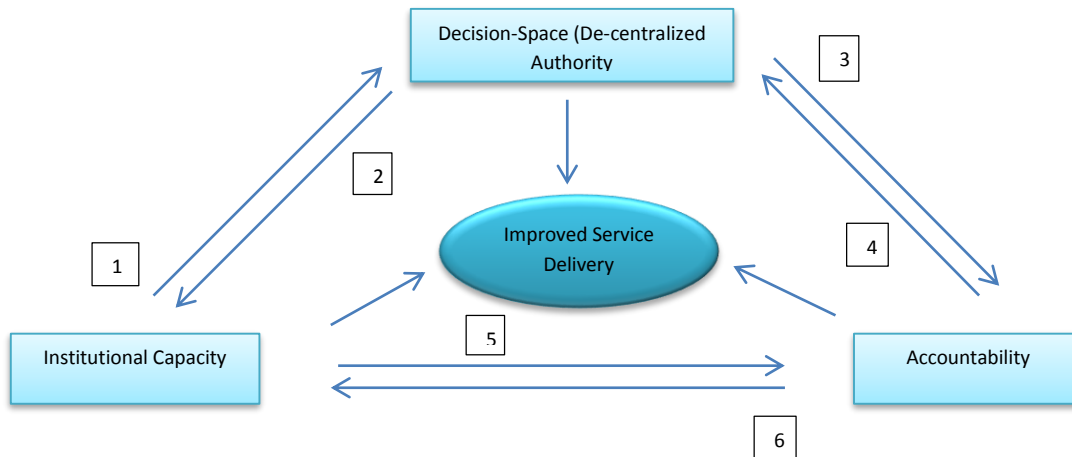


Figure 1: Mechanisms depicting synergies between De-centralized Authority, Accountability, Institutional Capacity and Improved service delivery (Bossert & Mitchell, 2011)

Key to Figure

- 1: Enables effective initiative-taking
- 2: **Builds future capacities (learning-by-doing)**
- 3: Permits responsiveness in choices to local priorities
- 4: Encourages appropriate choices
- 5: Increases ability to effectively respond to local priorities
- 6: Motivates capacity-building

**Process tracing**

“Process tracing braids factors, events and mechanisms” and studies how “decision-making links initial conditions to outcomes.” (Waldner, 2012) It attempts to “identify the causal mechanisms linking independent and dependent variables.” (George & Bennett, 2005) Process tracing has utility as a causal inference tool to discern the most probable and substantive explanation for observed social science phenomena. (Bennett, 2010) It is also seen to bridge “the Qualitative-Quantitative Divide” by focusing on processes of change through within-case qualitative analysis which “may uncover the causal mechanisms that underlie quantitative findings.” (Tarrow, 2010)

“Capacitated causal agents” acted during the commissioning process, which both explain and evaluate outputs, impact and outcomes under dynamic conditions, with logical linkages between the fundamental component variables. (George & Bennett, 2005) Causal mechanisms comprise of entities or “factors (actors, organizations, or structures) engaging in activities, where the activities are the producers of change or what transmits causal forces through a mechanism” and are critically “the combination of entity and activity.” (Beach, 2015) The decentralized district team is that entity engaging in activities expressed as decisions or deliverables, building alliances, and developing capacity that results in outputs and produces change throughout the course of the Du Noon narrative. Individual behaviors and norms within “pre-existing institutional and social contexts” become material. (Kincaid, 2012) Interactions of leadership, governance, and systems thinking as drivers and enablers of success to

engage with complexities in the Du Noon commissioning project. Health systems and policy researchers are calling for greater use of social science methodologies to better understand the interplay between people and changes in complex adaptive systems. (Daniels, et al., 2017)

### **Social Connection and social rootedness**

Carpenter argues that bureaucracies with strong reputations have two essential characteristics, namely, “actual organizational capacity” and that they are “socially rooted”. Linked to the first cited trait, the Du Noon CHC project has consistently had a social connection, mapping to the second trait for strong organizational reputation. Both political and higher DOH levels set the tone with commitment to delivering the facility once identified as an urgent need, however social rootedness was integral to implementation by the decentralized district team.

Organizations with strong reputations are “not ethereal but socially rooted”, where they are “grounded in diverse political affiliations maintained by career bureaucratic officials.” (Carpenter, 2001) It could be argued that this holds true for WCG: Health which has weathered several political changes over the past fourteen years, yet has a durable organizational structure and managerial capacity to execute its strategic plans. It is this very stability, institutional memory and recognized corporate capacity built over time at all levels of a large organization that facilitate innovation and protect its core mandate. In the latest two audited financial years it also succeeded to achieve a “clean” financial audit report; the only health department in the country to achieve this Thirteen years of unqualified financial statements by the Auditor-General, and in last two years it is the only health department nationally to have achieved a “clean” financial audit report. (Western Cape Government: Health, 2018) It consistently has some of the best health outcomes in SA, including life expectancy at birth, maternal mortality rate, neonatal mortality rate, under-five mortality rate and infant mortality rate. (Statistics South Africa, 2017) These performance outcomes have built trust in the WCG: Health brand with National and Provincial Treasuries and parts of civil society. Currently it seeks organizational culture change, and demonstrates evidence of progress from a pure efficiency identity to one focused on transformation and internal cohesion. (Western Cape Government: Health, 2018)

When bureaucracies add public value through greater efficiency, innovative problem-solving and deliver a public good (either morally, economically or prevent social hazards), their esteem and influence grows. (Carpenter, 2001) Successful delivery of the Du Noon project despite its myriad challenges represents a public good on multiple levels; at a systems level providing Du Noon community access to quality PHC services denied historically, evidence of DHS functionality, effectiveness of managerial decentralization, meeting core DOH programmatic mandates and contributing towards improving health system outputs and outcomes. At team and institutional capacity

level it supports the premise of organizational evolution and reputational enhancement.

The Du Noon CHC project has consistently had a social connection, mapping to the second trait for strong organizational reputation. Both political and higher DOH levels set the tone with commitment to delivering the facility once identified as an urgent need, however social rootedness was integral to implementation by the decentralized district team. The case study shall demonstrate an unwavering team vision to add public value to the Du Noon community by commissioning comprehensive PHC services and building effective alliances, and in doing so, fulfilled a social compact for redress and human dignity.

“Reputations that were embedded in multiple networks gave agency officials an independence from politicians, allowing them to build manifold coalitions around their favored programs and innovations.” (Carpenter, 2001) While the Du Noon project was always fully supported by relevant political heads, there were different coalitions forged to traverse uncharted territory during the commissioning.

## Chapter 3: Context and Measuring Du Noon CHC performance



### Part I: Context

#### Global, National, and Provincial policy context of District Health System development

Table 1 references some of the founding pillars of the global DHS and PHC framework that still have relevance today, however not all shall be discussed in this summary.

Table 1: Key global policy frameworks influencing Primary Health Care and District Health Systems (1978 to 2016)

Year	Publication	Implications and importance
1978	Declaration of Alma Ata	Primary Health Care philosophy Embeds health care within meaningful social and inter-sectoral connections
1988	WHO: The Challenge of Implementation: District Health Systems for PHC	Definition of DHS
2002	Towards Better Stewardship: Concepts and Critical Issues	Early position paper on governance and leadership in health systems
2006	WHO: Everybody's business: Health systems challenges and opportunities	Early introduction to health systems approach
2007	WHO: Everybody's Business: Strengthening health systems to improve health outcomes: WHO's Framework for Action	Fundamental primer for health systems understanding Adopted and customized by WCG: H DHS leadership (2009 to 2012)
2007	WHO: Governance and de-centralization	Emphasis on governance systems and leadership in de-centralized health systems
2008	WHO: Commission on Social Determinants of Health: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health	Major milestone linking health outcomes to socio-economic realities of communities
2016	Building resilient sub-national health systems – Strengthening Leadership and Management Capacity of District Health Management Teams	Affirmation of health system leadership, governance and team capacitation

#### Global influence of Alma Ata 1978

Declaration of Alma Ata of 1978 is recognized as the foundation of Primary Health Care philosophy, where health is seen as not just as the absence of disease, but attainment of full human potential. (World Health Organisation, 1978) The World Health Organisation (WHO) recognizes DHS as the best vehicle for implementation of Primary Health Care (PHC), and defines it in the following way:

*“A district health system based on primary care is a more or less self-contained segment of the National Health System. It comprises first and foremost a well-defined population living within a clearly delineated administrative and geographical area. It includes all the relevant health care activities in the area, whether governmental or otherwise. It therefore consists of a large variety of interrelated elements that contribute to health in homes, schools, workplaces, communities, the health sector, and related social and economic sectors. It includes self-care and all health care personnel and facilities, whether governmental or non-governmental, up to and including the*

*hospital at the first referral level, and the appropriate support services, such as laboratory, diagnostic and logistic support. It will be most effective if coordinated by an appropriately trained health officer working to ensure as comprehensive a range as possible of promotive, preventive, curative and rehabilitative health activities". (World Health Organisation, 1988)*

The philosophy of PHC demands local involvement with communities, consulting around health needs, co-creating solutions to health-related challenges and inter-sectoral action to address socio-economic or upstream determinants of health problems as described by the Commission on Social Determinants of Health (World Health Organisation, 2008).

Table 2 details the South African policy and legislative context in Annexure 3.

### ***National and Provincial Context impacting Western Cape and Metro DHS development***

Urgent health sector transformation was required in 1994 when the government of national unity was handed a fragmented, inequitably-funded public health system skewed towards costly hospital-centred, curative care at the expense of an under-resourced PHC services under the Health Act of 1977. Early political commitment to DHS was established through the National Health Plan of 1994 from the African National Congress (ANC), Transformation of the Health Services White Paper of 1997, and the Policy for development of a District Health System (DHS) for SA of 1995. The National Health Plan for South Africa asserted the "right to health for all" and sought to create a health system to serve all South Africans informed by the prevailing political views:

*"PHC is not just a cheaper, simpler approach to the delivery of health care, nor is it simply basic health interventions. It is a concept which is changing the medical culture. Previously this was centred around health professionals, where the community - the "patients" - were the passive recipients of health services and the doctors and health professionals alone were the dispensers of health. The change will inevitably bring about some radical transformations, not only of the health services and of the training and research institutions, but also of the attitudes of both health providers and those demanding health care services." (African National Congress, 1994)*

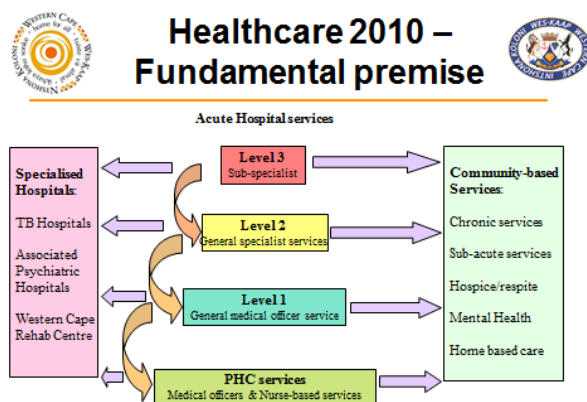
The National Health Act (NHA) was passed in 2003, setting a reform agenda, however the disjuncture between clear policy direction of the 1990s and final legal clarification provided by the National Health Bill only in 2002 contributed to delayed Western Cape decision-making on DHS governance and implementation. Health workers and managers working in the Cape Town Health District in the early post-democracy era faced key challenges stemming from legislative and policy indecision:

- 1) Slow formalization of DHS structures, which contributed to failures in rational PHC planning, service delivery and effective management;
- 2) The intractable dual health authority providing PPHC in City of Cape Town fragmented patient care and entrenched cost-inefficiencies; and
- 3) Chronic PHC under-resourcing entrenched historical inequity to PHC access, poor patient-centred care and in all likelihood, worsened health outcomes.

Between 1995 to 2014, three waves of health system reform in Western Cape contributed towards implementation of DHS, notably the 1995 Health Plan, the Comprehensive Service Plan for 2010 (CSP) tabled in 2002, and Healthcare 2030 introduced in 2013. From 1995 to 1999, apartheid-era Tri-Cameral departments merged into a single DOH organized into regions. Four Regional Directors were appointed as the vanguard of de-centralized health system management. In 1997, the Western Cape Bi-Ministerial Task Team (BMTT) was established between Health and Local Government Ministries and was mandated to rationalize PPHC governance options. Initial recommendations included transfer of all Provincial services, staff and assets to Local Government under available legal frameworks, which never materialized. Since then, the CCT Health Directorate, from local government partners with MDHS to deliver PPHC in Cape Town via an annual Service Lease Agreement (SLA) governing annual transfer payments of about R500m. Most CCT facilities do not offer comprehensive services, especially chronic adult care which is a major disease burden, depriving patients of access to integrated healthcare. Persistence of health system fragmentation in 2018 despite the National Health Act (2003) defining PPHC as a Provincial competence undermines optimized health outcomes in Cape Town.

Between 1999 and 2004, the Strategic Position Statement of Healthcare 2010 aimed to re-configure the DOH by re-prioritization of DHS and PHC approach under the banner of "Healthcare for all", re-shaping the service platform and re-engineering how patient care is delivered. Figure 2 shows relationships between different levels of care, with focus upon district hospitals, PHC facilities and community-based services that were to manage 90 per cent of all patient contacts in the re-structured health system, and regional hospitals (staffed by general specialists) responsible for managing eight per cent of patient contacts. Tertiary institutions (such as Groote Schoor and Tygerberg) managing two per cent of patient care. This structural reform has been achieved, with performance indicators evidencing DHS expansion, with total 2017/18 budget of over R5 billion and 6000 staff. (Western Cape Health, 2017)

Figure 2: Healthcare 2010: seeking seamless service delivery across different levels of care



Source: (Health Western Cape, 2003)

After years of working towards “localization” of PPHC or transferring the entire PHC platform to City of Cape Town local authorities, DOH leadership made a decision in 2002 based upon long-awaited legislative clarity provided by the National Health Bill, which offered a narrow definition of municipal health services which meant that DOH accepted Provincial accountability for all PPHC services and municipalities would only be responsible for environmental health. City of Cape Town District remains the sole district where two authorities render PPHC, as all rural health districts in the province are managed by WCG: Health. Between 2005 and 2010, a Strategic Implementation Plan, the Comprehensive Service Plan (CSP) for Healthcare 2010, established six decentralized district management structures across demarcated districts in Western Cape, and PHC integration in the five rural districts under Provincial authority. City of Cape Town Health district houses 70 per cent of provincial population, and was split into eight sub-districts for administration. See map below in Figure 3.

Figure 3: City of Cape Town Health District demarcated into eight Sub-districts



Cabinet approved the CSP, published on 11 May 2007. Appointment of key DHS leadership commenced from November 2006, with a new Deputy-Director General: District Health Services and Health Programmes (DDG: DHS & HP) followed by Chief Director: Metro District Health Services (CD: MDHS) in early 2007.

By April 2008, all District Managers were appointed for six promulgated health districts in the Province, commencing the current era of DHS management overseeing a self-contained geographic segment in the WHO definition-inspired CSP. With Cape Town District rapidly urbanizing at a rate of 1.5 per cent per annum since 2001 Census,

(Statistics South Africa, 2016) it was sub-divided into eight sub-districts, operationally overseen by four Directors to ensure effective internal governance. Strong accountability was an early emphasis by the then DDG: DHS and HP, who favoured the “decision-space model” (Bossert & Mitchell, 2011).

District offices were expected to develop de-centralized managerial capacity to oversee demarcated geographic areas with a defined population, and were accountable for all health services as defined in DHS. The Cape Town Metro District Health Services (MDHS), up until then managed by a single Director, would have a Senior Management team comprising a Chief Director and four Directors who had to appoint competent local teams to implement CSP in four constituent sub-structures, each consisting of two sub-districts, within Cape Town. The case study narrates a project that is located in the Western Sub-district that falls under the Southern Western Sub-structure portion of the City of Cape Town Health District, with core team formation commencing in mid-2008 which is outlined in Part I of Chapter Five.

For all the technical detail in the CSP 2010 to describe inter-linked and specific service, staff, infrastructure and financial plans, identification of a Du Noon health facility in the Infrastructure Plan was crucially omitted, creating the first major obstacle to the project documented in Part II of Chapter Five.

### Local Du Noon context: Urbanisation, Community profile, and Burden of Disease

Figure 4: Map locating Du Noon in Ward 104, Sub-council 01 in the Western Sub-district



Source: (City of Cape Town, 2018)

The large, socio-economically heterogeneous Western Sub-district is bounded by N2 in south, and the N7 on the east and is estimated to have 638 465 residents. (Statistics South Africa, 2016) The 100 km long Sub-district includes the Atlantic seaboard, Cape Town Central Business District (CBD), and extends north past Koeberg to include Atlantis and Mamre over 50km from the city centre. Western Sub-district comprises of several Sub-councils, and Du Noon community is located in the fast-growing Sub-Council 001 (which had an estimated population of 235 333 in 2011), within Ward 104, lying about 21km north of the CBD. (City of Cape Town, 2017) The Du Noon settlement is bounded by Potsdam Road, and the busy N7 highway, and abuts the Caltex Refinery and the large commercial and industrial zone of Killarney Gardens. Its sprawling spatial form, informality and rapid densification meant that there was almost no available land large enough for a large new health facility, and that community sentiment had to be carefully wooed to support essential services located on Potsdam Road.

Total population of Ward 104 was enumerated at 36 973 in 2011, an increase of 171% since 2001, with 14 390 households, an increase of 210% over the same time (City of Cape Town, 2017). The average household size has declined from 2.94 to 2.57. Ward 104 has a demographic that is predominantly Black African (90%), with increased representation from African diaspora in the past decade. Only 34 per cent of households are formal, with 56 per cent having piped water inside dwellings or yards and flush toilets connected to water-borne sewage system in 60 per cent. (City of Cape Town, 2017) Sixty-one per cent of the labour force aged 15 to 64 years old is employed, and 79 per cent earn an income of R3 200 or less. Grade 12 education or higher has been attained by 27 per cent of residents.

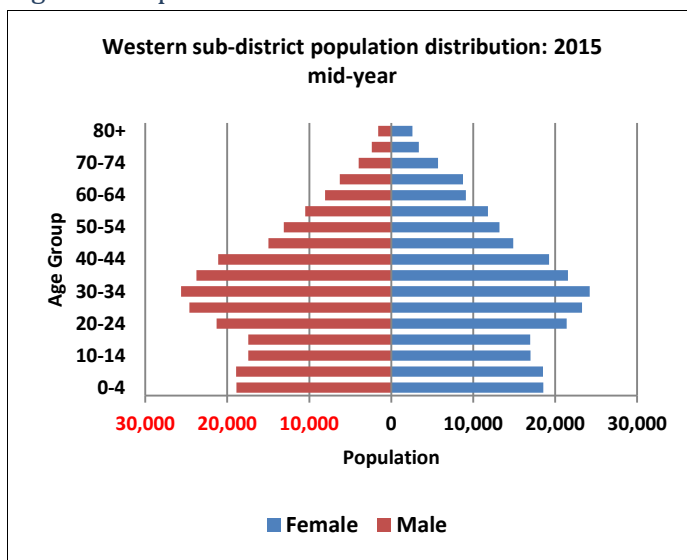
Although servicing primarily the Du Noon community, the facility draws patients from Parklands, Doornbach, and Potsdam within Ward 104. Residents from Westriding, Joe Slovo, Milnerton, and Melkbosstrand were part of initial planning figures to access PHC care at the new facility. With its location on Potsdam Road, a major transport route into the large commercial and industrial area, thousands of daily commuting workers from across the rest of the metro conveniently access healthcare during business hours. Original design considerations for the facility intended it to drain a 90 000-strong community across a catchment of more than three wards within the Western Sub-district, as well as to cater for mobile patients into the business zone.

### ***Burden of disease and PHC access***

Reliable data for burden of disease is only available at sub-district level, thus Du Noon's health needs are informed by aggregated Western Sub-district profiles derived from premature mortality analyses until more localized data sets are developed. (Morden, et al., 2016) Western has a typical transitional demographic bulge depicted in Figure 5, with a large cohort of younger people (between 20 and 44 years). Although Cape Town has Ischaemic Heart Disease (IHD) as leading cause of death, the highest number of years' life lost (YLL) are caused by HIV/AIDS-related illnesses, including TB as seen in

Table 3. Western Sub-district has Inter-personal violence as main cause of premature mortality, with high density Du Noon and Atlantis communities living in poor socio-economic conditions as key hotspots. Chapter Three presents Du Noon CHC health service outputs, including data on TB, HIV/AIDS, women and child health, and emergency care which provide insight to local health needs. Access to critical emergency and trauma care for the Du Noon community has historically been provided at New Somerset Hospital, which is 21 km south in Central Cape Town at significant financial, social and health cost to this community. The confluence of high socio-economic deprivation, high burden of disease and limited PHC access results in poorer health outcomes. (World Health Organisation, 2008)

Figure 5: Population distribution Western Sub-district



Source: MDHS (Stats SA)

Table 3: Causes of Premature Mortality in Western Sub-district (Years Life Lost)

Western Sub-district	Cape Town District
Inter-personal Violence: 9.1%	HIV / AIDS : 12%
HIV / AIDS: 9%	Inter-personal Violence: 11%
Ischaemic Heart Disease (IHD): 6.7%	IHD: 6.5%
TB: 6%	TB: 6%
Road Injuries: 5.5%	CVA: 4.8%
Cerebro-Vascular Accidents: 5.2%	Diabetes: 4.5%
Diabetes: 4.1%	Road Injuries: 4.3%
Trachea/bronchi / lung: 3.9%	Trachea / bronchi /lung: 3.8%

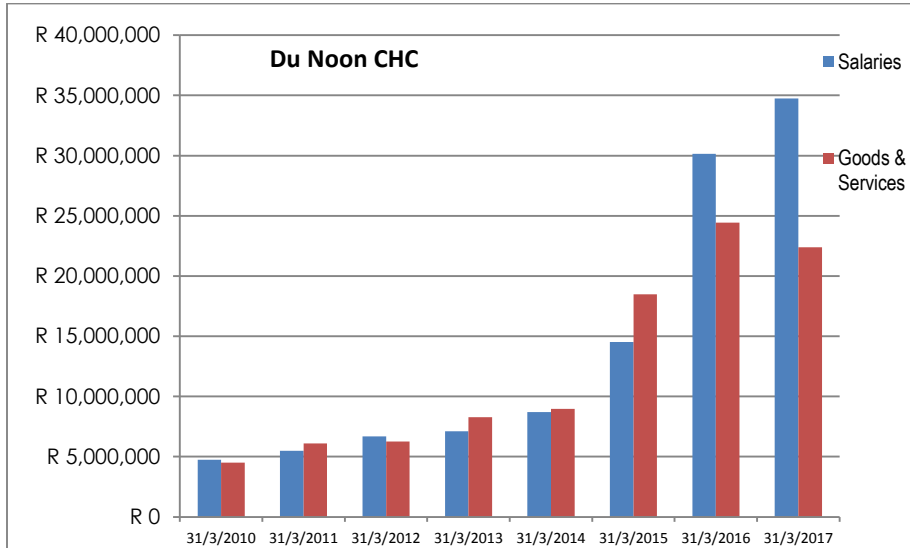
Source: (Morden, et al., 2016)

## Part II: Measuring performance of Du Noon CHC

### Resourcing

#### Financial

Figure 6: Total Budget growth of Du Noon CHC between financial years 2010/11 to 2017/18.

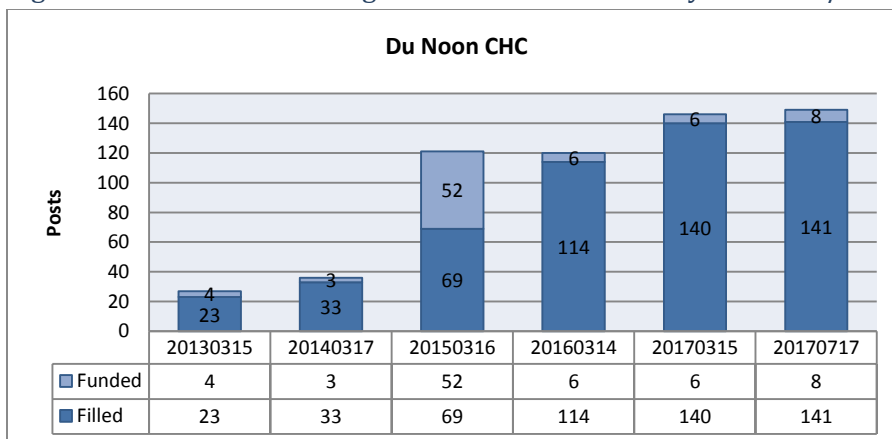


Source: Basic Accounting System (BAS) Western Cape: Government: Health (August 2017)

#### Staff establishment growth: 2008 to 2016

Staff accounts for 60% of operational costs, thus tracking growth is core prove investment into an under-serviced community with multiple parameters of social deprivation and inequity. Figures 6 and 7 depict the increase of resources to fund direct health care service delivery.

Figure 7: Du Noon CHC staff growth between financial years 2013/14 to 2017/18)



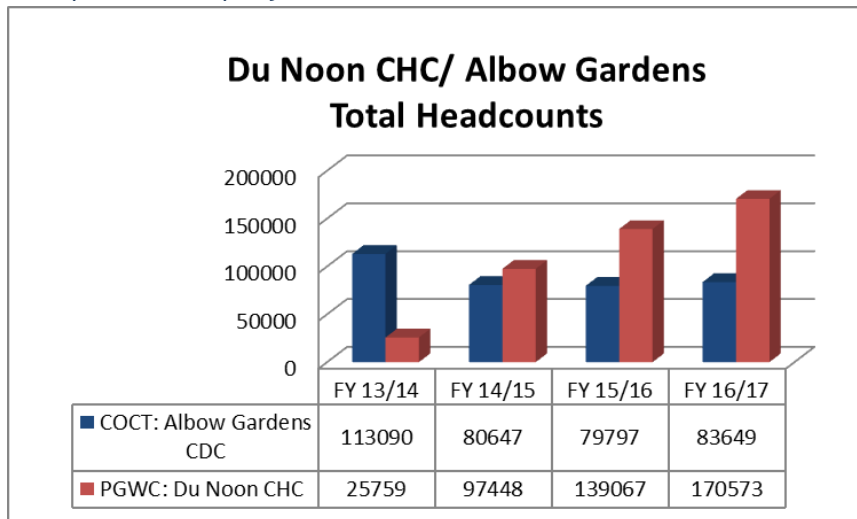
Source: Persal (31 July 2017) Western Cape Government: Health

Figure 7 shows expansion of staffing Du Noon from its core team in 2013/14 based at Albow Gardens Community Day Centre, which MDHS and CCT ran as a dual facility prior to MDHS relocating into Temporary Du Noon CDC. Staff appointments tailed off in 2016/17 and 2017/18 due to shortage of midwives, a specialized nursing category. This transversal skills shortage has impacted on opening the Midwife Obstetric Unit (MOU).

**Access:**

Expansion of PHC service access is a core tenet for achieving Universal Health Coverage (UHC). Increased headcounts verify improved patient entry into health facilities, system functionality and comprehensive package of care. Figure 8 traces increases in total headcounts between 2013/14 when MDHS commenced management of the Du Noon services and 2016/17. Figure 8 proves rapidly up-scaled access to care for the community, meeting a core health mandate.

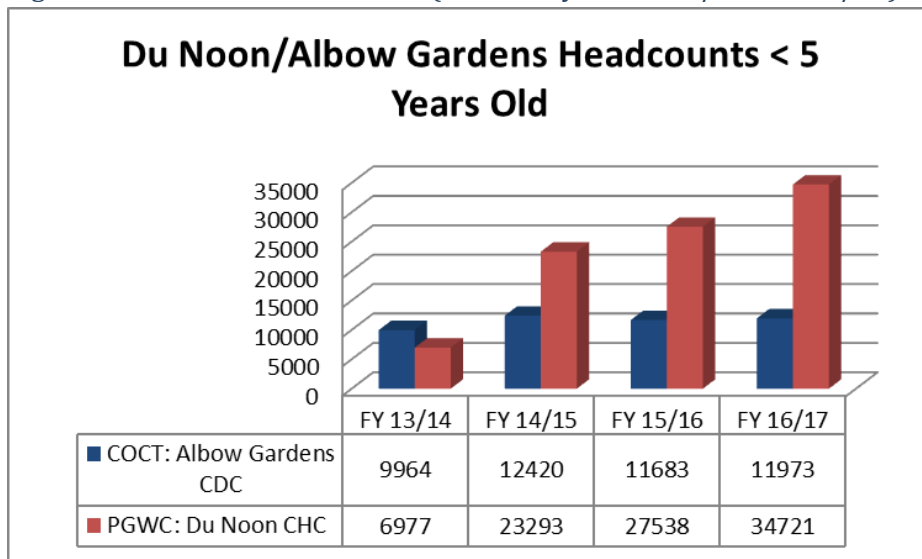
Figure 8: Total Patient Headcounts at Du Noon CHC and Albow Gardens CDC (Financial years 2013/14 to 2016/17)



Source: Sinjani (31 July 2017) Western Cape Government: Health

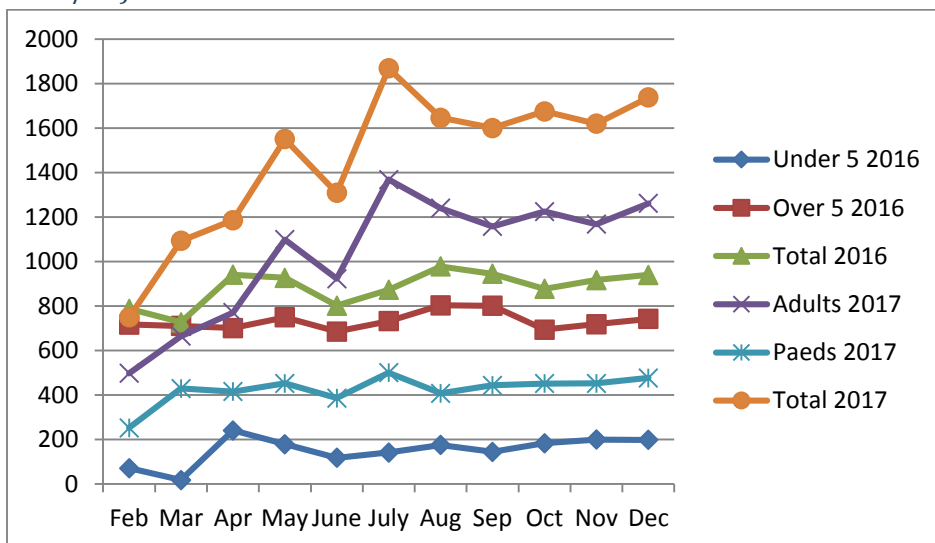
Figure 9 illustrates an exponential increase in caseloads of under five children seen between 2013/14 and 2016/17. This picture may be explained by newly-available adult health services which encouraged parents to bring children to the facility when they were seeking healthcare for themselves, which demonstrates the value of comprehensive PHC services. It is a key indicator measuring children's access to care.

Figure 9: Under- Five headcounts (Financial years 2013/14 – 2016/17)



Source Sinjani 2017 Western Cape Government: Health

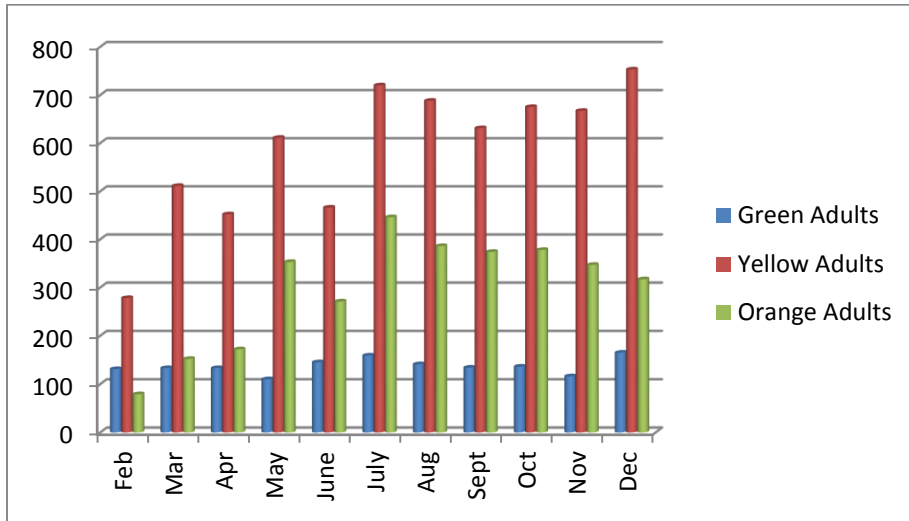
Figure 10: Adult and Paediatric Du Noon Emergency Centre Headcount Trends (2016/17 – 2017/18)



(Murie, 2018) Note: Under-five years is not equivalent to "Paeds" which includes all children under 12 years of age, which limits comparison between 2016/17 and 2017/18.

Data in Figure 10 show progressively increasing patient numbers throughout 2017, and an almost doubling of month on month comparison between 2016 and 2017 in adults and child caseloads. Du Noon CHC initially ran EC for 13 hours per day in 2016, with full 24 hour services from February 2017. The Clinical Manager ascribes increased adult headcounts to the high trauma burden, based on feedback from local clinicians.

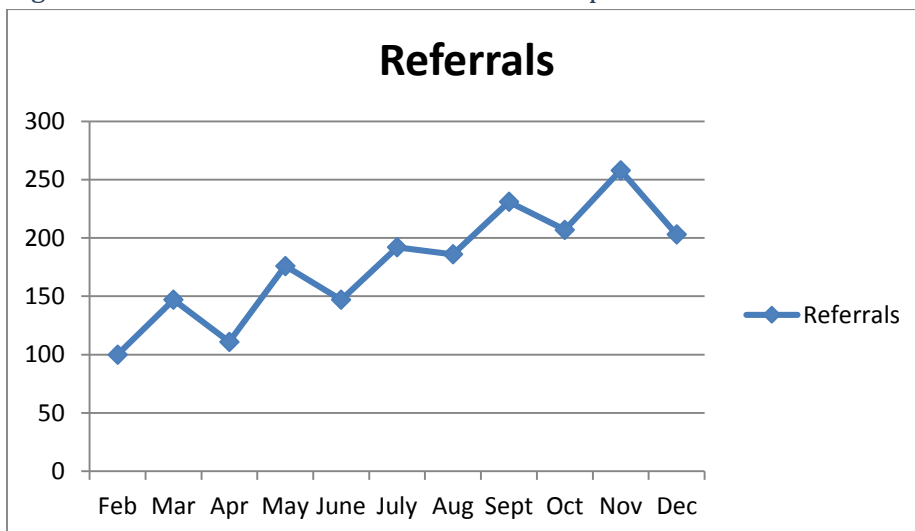
Figure 11: Adult Patient Acuity



(Murie, 2018)

Figure 11 represents illness severity that patients present with at the EC based on South African Triage Score (SATS) system. A relatively low proportion of adults scored green or stable is seen compared to adults scored yellow and orange, who are sicker and require more urgent care. This confirms effectiveness of a functional deferral system to discourage inappropriate EC access.

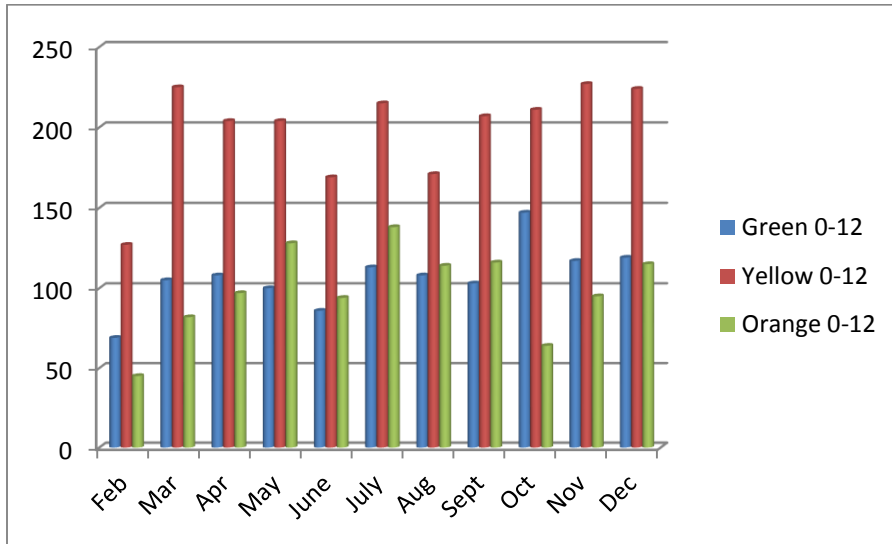
Figure 12: Total Patient Referrals to Acute Hospitals



(Murie, 2018)

Patient referrals to higher level facilities have risen as shown in Figure 12. Reports from senior clinicians at receiving hospital confirm that appropriate patients are reaching the next level of care for complex investigations and definitive clinical interventions. This implies effectiveness of clinical assessment and care at Du Noon CHC as part of DHS.

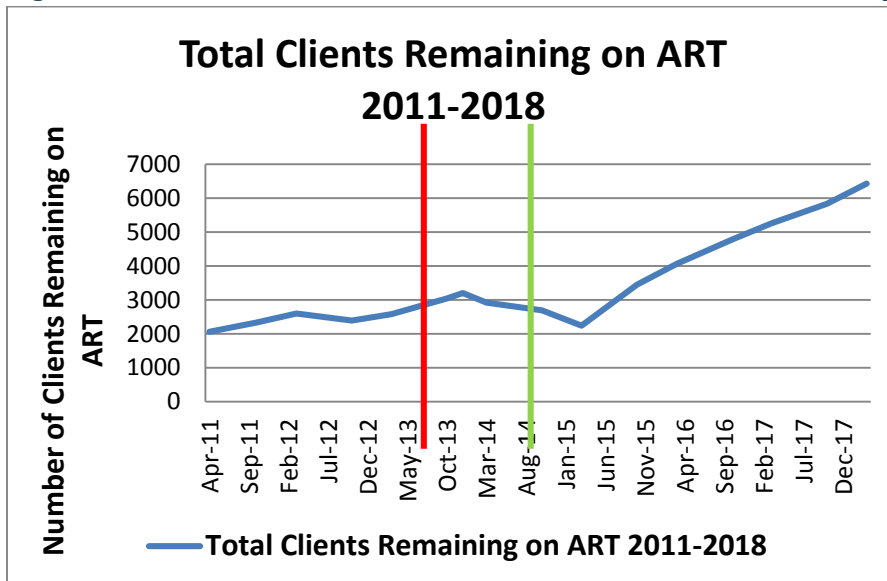
Figure 13: Paediatric Patient Acuity



(Murie, 2018)

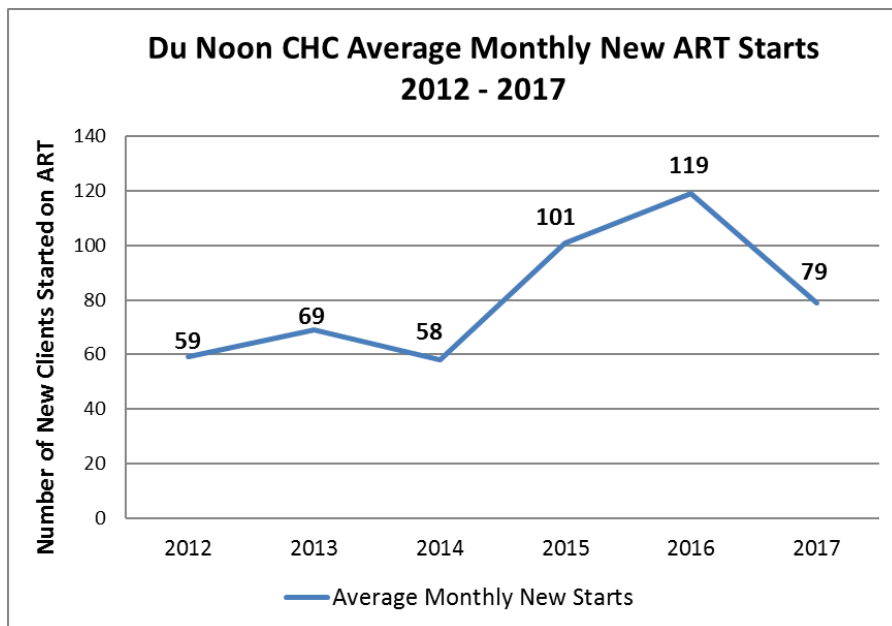
Figure 13 represents a picture that the proportion of children scored orange (represented by green bars) or sickest cases of totals seen is generally higher than proportion of adults scored orange. This observation supports the clinical experience reported by the family physician and paediatrician from Somerset Hospital attesting to the severity of illness seen in Du Noon children.

Figure 14: Number of clients Retained in Care for Antiretroviral Therapy (ART)



(Kriel, 2018)

Figure 15: Average number of clients commencing ART per month at Du Noon



(Kriel, 2018)

Figures 14 and 15 evidence the rapid access to Anti-retroviral Therapy (ART) for the Du Noon community, with the first graph depicting total clients in care over time and the second graph showing average number of new patients commencing treatment per month. The existing ART service managed by CCT transferred to SW team in December 2013. Initial data management challenges encountered during this learning phase included clinically-competent staff acquainting themselves with new stationery that fed directly into the online data capture systems, delays of post-consultation patient club register maintenance and data system updates, and folder archiving. Data system thus accounted for an initial drop-off in retention during 2014, however clinical care was uncompromised. Accelerated retention in care from 2015 is attributed to availability of integrated care (all medical needs dealt with during a single visit by a team of health professionals), more inclusive ART eligibility criteria through national policy, and community satisfaction with the modern, high-technology health facility staffed by a team committed to service excellence. (Kriel, 2018)

#### Quality: Ideal Clinic achievements

Du Noon is regularly studied for "ideal" patient flow in MDHS given its service configuration principles embedded early in the planning and design phases. Senior management delegations from provincial departments have visited to study Du Noon's service design, patient-centred systems and business processes. High achievement in Provincial and National Batho Pele Awards ceremonies were attained in 2016/17. Du Noon team has attained Gold Ideal Clinic status in 2017/18 as part of the National PHC re-engineering and quality improvement strategy.

## Chapter 4: Delivering Du Noon CHC

Chapter Four has three main parts: 1. Formation of a cohesive de-centralized district team in Southern Western Sub-structure during implementation of Healthcare 2010 in MDHS. 2. Analysis five critical junctures in the Du Noon project driving team capacitation and development by striking alliances. 3. Team transformation.

### Part I: Southern Western Sub-structure Team formation within MDHS context

The Southern Western Sub-structure team is one of four de-centralized district teams established in 2008 to administer MDHS during Healthcare 2010 implementation, and this case study author was one of four District Directors fulfilling this leadership role. These teams form “mezzo-level” (Carpenter, 2001) or “operational meso” offices in current governance terminology. District offices were established in December 2008 at the DP Marais Tuberculosis Hospital in the Southern Sub-district. Six staff occupied the offices compared to the current 50-strong district team; the first SW PHC Manager who retired in 2014, the Chief Medical Officer (CMO), the newly-appointed SW District Director, and three administrative staff. Trained as a mental health nurse, the PHC Manager was a senior supervisor, witnessing many difficult years of early MDHS development. Under-resourced and lacking organizational structure, increased community expectation accompanied rapid PHC service growth, placing chronic pressure on staff. Often deputizing for the original sole MDHS Director, her social connection to communities and strategic acumen for building alliances were valued. Another MDHS veteran, the Clinical Manager who retired in 2016, contributed vast institutional memory, problem-solving expertise and diverse contacts. His successor was the first family physician at Du Noon in 2015, providing continuity and extended clinical improvement strategies. The new SW Director had 13 years of health system management experience; six years at a small district hospital located in the same district system she was now responsible for, and seven years as a clinician-manager in a managed health care organization providing PHC to clothing industry workers. Both contexts provided contact networks and practice in health system strategic and operational planning, human resources, finance, and supply chain management.

Between January 2009 and October 2010, central recruitment for the four decentralized teams occupied the Chief Director: MDHS and his four Directors. The DHS pace and complexity saw staff turnover, as happened with first SW Finance Manager. A rapid transfer in blessed the team with a proficient, well-networked Finance manager who had worked at both MDHS and Head Office.

The new Comprehensive Health Programmes manager, a clinical nurse practitioner, had worked in City of Cape Town (CCT) Western sub-district clinics, followed by five years managing donor-funded provincial tuberculosis programme. A valuable addition

to the nascent district team, her previous work in the Du Noon community added reliable understanding of local health system challenges. Insight into both CCT and Head Office Programmes organizational culture and processes enhanced team technical aptitude. The pharmacy services manager was appointed after managing the provincial pharmaceutical supply for the fast-accelerating anti-retroviral programme. Her post-graduate public health qualification provided detailed planning, problem-solving, and technical capacity. Data-mining abilities and her Head Office contacts proved indispensable.

The SW Comprehensive Health team recruited a doctor and Programme Manager to run the HIV/AIDS and Tuberculosis (TB) programmes. They were responsible for clinical governance in the tuberculosis and ART programmes, and managing business relationship with non-profit organizations (NPOs) and other external partners in improving service delivery and health outcomes. This doctor was the youngest team member and had honed his clinical skills at Crossroads Clinic, located in an area that shared many characteristics with Du Noon community, notably high deprivation, and heavy caseloads of infectious disease. The HAST Manager was a seasoned trauma and ICU-trained professional nurse who had gone on to manage the largest existing CHC in Mitchell's Plain. Her even temperament, conflict resolution skills, and no-nonsense managerial expertise derived from the operational coalface of PHC service delivery engendered respect from all team members. It was this team member who was pivotal in adapting her role to manage to the unforeseen leadership changes in early 2014.

By mid-2011, the Manager: Medical Services of the Metro Tuberculosis Hospital Complex (MTBC), a doctor, transferred to the SW team after spending five years managing two rural hospitals that were 30 km apart, giving him ideal experience to manage a larger scale system at Brooklyn and DP Marais TB Hospitals in Cape Town. This manager brought quiet wisdom, pragmatism and readiness to remodel systems and test solutions. Aply supported by the Institutional Finance Manager and the Deputy-Director: Nursing services, the executive team played a critical role during the Du Noon project. All SCM processes for medical and surgical supplies, contracts and procurement were executed in accordance with prescripts to manage central compliance expectations. Good communication, slick business processes and co-ordinated planning allowed effective service delivery, growing collegial relationships between the core de-centralized district team and Hub hospital executive. Diverse skills, broad experience, and a shared patient-centred focus drove a single-minded objective to commission the new facility, tapping into existing knowledge and testing new methods. Building trust in the collective and consistently applying a developmental lens to problem-solve emergent issues were intrinsic principles. Recognizing operational challenges as opportunities became a team characteristic during its formation and normative processes, steadily creating credibility with small wins that were capitalized upon.

The Du Noon facility team was expanded from original 18 staff at Justin Street facility in 2008 to 114 in 2017. The new Du Noon facility manager was appointed in August 2014, with interim support from a long-standing Operational Nurse Manager. The critical new post of Family Physician was filled in February 2015.

Table: 4: Southern Western De-centralized District Team structure (2008)

<b>De-centralized District Team</b>	<b>Hub Hospital Executive</b>
Director	Head: Institution (Hub Hospital)
Deputy-Director: Primary Health Care Services	Deputy-Director: Nursing Services (Hub Hospital)
Deputy-Director: Comprehensive Health	Deputy-Director: Finance (Hub Hospital)
Deputy-Director: People Management	
Deputy-Director: HIV/AIDS / STI / TB (HAST)	
Deputy-Director: Pharmacy Services	<b>Du Noon Facility</b>
Deputy-Director: Finance	Facility Manager: Du Noon (Appointed August 2014)
HAST Medical Officer	Clinical Manager: Du Noon (Appointed February 2015)
Assistant Director: Supply Chain Management	Operational Manager: Du Noon (Long-standing employee)
District Team Clinical Manager	
Assistant Director: Finance	

### *Team growth shaped through Du Noon precursor PHC operational challenges 2008 - 2010*

By late 2008, the junior District manager was responsible for a 100 km-long geographic segment of Cape Town district health system, with operational accountability for two acute hospitals and 16 PHC facilities. By April 2009, two TB hospitals and another large acute district hospital were added to the District manager's span of management. With only the Director, CMS and PHC manager, there was limited mezzo-level managerial capacity available, however the opportunities for innovation and partnership knocked.

The Healthcare 2010 Infrastructure Plan focused on new hospital construction, notably Khayelitsha District Hospital, rather than any new PHC infrastructure. No new PHC capital works had been commissioned in years. By January 2009, the lease for Good Hope CDC, located in an old house in Justin Street, Brooklyn had expired, and the new District manager refused to prolong sub-optimal facility conditions by lease renewal. Multiple delays in completion of Albow Garden CDC, constructed by CCT on Koeberg Road, resulted in overdue Good Hope staff relocation. The intention was to offer all PHC services in a shared facility. City Health permitted MDHS staff relocation in January 2009. Two different organizational cultures had to operate in a single facility, and despite change management these "shared" clinics were loci of inter-authority staff conflict, often with negative impact on patient experience and staff morale. Over the next three years, the Good Hope team established themselves as best as possible in an unwelcoming environment, with space constraints and high workloads. Although the Inter-authority relationship was governed by a Memorandum of Understanding (MOU), pre-negotiated agreements were ignored and district and facility level conflict persisted. Once WCG: Health had identified that a new Du Noon CHC was being planned, CCT managers exerted pressure without understanding process complexity, often exacerbating conflict. Poor collaboration rather than finding co-operation for system transformation frustrated the team, but it rapidly learned resilience and trust.

## Part II: Critical Junctures of the Du Noon CHC project

Table 5 outlines critical junctures driving the Du Noon narrative. The de-centralized district team plays pivotal roles at each point.

Table 5: Summary of critical junctures, improved internal capability and enhanced external alliances

<b>TIMEFRAME</b>	<b>CRITICAL JUNCTURE</b>	<b>IMPROVED INTERNAL CAPABILITY</b>	<b>ENHANCED EXTERNAL ALLIANCE</b>
2008	Omission of PHC infrastructure for Du Noon in Healthcare 2010 strategy	Accountability and Stewardship  Planning  Knowledge management system  Trans-disciplinary collaboration and learning	EMS New Somerset Hospital CEO and Emergency Unit team Infrastructure technical team Deputy-Director: Professional Support
April 2008 – February 2012	Prolonged site search and acquisition for new Du Noon CHC delayed community consultation process	Stakeholder mapping and coalition-building  Advocacy  Accountability to oversight structures  Navigating political and media pressure	CD: Infrastructure and Infrastructure Planning Unit Department of Transport and Public Works (DTPW) CD: MDHS Ward councilor and new Health Committee and community networks Communications Directorate
January 2012 – October 2013	Unexpected community action protesting poor Du Noon Clinic conditions and subsequent commissioning of interim facility.	Alignment of short-term, Medium-term and Long-term planning  Community accountability and stewardship  Innovation and leveraging previous learning  Staff engagement and negotiation	New Health committee CCT Mayco member for Health Local councilor and his networks (taxi organization) CCT Roads DTPW Community Liaison Infrastructure CD & team HAST Directorate EMS Labour unions
January - September 2014	Unexpected leadership absence in decentralized team	Trust and integrated functioning Strategic decision-making and risk management Portfolio re-configuration and task shifting	Hub Hospital CEO & Executive Community partnerships  Unions
2015 - 2018	Funding uncertainty for full Du Noon commissioning	Negotiation and consensus-building Navigating changed organizational terrain Balancing patient and staff interests	District team and hospital managers Labour unions Head Office Finance Managers

## 1: Omission of PHC infrastructure for Du Noon in Healthcare 2010 strategy

### *Events*

Although Du Noon was the second-fastest urbanising provincial node, Healthcare 2010 Infrastructure plan had not proposed new facilities, resulting in health system incapacity to respond to PHC community needs, given parlous conditions at the City-operated clinic. Upstream social determinants of severe deprivation, chronic unemployment, inadequate policing, and poor basic service delivery saw high local trauma and infectious disease caseloads and exacerbation of inequity. Du Noon was an early flashpoint during the 2008 xenophobic violence outbreak which pressurized emergency services. (De Vries, et al., 2008) Following the social upheaval, the new SW district Manager was instructed by the then-HOD: Health to develop a business case for an eight-hour Community Day Centre (CDC). It was revised to justify a costlier 24-hour Community Health Centre (CHC) to address PHC needs and reduce social, financial and health costs of accessing Constitutionally- protected emergency services at New Somerset Hospital and Vanguard CHC. Comprehensive PHC offered in a purpose-designed modern health facility would provide dignity to staff and patients alike after years in dilapidated infrastructure. Once the HOD had decided to replace the City-run clinic, it was prioritized and served as a testing ground for SW team organizational capacity as an unfunded mandate. Subsequent to the HOD decision, which arguably was taken with true bureaucratic autonomy (he had authority, reputation and political legitimacy to give effect to the commitment), understanding the implications and next steps by the de-centralized team was crucial.

### *Improving internal capabilities*

As depicted in Table 5, key internal capacity enhancement in the earliest phase of the Du Noon project included:

- Accountability and Stewardship
- Planning
- Knowledge management system
- Trans-disciplinary collaboration and learning

The junior District manager, a former small hospital manager who had neither the experience nor the insight of the stakeholder complexity involved in navigating processes for an unfunded and unplanned capital project, had to take ownership of the project in addition to serving her DHS apprenticeship. Her capabilities were limited to single institutional management rather than whole systems level leadership, thus discovering and making meaning of district management, accountability and stewardship became a central tenet of learning around early project deliverables. The immediate remit of the district manager and her team was to draft a credible business case to justify the range of services, and work through the departmental processes and structures, some of which were only just established by the two principles she needed to work to, namely the Chief Directors of MDHS and Infrastructure, to progress the project through its many subsequent phases in a large public sector organization

The team applied public health thinking, institutional knowledge, and developmental principles to execute tasks that brought the project into mainstream capital priorities. Learning partnerships with Infrastructure and Works teams centred on design specifications and preliminary site searches. Learning by doing was a primary mechanism for the district manager: the upgrade from a smaller, basic eight-hour facility to a 90 000-population drainage facility was contrary to the stated Division: DHS position and required clarification and management as an outlier. The WCG: Health Infrastructure unit did not have separate Directorates for Infrastructure Planning and Delivery then, allowing only periodic consultations with the Chief Engineer, other technical drafting staff and the limited architectural capacity to discuss and decide design principles, envisaging patient flow and listing the schedule of accommodation. Standard design templates were unavailable, which made the process daunting and frustrating but ultimately empowering as a multi-disciplinary experience.

Sourcing quality data was challenging then due to less robust information management processes, and different systems, necessitating collation of health information from multiple sources such as CCT, Emergency Medical Services (EMS), the Office of the then-Deputy-Director General: Specialised and Emergency Services (DDG: SPES) and Institutional Head: Somerset Hospital to build a composite service situational analysis and develop models of all service components. Sign-off of the business case by WCG: Health hierarchy preceded dispatch to the Implementing Agent, Department of Transport and Public Works (DTPW) for next stages of design and delivery.

The district manager learned by exploring, doing, struggling, and adapting. Early phases of the project exercised team abilities around planning, process-mapping, documentation, data sourcing, finding technical expertise and advice in the corporate echelons of HO, thus building professional linkages. No blueprints or standard operating procedures existed for the new approach in delivering capital projects, thus the entire Du Noon project generated a pragmatic learning environment for the district team.

### **Strengthening external alliances**

By 2010, fragile alliances were built with WCG: Health Infrastructure team once the final business case was signed off. The district manager slowly gained a reputation for working collaboratively with technical colleagues to deliver required inputs to meet mandates in accordance with complex planning cycles. Her understanding of processes required to progress the project milestones solidified working relationships. Consulting the Professional Support Services Director in the Office: DDG: SPES for specialized data mining to model prospective patient numbers in the planned facility was a new organizational connection. Interactions with the CEO: New Somerset Hospital, and the Clinical Manager and Head: Emergency Medicine, to source data on emergency unit service usage supported an important alliance.

## 2. Prolonged site acquisition for new Du Noon CHC delayed community consultation process

### *Events*

Site location and acquisition delays persisted for the next three years, blocking progress. Provisional site confirmation is critical for allowing mandatory community consultation, permitting funding allocations and locking project into a delivery schedule. Pressure mounted on the district manager for site location, despite it being the primary function of DTPW (Property Management). Lack of urgency from partners demanded advocacy by the district manager in the site search process, otherwise the project risked re-prioritization amongst competing Provincial needs. Correspondence drafted on behalf of CD: MDHS and the then Executive Director: Health to CCT Property Management and town planning officials as perceived partners for infrastructure development, was unsuccessful. Ideal sites were ear-marked for housing developments. Alternatively, inappropriate options were offered, either located in 50-year flood-lines or inaccessible to the community. Multiple visits to Du Noon area by the HOD, who maintained direct interest in Du Noon, district manager and Infrastructure colleagues verified land limitations. An optimal site remained elusive, and community consultation an incomplete district task.

In mid-2011 an empathetic DTPW manager cognizant of the pressure, notified CD: MDHS about a Potsdam Road site (Figure 15) that met all geo-technical requirements. By then, Du Noon had acquired urgent status, and the large site owned by National Department Public Works (NDPW) which was undergoing intractable leadership and governance challenges was chased. (I-Net Bridge, 2011) (Parliamentary Monitoring Group, 2012). Delayed decision-making on property disposals entwined the preferred site in red tape with constant turnover of senior NDPW officials<sup>1</sup>.

Indicative of growing political pressure on WCG to deliver health services and infrastructure, a Parliamentary Standing Committee oversight visit for Du Noon project progress was scheduled on 24 August 2011. The District manager and Infrastructure Delivery Director clarified the health system planning rationale for Du Noon service, explained factors delaying site acquisition, and responded to questions tabled by MPs from across the political spectrum. When the Parliamentary group held its inspection in loco, Members of Parliament expressed unanimous agreement on its ideal location to promote equitable PHC access.

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<sup>1</sup> Anecdotally, the slow decision-making on the NDPW-owned site was linked to the acting role-players' reluctance to sign-off assets, especially affecting Western Cape projects. It was quietly shared that eventually Presidential sign-off permitted release of Du Noon site to WC: G DTPW, however this has not been independently verified.

District management approval meant community engagement could commence about the Potsdam site on 12 February 2012. The newly-forged links with the health committee spanning old and new guard membership supported this process. A few objections raised around site location outside of the main residential zone were quelled when explanations from district manager on protracted process and maps evidenced the shortage of adequately-sized sites in the congested settlement. Preparatory groundwork by the PHC Manager through bilateral meetings with health committee and local councilor smoothed the process.

A co-operative relationship with the Mayco member for Health bridged central CCT politics, generating tacit approval from Local Government. Partnership with the local ward councilor, a member of the new guard health committee, meant backing from his constituency. Links with local NPOS, reinforced community meeting success via district team NPO co-ordinator. Effective communication, through a DTPW Community Liaison Officer, and his technical colleagues to respond to community queries about job and business opportunities promoted project transparency and accountability.

Media queries surfaced after publicizing the Potsdam sign-off, potentially sowing community dissent and further delays. Inter-authority clarification at political level was requested by the district manager and Health Communications to ensure that all Sub-council representatives had factual information on the Du Noon project.

### *Improving internal capabilities*

Referring to Table 5 once more, between April 2008 and February 2012, the primary capabilities developed within the team and individuals through the slow progression of Du Noon project included:

- Stakeholder mapping and coalition-building
- Advocacy
- Accountability to oversight structures
- Navigating political and media pressure

Team capacity grew through iterative consultation processes, advocacy, and taking initiative and stakeholder mapping. Interaction with City, and DTPW taught lessons about idealistic assumptions of shared vision. Understanding Capital Works internal business cycles for funding emerged with navigating the inter-sectoral realm between client and Implementing Agent, thus creating value for both parties.

The Parliamentary oversight visit strengthened the district manager's strategic capacity to function within an increasingly politicized environment. Liaison between the district team, Health Communications Directorate and Health Ministry managed media scrutiny and political risks. Clarity of communication was critical between the multiple stake-holders, and forged greater trust in decentralized district offices. Authentic social connection and community accountability assumed primacy in the team ethos.

### *Strengthening external alliances*

Conscious relationship-building with different community networks inspired both planning and implementation. This social rootedness that Carpenter alludes to enhanced district team respect and legitimacy, that gained trust from various community role-players through linkages with leadership. Interface with local political leadership protected the project milestones.

Local media interest in Du Noon and community participation increased liaison between Health Communications Directorate and SW district team.

Both district and Infrastructure Directorate teams reinforced their original relationship to manage the Parliamentary oversight visit. A shared achievement was cross-party political support at the high-level session won by consistent close collaboration. Relationships with Department of Transport and Public Works (DTPW), were often challenging. As the Implementing Agent (IA) responsible for all capital works and maintenance projects across provincial departments, DTPW has complex financing and planning protocols between three governmental spheres. Governance structures called “Inter-Departmental Capital Works Project Teams” (IDCWPT) were established to better co-ordinate projects in geographic areas to reduce duplication, align efficiency in project planning, delivery and appropriate expenditure.

Figure 15: Google Map view of Du Noon Ward 104 and final CHC site (2010)



### **3: Community action protesting old Du Noon Clinic conditions and innovative commissioning of Temporary Du Noon facility**

#### ***Events***

In January 2012, community action highlighted poor Du Noon Clinic conditions and precipitated a sequence of decisions and actions. The old Du Noon health committee, with several influential community leaders, protested after an Eskom power outage caused clinic air-conditioning failure. The health committee locked down the facility, held CCT district management hostage and shut down the clinic from 27 January 2012. Denying PHC access posed a potentially life-threatening situation for many Du Noon children during diarrheal disease season due to severe dehydration, and the CCT Western district manager wrote to WCG: Health requesting assistance.

A delegation consisting of Head: Health, CD: MDHS, CD: Infrastructure and district manager visited the Du Noon Clinic, and found unmaintained infrastructure. A decision was taken to seek an urgent interim solution to the untenable situation by expansion of the CCT Table View Clinic, two km away from Du Noon with a pre-fabricated unit funded by WCG: Health. Du Noon children would be transported daily by MDHS to access care and the reconfigured service design appeased the community governance structures. A further Temporary facility would also be commissioned to replace the CCT-run clinic as soon as possible.

The permanent Du Noon CHC, scheduled for completion by 2014, had endured incessant site delays which had shelved community consultation until 12 February 2012. Community concerns about the old facility were addressed and plans for transitional relief communicated. Swift decision-making and interventions were greeted positively, enhancing team confidence. On the same day of this meeting, the district team visited a new warehouse in Racing Park Business area to explore interim facility options. Both infrastructure and district teams recognized an opportunity for a radical solution. The warehouse was leased and design of Temporary Du Noon CDC commenced.

When the HOD questioned why MDHS was not operating the Temporary facility in October 2012, the district manager explained that it was unrealistic for the small Albow Gardens staff (the core team of permanent Du Noon CHC) to cover clinical capacity for high child health and infectious disease caseloads. He accepted the rationale for additional time, staff and training, as the district team needed a year to mobilize resources, consolidate lessons and implement. By 27 November 2012, CCT staff in the old CCT-run Du Noon Clinic relocated to the new Temporary Du Noon Warehouse facility, however without chronic non-communicable disease or acute adult services. The plan for MDHS to operate the temporary facility by November 2013 was commenced.

It was assumed that the chronic infrastructure problems experienced by staff at the two preceding facilities would motivate staff to moving into the Temporary Du Noon. This core team relocated thrice between January 2009 and December 2014 and change burnout took root. Along with need to adapt to an expanded staff establishment from 27 in 2009 to 149 in 2017, development of a shared new team identity and organizational culture stretched even the most spirited of individuals. Once the district management team made the call in mid-2012 to relocate the staff in the Albow Gardens-based services into the temporary Du Noon Warehouse facility by late 2013, staff preparation was crucial for the move to an innovative yet atypical health facility. Funding for additional nursing staff, and comprehensive training to grow clinical competencies were urgent challenges to deliver a full PHC service.

Staff consultations commenced in June 2013 to discuss relocation to Temporary Du Noon facility as a stepping stone towards the permanent facility. Worries about transport, safety and working in a warehouse prevailed. Although professional relationships worsened at Albow Gardens, staff negativity persisted. Monthly interactions occurred between a multi-disciplinary team including human resources practitioners, district pharmacy services manager, and health programmes staff to allay fears and negotiate solutions. Union representatives attended and team capacity to map progress and communicate commissioning plans, assembled a foundation of trust and belief in project success. Staff had to build their confidence in the district executive to deliver on undertakings for security, transport costs, training, inclusion in the new staff establishment, and additional resources. By October 2013, three more nursing posts were funded by Health Programmes, securing baseline capacity for the TB services.

The district team successfully transferred Albow Gardens staff into Temp Du Noon Facility and provided full adult care in November 2013. Complex co-ordination and logistics allowed a phased shut-down of MDHS-rendered services at Albow Gardens until CCT staff took on managing the adult caseloads, and commenced full PHC services at the Temporary Du Noon facility. Both frontline and district teams dealt with the unexpected: contrary to agreements, the departing CCT authority disconnected all telecommunications, removed IT hardware and outgoing clinical staff failed to reduce pre-booked patients. The opening day was a baptism of fire when eight critically-ill patients presented for care whilst commissioning service departments. Good partnership between local Emergency Medical Services (EMS) paramedics and the clinical team ensured stabilization of emergency cases and rapid hospital transfer.

### *Improving internal capabilities*

In the January 2012 to October 2013 timeframe, team and individual competencies grew in the following focus areas summarized in Table 5:

- Alignment of short-term, Medium-term and Long-term planning
- Community accountability and stewardship

- Innovation and leveraging previous learning
- Staff engagement and negotiation

#### **Alignment of short-term, Medium-term and Long-term planning**

Both District and PHC managers collaborated with Works and Infrastructure teams by joint decision-making on the location of temporary Du Noon Clinic. Discussions occurred between architects from role-players from Revel Fox, DTPW, Health Infrastructure and the District to rapidly design a novel facility comprising 32 shipping containers, specially outfitted and configured to render comprehensive PHC within the large warehouse. Temporary Du Noon CDC was an innovative, cost-effective experiment to solve critical infrastructure gaps whilst awaiting permanent Du Noon construction.

Operational responsiveness to address short-term service delivery requirements for community-driven health demands had to be implemented. The team developed integrated solutions to problems in context and had a heightened awareness of social determinants of health being surrounded by the desperately difficult conditions that patients faced. In not succumbing to pressure for the premature service take-on, the district manager asserted leadership and effective risk management. Team reliance to build an emergent strategy that drove priorities for training, recruitment and resource allocation for the next two years was consolidated. Planning to build internal capacity over the following 12 months to move into Temporary Du Noon meant alignment of budgeting and planning for medium-term objectives, improved integrated functionality across the PHC, People Management, Pharmacy, Health Programmes and Finance components. Resources from Head Office Health Programmes were mobilized to make the 2013 service take-on realistic and affordable.

#### **Community accountability and stewardship**

Although MDHS was not the primary service provider at the Old Du Noon facility, the district accepted the stewardship role for community health needs and took accountability to find solutions. Team cohesion around a shared objective to substantially improve service delivery was rooted in its social connection, which resonated in the team. Re-building community relationships via bridging the old and new guard health committees was an active process that the district team participated in and deepened understanding and respect of community dynamics. Advocacy and building partnerships with political role-players and patient representatives became core competencies.

#### **Innovation and leveraging previous learning**

Inventive problem-solving for unanticipated health system challenges, offered a steep learning curve. Teamwork to address multiple issues impacting one facility grew strong operational skills and competent clinical decision-making, with the outcome of better meeting expanding health needs in an under-serviced community. Previous lessons of

interim service relocation to consolidate clinical capacity was applied, as well as in service design.

#### **Staff engagement and negotiation**

Skills to negotiate sensitively with concerned and burned out staff were enhanced, built upon an existing culture of person-centredness and caring.

#### ***Strengthening external alliances***

Stronger working relationships with team from Infrastructure and Works developed as Temporary Du Noon offered a unique learning experience across two departments for multiple role-players.

The SW team commenced interfaces with Du Noon health committee that had lost trust in CCT officials, establishing a tenuous link that slowly strengthened. Re-building community relationships via bridging the old and new guard health committees continued. New community leadership, inclusive of a dynamic ward councilor, shifted power from more established role-players. The interactions were difficult, with sensitivities around the emergent role of SW district team and declining communication with CCT managers. Relationships solidified when it was clarified that MDHS was leading commissioning processes, and delivering the transitional facility solution. Interactions were also held with the then Mayco member for Health to reaffirm interim arrangements. Ongoing community discussions centred on concerns raised about the new Temporary facility location across Potsdam Road, the busy arterial route into adjacent industrial areas. Time was spent with the health committee, who engaged the taxi association to support local road safety initiatives.

Contracted NPOs were relied upon to support service commissioning, especially with linking community-based services (CBS) workers who provided treatment adherence and patient follow-up. A mutually respectful bond was forged with labour unions during the staff engagement process that served the team well over time.

#### **4: Unexpected district team leadership absence in January 2014**

##### ***Events***

In January 2014, the district manager was seriously ill, with immediate delegation of duties to the Pharmacy Services manager and Metro TB Hospital CEO. Existing relationships between individuals and the team components had to rise to the dual challenge and opportunity presented by the absence of the senior authorizing manager and decision-maker. The team baseline for collaboration was well-developed by this stage, however the situation now demanded optimal integration of planning and implementation across components to manage the system stressors.

Between February and September 2014, pressure mounted to finalize a new format commissioning plan, and facilitate change management processes to build a unified Du Noon team culture. Although an initial commissioning plan was drafted by the Director, the team had to adapt and learn to meet new external partner requirements. Rapidly ramped up recruitment to expend increased financial resources allocated from April 2014 was counter-balanced by high community interest in employment opportunities. People Management and Communication teams advertised jobs in local newspapers, made application forms accessible and explained recruitment processes to manage community expectations.

Management capacity was further reduced in May 2014 when the PHC manager took unexpected leave, and the CEO of the largest acute hospital relocated. The team re-grouped and reconsidered roles and tasks. The hospital manager from Metro TB fulfilled an acting CEO role until August 2014. The district team negotiated with the HAST manager to take up a dual role as Acting PHC manager and project lead role based on her prior experience as the Mitchell's Plain CHC Manager.

Further portfolio re-organization happened, with the HAST Medical Officer accepting complexities of NPO contract management in addition to clinical governance functions. Once the team re-set tasks, they focused on person-centred design flows in the facility, building a culture of quality improvement that was consolidated by the new facility manager the district team appointed in August 2014.

Emphasis on step-wise problem-driven solutions settled the team into a rhythm of matrix management and project milestones were steadily achieved, with practical completion scheduled for 30 September 2014, and service opening planned for mid-December 2014. In early September the district manager returned to discover project delay from late installations. The November-December window of service de-escalation to relocate services from Temporary Du Noon to the permanent facility was at risk. Direct intervention resulted in practical completion on 31 October 2014. The Health Technology (HT) unit commenced equipment commissioning and staff training.

Friday 12 December 2014 was the cut-over day from Temporary Du Noon to the modern health centre. Hub hospital supply chain management (SCM) staff had spent months calculating store stock, procuring medical and surgical supplies, negotiating contracts for support services, and finalizing logistics. District office employees and SCM pitched in for the service transfer, and everyone worked hard to finalize tasks. On Monday 15 December 2014, the doors of Du Noon CHC opened to the public. Comprehensive PHC was provided from Monday to Friday for eight hours per day, but it took another two years before the EC remained open for 24 hours per day. Annexure 4 depicts the infrastructure journey between 2008 and 2014.

Formal facility opening by the new Minister of Health happened on 18 August 2015, with the newly-retired HOD who had initiated the project, his successor, and the newly-promoted Chief of Operations, the previous CD: MDHS, in attendance. Between 2015 and 2016, a cohesive organisational culture grew under the leadership of the facility manager, with his capabilities tested with operating hour expansion to a 12-hour service running daily by 2016. Strong community linkages and embedded service quality have remained integral to the Du Noon team.

Full EC capability commenced on 6 February 2017, which finally realized a Constitutional right for Du Noon community. Another unique project is underway under the leadership of the SW Clinical Manager and Somerset Emergency specialist, with a new staffing model across the two Emergency Centres. A shared pool of doctors is rostered across the units, reducing reliance on outsourced clinicians, saving costs and improving clinical care. Provisional feedback hinted at better team relationships.

### ***Improving internal capabilities***

Core internal capabilities enhanced at this critical juncture between January and September 2014 included:

- Trust and integrated functioning
- Strategic decision-making and risk management
- Portfolio re-configuration and task shifting

Team responsibility and accountability for project delivery was unequivocal. Clear maturation and alignment across functions permitted smooth district operations, good governance and maintained performance. Task-shifting happened to remain goal-directed and met system needs. Executive team members mentored each other to manage uncertainty. Greater trust, loyalty and collaboration fueled team cohesion despite organizational strain. The authorizing role of an experienced senior manager was missed but the team adapted through mechanisms of collective decision-making and risk evaluation. Partnerships with labour, community and technical colleagues worked through emergent challenges in a learning cycle, further maturing team competencies. Capacity to manage uncertainty allowed greater experimentation to do things differently and learn through both failures, struggles and successes. Team capacity for service design was vested at district office and facility levels.

### ***Strengthening external alliances***

Alliances strengthened with the hub hospital executive team throughout this phase of the project, with these members committing significant time, energy and passion to the greater good beyond the walls of their own Institutions. The Metro TB CEO stepped into acting roles as district manager and an interim CEO at the large district hospital, which meant his own Institutional team had to adapt to his absence, task-shift and learn.

## **5: Funding uncertainty between August 2015 and April 2016 for full Du Noon commissioning**

### ***Events***

The celebratory mood was dampened when national financial austerity warnings were sounded in 2015 and the full 24-hour EC remained un-commissioned. A concept of “Sector planning” was introduced to stem WCG: Health staff numbers to mitigate over-expenditure in the Medium-Term Expenditure Framework (MTEF). Despite earlier HOD undertakings to fund Du Noon CHC, resources were now not guaranteed for an expensive essential service. Despite prudent financial management, stringent cash flows were enforced due to wider fiscal pressures, which delayed the EC commissioning by several months as scarce trauma-trained staff were difficult to recruit. March 2016 saw the after-hours services commence as next step towards the planned 24-hour operations. Staff tensions rose with imminent shiftwork and uncertainty of resources, especially with newly ascendant labour representatives subsequent to rapid recruitment of staff, changing the relative balance of power between different unions.

### ***Improving internal capabilities***

Areas of team capacity development in the wake of the fifth critical juncture after 2015 to date focused upon:

- Negotiation and consensus-building
- Navigating changed organizational terrain
- Balancing patient and staff interests

The new Head: Health and CD: MDHS requested that all projects required re-motivation for funding prioritization, which called for internal consensus within the district team and between SW service entities, as limited posts could be funded. Negotiation and deal-making capacity had to be exercised to keep the peace. All health facilities had ongoing staffing needs, but Du Noon posts were protected by team cohesion and collaborative decision-making. Staff tactics and district team response were analyzed carefully prior to intervention to maintain labour peace, yet assert the primacy of patient care. Line management honed negotiation skills during interactions with staff and union leadership.

### ***Strengthening external alliances***

There was support from the older labour caucus based on the earlier partnership during the commissioning phases that assisted in dispute resolution.

Technical capacity was now well-recognized inclusive of corporate governance, organizational culture and innovative service delivery. With the return of district manager in September 2014, there was stabilization of team and networks of support called upon to process submissions for funding. Maturing organizational capacity was demonstrated through alignment, conscious application of experiential learning, integration of central DOH strategies into business and local innovation.

### Part III: Team transformation

Phased development of team capacity is depicted over three main time-periods in Table 6 through six core pillars: 1) Team identity and organizational culture (2) Team vision and purpose around social connection (3) Leadership development (4) DHS organizational capacity (5) Team cohesion and alignment and (6) External stakeholder relationships. These categories are inter-related and self-reinforcing through the learning-by-doing cycle. Baseline capacity of team members is summarized generically in the 2008 to 2010 period, noting that not all members were present from the earliest years. A mid-phase of team transformation is set between 2011 and 2014, and a consolidation phase with team maturation happening between 2015 to 2017. The team transformation under consideration would reflect a current state in 2018.

Table 6: Team transformation over time (2008 to 2017)

Pillars	Baseline 2008 - 2010	2011 - 2014	2015 - 2017
<b>Team identity, organizational culture and formation phase</b>	<p>Early phases of SW Substructure team identity development; slow percolation of experiences from diverse professional and organizational backgrounds into communal team space</p> <p><i>Trust and loyalty</i> Limited within early professional relationships</p> <p><i>Communication</i> Fragmented; bilateral to district manager instead of horizontally within team</p> <p><i>Team phase</i> Forming, storming, learning-by-doing</p>	<p>Forged de-centralized team identity with clarity of shared values</p> <p>Enhanced between team members</p> <p>Improved phase; networked across team</p> <p>Norming, Performing, Innovating, learning-by-doing, consolidating</p>	<p>Robust team identity and organizational culture able to navigate challenges as a strong collective; ethical, values-based, internally-motivated, and dispersed leadership; resilience and authenticity in daily work, harnessing diverse skillsets and perspectives</p> <p>Embedded within team</p> <p>Open interaction; divergent voices exercised</p> <p>Performing, applying previous learning-by-doing, innovating, mentoring</p>
<b>Team vision and purpose around social connection</b>	<p>Common team purpose formed slowly</p> <p>Social focus in all components, expressed less as primary motivation</p>	<p>Unity of team purpose developed with solid gains in Du Noon project and emergent challenges</p> <p>Social linkage galvanizes team as critical rationale</p>	<p>Shared vision translated into successful major achievement consolidates team purpose and commitment to improving health outcomes</p> <p>Commitment to service improvement for community central tenet</p>
<b>Leadership development</b>	<p>More centralized team leadership; District manager took initiative and drove Du Noon project; major leadership development phase for District Manager</p>	<p>Major growth period for all Deputies-Director and District Director to develop and share leadership roles, expanded responsibilities in project scale-up</p>	<p>Distributed leadership capabilities evident in all components of District team; mentorship and coaching capacity practiced by all members</p>

<p><b>DHS organizational capacity</b></p>	<p><i>Strategic &amp; operational managerial confidence</i> Inexperienced and overwhelmed; low confidence and initially tentative in response</p> <p><i>Internal governance capabilities</i> Individually skilled managers from diverse backgrounds but not an aligned group</p> <p>Good transactional &amp; technical baseline but steep learning curve commences</p>	<p>Growing confidence in decision-making; early lessons from Du Noon applied in other areas</p> <p>Enhanced individual skills Cross-learning &amp; capability development</p> <p>Systems improvement across components (Info Management; SCM; Finance; People Management)</p> <p>Steady evolution of inter-component work during Du Noon project (PHC and Programmes; Finance, People Management; Pharmacy &amp; PHC; Hub hospital &amp; District Office SCM)</p>	<p>Experienced decision-makers within complex adaptive system; individual and team leadership capabilities and practiced across DHS; manage competing interests, balancing different principles and understanding trade-offs</p> <p>Individual and team competencies synergised to problem-solve, commission, and innovate</p> <p>Strong corporate governance within District team with mentorship capacity of Institutions within broader organization</p> <p>Lessons learned applied during new large Infrastructure commissioning project at District Six CDC between 2016 and early 2018</p>
<p><b>Team Cohesion &amp; alignment (skills, activities &amp; processes)</b></p>	<p><i>Collaborative &amp; creative functionality</i> Siloed, vertical functioning</p> <p><i>Team cohesion</i> Early nascent stages</p> <p><i>Role clarification</i> Not completely certain, evolving; occasional contestation over roles and functions</p>	<p>Improved collaborative work on specific projects; greater risk-taking with constant learning, reflection and application</p> <p>Accelerated, good camaraderie, confidence</p> <p>Emergence of technical vs line managerial roles; ongoing exploration of interaction of different roles within team</p>	<p>Integrated functioning to achieve shared objectives across prioritized projects; Co-mentorship and matrix of inter-disciplinary support</p> <p>Well-developed, matured and aligned functionality</p> <p>Clarity on complementarity of component roles achieved; uncertainty managed quickly and formalized within business process; comfort with working within multi-disciplinary matrix to achieve shared objectives</p>
<p><b>External stakeholder relationships</b></p>	<p>Early phases of identifying potential partners, establishing connections and building of alliances</p>	<p>Progressively strengthened linkages to different partners both within own organization and other strategic role-players and organizations</p>	<p>Positive relationships with key partners after successful milestones attained</p>

#### Early team transformation: 2008 to 2010

Between 2008 and 2010, the district team identity, vision and purpose were in an embryonic phase, with slow mingling of different work experiences, backgrounds and ideas to formulate an identifiable unique SW Substructure character. Social connection was evident across all team components, however not always expressed as primary motivation of work. Communication was initially mainly upwards to the district manager rather than horizontally well-networked across the components. Leadership was more centralized around the district manager driving strategic and operational deliverables across the larger system and specifically for Du Noon. Baseline confidence of the inexperienced district manager was initially tentative with overwhelming span of control in MDHS and emerging scale of Du Noon project. Role-clarification was not developed, with some contestation over roles and functions at times. Team cohesion was in its nascent stage, with limited trust in professional relationships across different components. The early reference point in 2008 to 2010 for transactional and technical capability within the team was one of individually skilled managers from diverse backgrounds but not functioning as an aligned group towards common objectives. Collaborative functionality between team components was almost absent, with predominantly verticalised or silo-like work streams.

#### Mid-phase of team transformation: 2011 to 2014

The mid-phase of team transformation is during rapid acceleration of the Du Noon project between 2011 and 2014. Referring to Table 6, notable headway in all six pillars of team transformation can be identified and corroborated.

##### *Team identity and organizational culture*

A distinct team identity with shared values, and a unity of purpose to face and resolve emergent challenges was forged. Enhanced team trust, loyalty and communication was brought about through shared values clarification.

##### *Team vision and purpose around social connection and patient-centredness*

Social connection emerges as critical rationale for all team members during the 2011 to 2014 transformation journey, galvanizing everyone around a shared vision and purpose to deliver the much-needed services. Sentiments of shared purpose and self-belief were a common refrain during interviews:

***“This was doing the right thing for the people. Everyone bought into the cause.”***

***“it was on everyone’s agenda that this was the priority in the director’s absence, and we needed to make a success of it.”***

***“If we decide on a common goal and vision and how to draw on one another we get stuff done.”***

***“Goals were clear, parameters were clear. People could never say what was not happening as they knew exactly through role-clarification.”***

***“The director had made sure that Du Noon CHC was the deliverable for the year – and it was part of this that we could not fail you, we had just better get it right.”***

***“What stood out for me – we worked well as a team an everybody understood doing the commissioning well and the real social need and doing this could redress past inadequacies. Everyone was inspired by a moral cause, fix what we could fix as an additional drive to deliver.”***

### *Leadership development*

A major leadership growth for all Deputies-Director and District Director, sharing and developing roles with expansion of responsibilities in response to Du Noon project challenges is witnessed. The district manager became more secure and self-assured in her role with growing insight into district governance, accountability and stewardship functions, and milestone achievements during Du Noon project implementation.

### *DHS organizational capacity*

Learning cycles began taking root as the modus operandi by the end of the first three years, ensuring an iterative series of discovery, sense-making and reflection after implementation, analyzing and understanding processes and events, and drawing lessons for improvement and adaptation going forward from both successes and obstacles linked to Du Noon project. Growing confidence in strategic and operational decision-making in other parts of the health system was leveraged from earlier lessons in the project. By January 2014 the de-centralized team had worked together for six years and were technically proficient and recognized across components, but operating as a collective with a rotating acting district manager for eight months presented simultaneously an intrinsic developmental opportunity and a stressor to the team, which augmented transformation. Multiple unforeseen problems linked to Du Noon commissioning meant greater team self-reliance in the absence of the district manager. Decision-making and mentorship, capacity to align information from different parts of the system, and risk recognition and mitigation was required.

Examples of integrated functioning in planning, implementation of projects and programmes were evident between 2011 and 2012, but missed opportunities for tighter alignment were apparent in the PHC and Health Programme components due to different operational focus areas and work approaches by the relevant heads. The PHC manager had set ideas drawn from long-standing district work performed in the more under-resourced previous dispensation, and not then deemed a health system priority. Partnership was still difficult to align. Communication and responsiveness between components required ongoing work. Integration of activities and sharing perspectives for problem-solving needed encouragement. Groundwork for private sector collaboration in child and women's health, with core inputs from pharmacy services

and health programmes managers had improved alignment between these units. More inter-component work was conducted, reinforcing learning-by-doing motifs on specific deliverables, and enhancing collaborative functionality. Expanded external governance relationships with NPOs built stronger professional interlinkages between health programmes and finance components. Capacity gaps at the time in People Management and Finance teamwork revolved around planning, information-sharing and monitoring. Improved co-operation around problem-solving needed tightening between Pharmacy and PHC components.

Strong internal governance and performance orientation were well-developed across components such as finance and people management as technical support functions. Consolidation of systems improvement was seen across both health service and support components through an organizational culture project in 2013 and SW district team enjoyed departmental success. It emphasized patient-centred care, values-based leadership, and innovative solution-finding to operational problems. Enhanced trust, loyalty and communication accelerated team cohesion and camaraderie between 2013 to late 2014. Focus on resolving Du Doon-related dilemmas, adaptation to unpredicted organizational structure changes and a healthy organizational culture were the breakthrough elements of mid-phase transformation.

#### *Technical and transactional capacity*

Technical capability to design integrated, patient-centred health care in a large facility demanded days of detailed workflows, staff training and mentorship, and learning by trial and error.

***“We knew we had to hold the (facility) team a little longer that thought to commission the facility due to complexity of how to integrate services completely at a systems level.”***

***“We used other people’s strengths which made it easier.”***

***“The staff - we had to keep on supporting them through the change when they saw as a difficult change.”***

#### *Team Cohesion & alignment (skills, activities & processes)*

Role clarification is a formative element of team transformation during the project, especially with shifts across original designated functions to respond and adapt to the unforeseen system changes. In the mid-phase of team transformation, there is better understanding between the more technical functionaries compared to line managerial roles. Task-shifting and portfolio re-configuration resulted in certain role-players decreasing a clinical focus and taking on managerial and leadership roles with external role-players, such as the HAST doctor. The HAST Manager taking on acting PHC manager role and designated project manager assumed a direct line managerial function. An Acting Director was appointed from within team, with later relief from the CEO of Metro TB Hospital. Key requirements were managing uncertainty by focus on

critical goals, role-clarification, co-ordinated completion of tasks and clear communication around expectations and accountability. Sound camaraderie and collaboration helped to execute tasks on time and to the expected quality standard.

There is also ongoing exploration of different roles within team, especially with the temporary changes, however “they spoke to the Chief Director, and said that they were not sure how to do this.” Unlike another de-centralized MDHS team that was also commissioning a smaller new PHC facility, external project management capacity was not funded for a contract appointment, which meant that the SW team accepted project ownership and accountability, and learned by doing to get the job done. On asking study participants which elements contributed towards success, responses included themes of teamwork, technical capacity and a values-based approach:

***“Teamwork, more than just teamwork. Role-clarification – everyone was committed to exercise of delivery. We worked together for the greater good. Doing the right thing gave people extra inspiration to make it work.”***

***“Respect and trust between each other to do what we committed to do.”***

***“Teamwork. Not one single person was responsible for milestones on that chart.”***

***“People realized as the substructure team we had one another’s backs, we worked well as a team together”***

#### *Leadership development, team cohesion and collaborative functionality*

Organizational functional capacity improved, and although strategic input on major decisions was sought at higher levels on occasion, team members discovered their own personal growth through the Du Noon experience:

***“I was very anxious to act (as Director) – really – this whole thing – the personal lesson is that you don’t have to do it on your own – think about who is there. As a manager you should not be the cleverest person in the room – just know who can solve the issue.”***

Overall there was better integration in decision-making across components:

***“We would consult constantly – nobody made a decision on their own. Good communication. We acted collaboratively, and acted with urgency.”***

***“Team spirit, believing in ourselves. The importance of having a leader, someone directing the project, although there was leadership from every chair.”***

Learning by doing as a concept was highlighted as an enabler in the process:

***“When you work in a complex system and things change and correct from learning. It is okay if things don’t work out as planned, keep on refining.”***

***“What worked well, because we were not familiar with process we had to sit and think and discuss carefully and double-check with everybody – no hasty decisions.”***

***"We learned as we went along in the process. It was new for all of us, we had to find the right way through team input. The team supported each other."***

The demands put upon them from the infrastructure team were raised as a significant stressor, citing that:

***"nobody had lived through this before" with "curveballs sent in our direction at every meeting."***

Participants recognized that project success was dependent upon constant adaptation, learning, and building relationships and alliances to achieve milestones.

The pathway followed by the team was a combination of reliance on experience, pooling of intellectual and institutional resources and making calls outside of usual comfort zones of component functions. All members had to step up and take on additional workload and exercise leadership in expanded roles for seven months, testing both individual and team resolve. In response to describing team or personal level impacts of dealing with stressors, whether positive and negative, participants shared the following:

***"I was in at the deep end and it gave me confidence, although I have experience but using this experience and opportunity you can move through this process. Having a little insight, I could from a little past experience, track and support others in process as we went along."***

Individuals described their personal transformation and what they observed in the rest of the team and their strategic alliances:

***"We kept each other accountable in a positive way."***

***"For myself, you don't know everything, you fool yourself if you think you do. The best way of learning is to be involved and do it yourself, and take responsibility and opportunity of how I can grow. I have grown so much in process, I can see where things go skew, understand language and give advice as it gave me a lot of self-confidence in whatever I need to do."***

***"When we commission another facility, we have experience and hindsight, and we can try not to do same mistakes and try to do better next time."***

Based on initial summation of inputs from interview participants there was mindful effort to improve the individual and team internal capabilities during this time, giving effect to a significant transformative experience, resulting in augmented team performance. Acquisition of knowledge and experience through implementation-based learning resulted in a transformed team and individuals. Personal adaptation and professional portfolio flexibility was required of all team members. All members had to confidently expand their executive decision-making, risk management, exercise understanding for

whole-system thinking, and closely align activities for efficiency and effectiveness in an integrated manner. Protecting an existing hard-won performance-based reputation and maintaining team integrity was central to the team.

#### External stakeholder relationships

Alliances were identified as a critical component of success. A participant simply said:

***“Invest in relationships. It is important to get the right people on your side, at an early stage have people on your side.”***

An enhanced alliance grew between the district team and the hospital management team to better expand senior managerial capacity in a large and complex system requiring constant scanning, risk management and decision-making. This was evidenced by a respondent saying that there was a:

***“much better working relationship between hub hospital and substructure office which entrenched positive relationships and the way we conducted meetings with support of substructure and CEO (Acting Director), trust (was) built with infrastructure colleagues.”***

A study participant shared how the “infrastructure people had anxiety” but everyone was “consistent in meeting regularly at Brooklyn (the hub hospital) and everyone was committed and built trust, were very supportive and did things together.” Existing alliances were called upon when problems emerged with expanding Du Noon staff numbers (labour) and changes in the balance of power amongst unions with newly-recruited staff: Another participant reflected on an unanticipated stressor of

***“inexperienced union representatives who used their power and gave people wrong information, and convinced people based on incorrect info and had to call in Labour Relations at Head Office and Provincial level union representatives to address those issues, and meet with their principals to clarify roles and responsibilities of shop stewards. It was an opportunity for them to engage own shop stewards locally, and the education took a few months to settle.”***

#### Social connectedness and community alliances

Social connection emerges as a critical rationale for team vision, purpose, cohesion, and external alliances. Interaction of all elements are fundamental to the final team transformation. Key partnerships with community, ward councilor, health committee were called upon to ensure attainment of milestone events. As one of the participants stated:

***“I think we knew commissioning would not go well if we did not have the community on our side with Councilor Makaleni and Mr Jali” (Health committee Chairperson). Community support was critical and explaining with them – made sure that we had it as an enabler. It was important to navigate that the Community Health Centre was not***

***inside the community because of site and space, but there would be access to world-class facility with some adaptation.”***

***“In acknowledging people around me in doing this together, as everyone is needed, top to bottom. I learned the importance of community contacts and doors opened for you. The Councilor initially said community was very negative, but actually people very open for community participation.”***

With increasing capabilities, demonstrated through achievement of successive milestones, there was growth in self-belief, Alliances strengthened through mutual respect and co-operation, as well as completion of tasks and attaining shared goals, further reinforcing confidence at de-centralized level in decision-making to solve local challenges.

#### **Consolidation and maturation of team transformation: 2015 to 2017**

The permanent Du Noon is formally commissioned by December 2014, however much work followed over the next three years to capacitate, monitor and evaluate service delivery capacity, and mentor the new facility leadership and team. A robust district team identity and organizational culture is entrenched and navigates challenges as a strong collective. Shared vision translated into successful major achievement consolidates team purpose and commitment to improve health outcomes.

Transformation into experienced decision-makers operating in complex adaptive system, confident in exercising individual and team leadership capabilities is seen when performing health system strategic and operational management. Distributed leadership is visible in all components, with mentorship and coaching practiced in all teams. Strong internal capabilities in corporate governance within District team with mentorship capacity of Institutions cascaded across the broader organization. Lessons learned during Du Noon commissioning applied during the new Infrastructure commissioning project at District Six CDC between 2016 and late 2017, reinforcing the learning-by-doing motif. Individually skilled staff and team competencies are honed to work synergistically to problem-solve, commission, innovate and improve systems. By 2017, role-clarification is well-developed, with complementarity of component roles. Any new functional uncertainty is dealt with quickly and formalized within business processes. Greater comfort within a multi-disciplinary matrix to achieve shared objectives is reported by study participants. Sharing of perspectives and collective decision-making as a risk mitigation approach improved. Embedded trust and loyalty and more open communication is experienced within the team. Team cohesion to implement different projects is underpinned through a common commitment to service improvement for the community. Ongoing learning through experience and application to new challenges embeds iterative adaptation and internal capacity growth. Positive relationships with key partners are mutually reinforced after successful milestones attained.

## Chapter 5: Synthesis, conclusion and recommendations

Chapter Five summarizes empirical findings of the case study and relates these to the research questions. Conclusion and recommendations will wrap up this chapter.

Hypothesis I postulated that SW district health team's success in commissioning Du Noon CHC was embedded in persistent, iterative and experiential team-based learning by doing – resulting in ongoing, mutually-reinforcing strengthening of (i) internal organizational capacity; and (ii) external partnerships. In Chapter Four, Parts I and II, evolution of team capability is demonstrated by tracing critical junctures, and describing iterative team learning to resolve challenges in project prioritization, site acquisition, community support, and leadership gaps to progressively achieve milestones through different partnerships. A summary of enhanced team capacity is tabulated below against the pillars of team transformation in Table 7.

**Table 7: Enhanced team capacity and transformation**

<b>Pillar of team transformation</b>	<b>Enhanced team capacity</b>
Team identity, organizational culture and formation phase	<ul style="list-style-type: none"> <li>• Trust and integrated functioning</li> <li>• Trans-disciplinary collaboration and learning</li> </ul>
Team vision and purpose around social connection	<ul style="list-style-type: none"> <li>• Community accountability and stewardship</li> <li>• Balancing patient and staff interests</li> </ul>
Leadership development	<ul style="list-style-type: none"> <li>• Community accountability and stewardship</li> <li>• Accountability and stewardship</li> <li>• Strategic decision-making and risk management</li> </ul>
DHS organizational capacity	<ul style="list-style-type: none"> <li>• Planning and knowledge management</li> <li>• Alignment of short-term, Medium-term and Long-term planning</li> <li>• Staff engagement, negotiation and consensus-building</li> <li>• Strategic decision-making and risk management</li> <li>• Navigating changed organizational terrain</li> <li>• Portfolio re-configuration and task shifting</li> <li>• Balancing patient and staff interests</li> <li>• Staff engagement, negotiation and consensus-building</li> </ul>
Team Cohesion & alignment (skills, activities & processes)	<ul style="list-style-type: none"> <li>• Innovation and leveraging previous learning</li> <li>• Navigating changed organizational terrain</li> <li>• Portfolio re-configuration and task shifting</li> <li>• Trans-disciplinary collaboration and learning</li> <li>• Stakeholder mapping, coalition-building and advocacy</li> </ul>
External stakeholder relationships	<ul style="list-style-type: none"> <li>• Navigating political and media pressure</li> <li>• Community accountability and stewardship</li> <li>• Stakeholder mapping, coalition-building and advocacy</li> </ul>

Agreements were negotiated, collaboration forged and deals brokered to resolve unforeseen obstacles in the pathway to final commissioning. Chapter Four delineated development of multiple, often fraught internal and external governance relationships with diverse stakeholders to ensure that the health system was responsive to community needs, which is at the heart of PHC philosophy. Hypothesis I holds true that through an iterative and experiential learning process of team capacitation and nurturing winning

partnerships, district team capability, confidence and autonomy were strengthened, step-by-step in the course of Du Noon project implementation. Partnerships with actors listed below were sought, built and maintained to deliver milestones and reinforced district team capability:

- Regional and tertiary hospital service managers
- Technocrats in Public Works, Health Infrastructure, and City of Cape Town
- Political leadership at local government, provincial and national levels
- Community leadership, NPOs and organized labour

Hypothesis li theorized about the centrality of de-centralized organizational culture, and developmental approach working towards achievement of outputs. Throughout interviews with study participants, themes of teamwork, social commitment, accountability and striving towards high performance were identified, lending credence to intrinsic team cohesion and social connectedness as factors in the Du Noon success. Chapter Four, part III reflects on team transformation (summarized in Table 6) by documenting:

- Progressive growth in confidence through learning-by-doing and small wins
- Harnessed self-assurance and capacity with early implementation success to take on greater challenges through constant learning, reflection and application
- Enhanced competencies to manage competing interests, balancing different principles and understanding trade-offs
- Practice of ethical, values-based, internally-motivated, and dispersed leadership
- Co-mentorship and matrix of inter-disciplinary support.
- Resilience and authenticity in daily work, harnessing diverse skillsets and perspectives, both at individual level and through coalitions and alliances

Service data showed documented increased health outputs between 2012 and 2017 in Chapter Three. This is quantitative evidence of successful Du Noon CHC commissioning by a cohesive, socially connected team with internal capacity that delivered:

- Increased Total PHC headcounts (proxy for comprehensive service access)
- Increased under five years-old headcount (evidence for child health access)
- Increased Emergency Centre Headcounts (Constitutional imperative)
- Increased number of patients on Anti-retroviral treatment
- Expanded financial resources (approximately R10 million in 2013/14 to R75 million in 2017/18) to incrementally fund staffing and operational cost

Service growth was directly related to expanded staffing capacity, resource mobilization, and execution of integrated planning by the team through its journey of augmented capacity and fruitful alliances. Mapping organizational performance, project deliverables and service outputs over time measured change after “intervention of the causal mechanism and in temporal or spatial isolation from other mechanisms”. (George & Bennett, 2005) The “capacitated causal agent” or entity, the decentralized district team, caused successful outcomes via its enhanced capabilities.

## Conclusion

This case study of a protracted project commissioning process, initially completely unprioritized in central departmental planning offered:

- lessons that built internal team capability and enhanced external alliances to traverse uncharted territory
- descriptions and explanation of persistent, collective and effective action by the inexperienced decentralized team to develop and consolidate their capabilities through problem-solving and a learning-by-doing approach
- experiential insight into system and individual resilience
- an honest review of developmental policy implementation in the lived reality of decentralized teams to improve central policy formulation
- insight that strategic alliances both enabled internal capacity and drove success

Accessible and person-centred PHC services acceptable to communities protect acute hospitals from inappropriate, costly clinical case management, and fulfil critical linkages for a sustainable and functional health system impacted by rapid urbanization, growing co-morbidity and diminishing resources. Through this problem-driven learning-by-doing and adaptation process, the team overcame multiple obstacles to successfully commission a facility that:

- improved comprehensive PHC access and reinforced DHS
- is accepted, celebrated and used by Du Noon community
- garners awards for service and organizational culture excellence
- forms an ongoing learning space for public health specialists, architects and provincial and national DHS managers for health systems improvement
- shifted health system response to a more local, person-centred service

Health policy and systems research (HPSR) comprises trans-disciplinary approaches for knowledge creation, evaluation and application with core interest in policy practice to strengthen health systems. (Sheik, et al., 2014) Change rarely happens according to a narrow think-plan-implement paradigm. Innovation, and adaptive learning to situational contexts, unforeseen circumstances and consequences become lessons for the future. This case study:

- shares operational research understanding of how policy is really implemented on the ground within DHS complexity through learning-by-doing
- exposes the myth of centralized policy implementation in accordance with conventional top-down strategic planning
- illustrates the messy reality of system complexity, multiple stakeholders as social agents, unforeseen consequences and uncertainty

- traces consequences and impacts of the successful Du Noon CHC project in the broader system, both unintended or intended
- confirms that iterative cycles of development through implementation-driven learning, oftentimes stumbling and then adapting from temporary setbacks, leads to innovation, greater understanding and organizational aptitude, improved health service delivery and system strengthening
- conveys how multiple small wins enhance the broader District and WCG: Health reputation over time, thus slowly improving overall system legitimacy

Maturation of team governance and leadership were causal agents and mechanisms to grow capacity in context (e.g. de-centralization in DHS development). Agencies that innovated and developed good service reputations shared specific characteristics, notably “political and organizational capacity” according to Carpenter, where they executed planning, creatively solved problems, and could manage and adapt their programmes, which was described in the case study.

The team displayed synergies between accountability, enhanced decision-space, institutional capacity and improved service delivery. Stewardship of geographic service delivery was elementary to team ethos, and drove appropriate choices and decision-making. Context-appropriate choices were exercised by an empowered district team, consequently enriching internal capabilities and bolstering team confidence. With proven ability to respond to local health needs, greater decision-space was granted by central managers to determine next steps, and the team gained community trust. Investment in future capacities through learning-by-doing harvested returns when new problems required quick solutions. Alliances were capitalized upon from earlier successes and established trust, consolidating achievement of service milestones and further enhancing decision-space authority.

Loyalty, good governance, accountability, novelty, continuity and alliances become core ingredients of institutional agency in DHS, however over many years, multiple role-players at different levels informed the ethos and organizational reputation of being “socially rooted” (Carpenter, 2001) in a manner that aligns with distributed or multi-agent leadership. (Andrews, 2013) Responsiveness to local community needs was facilitated by increased decision-space earned by the team through tangible achievements and enhanced internal capabilities. Subsequent successes were built through learning-by-doing, often mediated via external alliances, and the ability to effectively respond to local health priorities grew over time.

People become part of institution building and organizational capacitation, where “durable career officials” and “middle-managers and monitors” become part of “networks of attachment” and “patterns of collaboration” to build “state capacity”, especially through longitudinal organizational relationships. (Carpenter, 2001) Through this case study the voices of institutional teams at the “mezzo-level” are heard to reflect

on actual practice of developing internal capability through lived experiences in a complex system.

Some additional ramifications of this project include:

- Adaptation of the Temporary Du Noon facility model in 2016 for Mfuleni Temporary CDC by another de-centralized MDHS team in partnership with WCG: Health Infrastructure. De-commissioned Du Noon containers were relocated, creating critical PHC access for another vulnerable community, and confirming WCG: Health learning-by-doing motif after pioneering pilot project at Du Noon
- SW team successfully commissioning another large PHC facility at District Six CDC in Cape Town CBD on 26 February 2018, drawing upon lessons learned during Du Noon CHC commissioning experience
- Widened delegations (de jure decentralized authority), uptake of increased decision-space (empowered leadership and teams), and responsive decision-making for local health needs are integral to de facto institutional capacity. (Bossert & Mitchell, 2011)

“Autonomy prevails when agencies can establish political legitimacy – a reputation for expertise, efficiency or moral protection and a uniquely diverse complex of ties to organized interests and the media – and induce politicians to defer to the wishes of the agency even when they prefer otherwise. Under these conditions, politicians grant agency officials free rein in program building.” (Carpenter, 2001) Between 2008 and 2017, the SW team exhibited progressive internal capability, and expression of its decentralized mandate to plan and deliver health services to communities in its geographic area. It achieved this through focus on accountability, learning through practical experience, and forging alliances, cementing a reputation for partnership, reliability and technical competence at de-centralized level. This in turn built trust and leveraged its partnerships to continue health service delivery in a manner that is guided by central policy but allowed decision-space for innovation and customization.

“Agencies with strong reputations possessed greater talent, cohesion, and efficiency than agencies with reputation for weakness, corruption, or malfeasance.” (Carpenter, 2001) The SW team was imbued with cohesion, creativity and competence that carried the Du Noon project to success. It possessed perseverance, curiosity, and courage in managing uncertainty in complex environments through constant exploration, sense-making, reflection, testing and learning from both success and failure. Social connectedness and collaboration were enablers for healthy and helpful alliances throughout the Du Noon project. Team transformation continues to drive sustained organizational performance and institutional stability within the operational meso.

## Recommendations

1. Practice-based experiences of planning, commissioning and delivering frontline health services need greater voice in decision-making and policy design in WCG: Health to iteratively improve as a learning organization.
2. Narrow views of how policy is effectively fulfilled at the coalface have to be broadened via proper feedback loops from implementation role-players in the health system at all levels to build real systems-strengthening interventions based on context-rich and practice-based evidence and learning-by-doing.
3. More research embedded in the implementation space needs to be conducted to realize lessons of "social construction, requiring those conducting Health Policy and Systems Research to locate their own position in the system, and conduct and publish research in a manner that foregrounds human agency attributes and values, and is acutely attentive to policy context." (Bennett, 2007)

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Annexure 2: Southern Western Substructure (Metro District Health Services) organogram

**SW Sub-structure: Span of management & Governance**



*Annexure 3: Health Policy Framework at National and Western Cape Provincial Levels between 1994 and 2016*

	<b>SA NATIONAL LEGISLATION, POLICY CONTEXT AND IMPLICATIONS</b>	<b>WESTERN CAPE POLICY CONTEXT AND IMPLICATIONS</b>
1977	<b>Health Act</b> Fragmented, inequitable PHC service delivery	
1994	<b>ANC National Health Plan</b> Transformation of health system Health for all, PHC philosophy with decentralized management via a District Health System as part of National Health System, community governance and multi-disciplinary, inter-sectoral and human rights approach	
1995	<b>“A Policy for the Development of a District Health System for South Africa”</b>	<b>New Provincial Health Plan</b> adopted in October 1995 DHS implementation as foundation
1996	<b>Constitution of SA</b> Section 27: Right to access healthcare services, including reproductive health care, sufficient food and water and social security and no one to be refused emergency medical treatment Broad definition of municipal health services Prohibits transfer of any local government functions to province	Old Tri-cameral Parliament system merged into unitary health department that was organized into Regions  One Chief Director and four Regional Directors appointed as first step on road towards de-centralized management of health services
1997	<b>White Paper: Transformation of Health Services</b> WHO definition of DHS Outlined role, principles and goals of DHS Provided DHS governance options Intended to improve population health outcomes and health status by improved primary health care (PHC) delivery through effective DHS	Bi-Ministerial Task Team (BMTT) established (Health and Local Government Ministries) Mandated to investigate governance options for PPHC services and to seek standardization and rationalization of the historical inefficiencies and fragmentation Recommended transfer of all Provincial PPHC services, staff and assets to Local Government under available legal framework  Cost of operation was R530 million based on 1997, with 2100 staff and 100 PHC facilities, and majority based in Cape Town metro Province was to finance PPHC
1998	<b>Local Government Municipal Demarcation Act (Act Number 27 of 1998)</b> Provides for Demarcation Board to demarcate boundaries, delimitation of wards, and assessment of capacity of municipalities to perform functions	
1999	1 February 1999 Demarcation Board established Total number of municipalities in South Africa reduced from 843 to 284	
2000	<b>Local Government Municipal Systems Act of 2000</b> Each municipality to prepare and Integrated Development Plan (IDP) Inter-sectoral planning to address social determinants of health that affect PPHC is expected (water / sanitation / etc)	April 2000: BMTT report finalized and recommended transfer of all provincial PHC facilities and staff to local authority, with majority in Metro 29 September 2000 saw declaration of final boundaries published in Government Gazette Western Cape Province demarcated into one metropolitan municipality (Category A) 24 Local Municipalities (Category B) Five District Managed areas (category C)
2001	<b>“A comprehensive Primary Health Care Service Package for South Africa”</b> Universal access to comprehensive PHC	

2002	<p>MinMEC: Meetings between Minister of Health and nine Provincial MECs of Health resolved that “functional integration” of provincial and municipal health systems sought for provision, delivery and management of PPHC in order to reduce duplication, fragmentation and inefficiency</p> <p>July 2002: Municipal Health Services defined narrowly as “environmental health services” only</p> <p><b>National Health Bill</b></p> <p>Municipal health services definition circumscribed to environmental health functions</p>	<p>DOH Leadership reviewed all implications of National Health Bill’s revised narrow definition of municipal health services and recommended a diametrically opposite position on DHS governance than that proposed by BMTT, viz. accepted Provincial accountability for all PPHC and local authority responsible for environmental health only.</p>
2003	<p><b>National Health Act, (61 of 2003)</b></p> <p>District Health Services managed per health district</p> <p>Personal Primary Health Care (PPHC) deemed a Provincial Government function</p> <p>Compilation of District Health Plans (DHP) legislated for all 52 health districts</p> <p><b>Municipal Management Act (Act Number 53 of 2003)</b></p> <p><b>Municipal Structures Act (Act Number 117 of 1998 as amended)</b></p> <p>Informed the financial and operational control by DOH Province of rural PPHC services in 2005 and 2006 respectively)</p>	<p><b>Western Cape: Strategic Position Statement: Healthcare 2010</b></p> <p>Improve quality of healthcare services and sustainability of health care system through re-configuring service delivery platform so that health care services are delivered in accessible, acceptable, appropriate, effective, efficient, effective and equitable manner.</p>
2004		
2005	<p><b>National Health Act</b> came into effect on 2 May 2005 (excluding Chapters 6 and 8)</p> <p>New health structures in Western Cape</p>	<p><b>Rural DHS Unitary Authority</b></p> <p>1 April 2005: DOH assumed financial responsibility for personal primary health care (PPHC) in rural areas</p> <p>All TB hospitals placed under WCG: DOH management</p> <p>May 2005: First draft Comprehensive Service Plan (CSP)</p> <p>September 2005: Top Management DOH CSP workshop for framework and content finalization for HC 2010 implementation plan</p> <p>December 2005: Cape Town Metro District sub-district boundaries changed and approved by MEC to demarcate eight sub-districts</p> <p>Commencement of transfer of five rural districts from local municipalities to Western Cape Provincial Government</p>
2006		<p>February 2006: Second draft CSP workshop with DOH prior to external consultation</p> <p>1 March 2006: Operational control assumed for all rural PPHC by Provincial DOH</p> <p>19 July 2006: WC Provincial Cabinet approved CSP</p>
2007		<p><b>Comprehensive Service Plan / Healthcare 2010</b></p> <p>11 May 2007: Consulted CSP signed off by Minister and published</p> <p>DOH commissions Burden of Disease (BOD) study in WC</p> <p>Regional Organisational Structure changed to District Health System implementation</p> <p>New Chief Director: MDHS appointed as District Manager of Cape Town Metro</p>
2008		<p><b>Provincial Growth and Development Strategy (PGS)</b></p> <p><b>Integrated Approach for Improved Service Delivery</b></p> <p>Sharing the Burden of Disease</p> <p>DOH headed Social Cluster of PGWC</p> <p><b>DHS established in Western Cape</b></p> <p>Boundaries and functional domains of Districts set up.</p> <p>Six Health districts unbundled into five Rural districts and</p>

		<p>the Metro into four Sub-structures headed by total of eight District Managers.</p> <p>April 2008: Three additional Metro District Directors appointed to head up four sub-structures with original MDHS Director reporting to CD: MDHS</p>
2009		Transfer of large hospitals previously designated Regional Hospitals and 600 bed tuberculosis hospital in metro to DHS
2010	Ten Point Plan Re-Engineering PHC Discussion Document	<b>Western Cape District Health Councils Act, 5 of 2010</b> DHCs will provide governance within districts in accordance with NHA
2011	<p><b>National Planning Commission</b> Announcement of Vision for 2030 National Development Plan (NDP) identifies the inability to get PHC services and the DHS to function effectively as the root cause of multiple health system failures and inability to manage burden of disease</p> <p><b>PHC re-engineering</b> Ward-based, geographically-planned approach PHC outreach teams , school health and clinical specialist teams Pro-active, community-centred Outcomes-based Comprehensive focus on wellness, health promotion, disease prevention and screening for early diagnosis Improve healthcare and life expectancy</p>	<p><b>Negotiated Service Delivery Agreements (NSDA)</b> National embedded in Provincial Minister of Health performance – outcomes-based</p> <p>Increase life expectancy Decrease maternal and child mortality Combat HIV / AIDS (HIV incidence) and decrease TB burden (TB incidence) Increase wellness Improve patient experience in health service Strengthen health system effectiveness</p> <ul style="list-style-type: none"> <li>✓ PHC re-engineering</li> <li>✓ Improve patient satisfaction and care</li> <li>✓ Accreditation of facilities</li> <li>✓ Improve infrastructure availability</li> <li>✓ Improve health human resources</li> <li>✓ Strengthened financial management</li> <li>✓ Improve financing of healthcare via NHI</li> <li>✓ Improve health information systems</li> </ul>
2012	<p><b>National Development Plan (NDP)</b> 14 priority outcomes to reduce inequality and eliminate poverty by 2030: Quality basic education Improving health outcomes Reducing crime Creating jobs Developing skills and infrastructure required for the economy Rural development Sustainable human settlements Effective and efficient local government and public service Protecting the environment Social development Social cohesion Nation-building International relations <i>“strengthen PHC services and broaden district-based health programmes, and health education”</i> <i>“better nutrition and health care”</i></p>	<p>Health Care 2030 informed by NDP, SDG and UNDP parameters. The health system should provide quality health care to all, free at point of service, or paid for by publicly- provided or privately-funded insurance. The NDP prioritises areas in public health system for reform:</p> <ul style="list-style-type: none"> <li>✓ Improved management at institutional level;</li> <li>✓ More and better trained health professionals;</li> <li>✓ Greater discretion over clinical and administrative matters at facility level, combined with effective accountability; and</li> <li>✓ Better patient information systems supporting more de-centralized and HBC models.</li> </ul> <p><b>The section on health also identifies the following key targets and actions</b></p> <ul style="list-style-type: none"> <li>✓ By 2030, life expectancy should reach at least 70 for both men and women;</li> <li>✓ The under-20 age group should largely be an HIV-free generation;</li> <li>✓ The infant mortality rate should decline from 43 to 20 per 1 000 live births and under-five mortality rate should be less than 30 per 1 000 from the 104 it is today;</li> <li>✓ Maternal mortality should decline from 500 to 100 per 100 000 live births;</li> <li>✓ All HIV-positive people should be on treatment and preventive measures</li> <li>✓ such as condoms, and microbicides should be</li> </ul>

		<p>widely available, especially to young people;</p> <ul style="list-style-type: none"> <li>✓ » Non-communicable diseases should reduce by 28% and deaths from drug abuse, road accidents and violence by 50%; and</li> <li>✓ Everyone should have access to an equal standard of basic health care regardless of their income.</li> </ul>
2013	<b>National Health Amendment Act 12 of 2013</b> Office of Health Standards Compliance (OHSC) established to protect and promote safety of patients	DOH re-structures and amalgamates two service Divisions into single Branch: Operations
2014	<b>Medium Term Strategic Framework (MTSF) 2014 - 2019</b> Implementation Framework for NDP Improve Health Outcomes by: Address social determinants of health Strengthen the health system Improve health information Prevent, reduce burden of disease and promote health Universal health coverage financing Improve human resource production, development and management Strengthen accountability mechanism Improve quality through evidence- based interventions Meaningful public-private partnerships  <b>DHS Policy Framework and Strategy 2014 to 2019</b>	<b>Provincial Strategic Plan 2014 -2019</b> SG1: Create opportunities for growth and jobs SG2: Improve education outcomes and opportunities for youth development SG3: Increase wellness, safety and tackle social ills SG4: Enable a resilient, sustainable, quality and inclusive living environment SG5 (Transversal): Embed good governance and integrated service delivery through partnerships and spatial alignment.
2015		<b>Draft Western Cape Health Facilities Boards and Committees Bill, 2015</b>
2016		DHS and CBS are protected in tough fiscal context as buffer to more expensive hospital services Anticipation of further DOH re-structuring to consolidate DHS in Metro
		Hearings for WC Health Facilities Boards and Committees Bill on 13 May 2016
2017		WC Health Facilities Boards and Committees Act
2018		WCG: Health restructured

Sources: Case Study: Phased Implementation of DHS in Western Cape, P Barron; Annual Statistical Report DOH 2008/09; Annual Performance Plan 2011/12; Annual Report DOH 2011/12, 2014/15; Comprehensive Service Plan, 2007; National Development Plan, Executive Summary, 2012; District Health System Policy Framework and Strategy 2014 – 2019; Circular H38 / 2015: Position paper on PHC; WC User Asset Management Plan 2016/17 (Grammer, 2016)

*Annexure 4: Infrastructure journey to Du Noon CHC (2008 – 2014)*

