CASE STUDIES FOR HEALTH SYSTEMS AND POLICY ANALYSIS

CASE STUDY OF ROUTINE GOVERNANCE
Mitchells Plain sub-district in South Africa

This case study draws on the research of the Resilient and Responsive Health Systems Consortium (RESYST). Its writing was made possible by the financial support of RESYST. http://resyst.lshtm.ac.uk/

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About this case

Drawing on the experience of the Mitchells Plain sub-district in Cape Town, South Africa, this case study provides a window onto the routine functioning of a local-level health system and the ways in which middle managers and frontline staff have sought to cope with their challenges and do things differently to improve the health system’s functioning. While the experiences and dynamics of this context are interesting in themselves, many of them are also likely to be widely shared, and so hold the potential to stimulate wider thinking about how health systems work and what it means to strengthen and develop them.

The case study was written for use with CHEPSAA’s open access course *Introduction to Complex Health Systems*. It is useful for stimulating students’ thinking about topics such as:

- The structural complexity of health systems, as well as the complex, multi-directional relationships that are required for the system to work;
- The different ways in which a health system can be governed;
- The full range of skills required of mid-level managers and health facility managers;
- The values, mind-sets and relationships of different health system actors; and
- Ways in which managers can strengthen the health system, especially through strategies that are sensitive to power, communication, relationships and values.
Case study: routine health system governance and improvement in Mitchells Plain (2010-2014)

Case study focus
This case study describes aspects of day-to-day health system functioning in Mitchells Plain, a sub-district of Cape Town, located in South Africa’s Western Cape province. Giving a view of the district health system from the inside, it explores its organisational context; the mind-sets, relationships and processes that influence health system functioning and policy implementation; and efforts to strengthen the health system and improve health service delivery. It focuses on routine system functioning, not any particular policy or intervention.

Mitchells Plain was established in 1976 when the racially segregationist apartheid regime forcibly relocated various communities to this area, which was designated for so-called “coloured” people. A relatively poor urban community where about 30% of the 1 million residents live in informal settlements, Mitchells Plain faces many social challenges, including substance abuse, poor schooling and crime. The community’s health status is relatively poor and the public health system is comparatively under-resourced and has, over the last two decades or so, experienced a major increase in patient numbers due to both increased access to services and a greater disease burden.

The complex structure of the health system in Mitchells Plain (2010-2014)
Two structures managed health services in the Mitchells Plain sub-district. The first, a local government authority, was the City of Cape Town’s health department (CoCT Health). The sub-district manager had overall responsibility for the sub-district. Beside the sub-district manager, this level contained administrative support staff, such as the administrative and health information officers, and staff who more directly influenced the delivery of care, particularly the programme and primary healthcare (PHC) manager. The latter was the line manager of TB/HIV/STI coordinators, who supported these programmes in clinics.

The district level was located above the sub-district level and here the sub-district managers reported to the Executive Director of Health and his/her team. The Executive Director of Health answered, in turn, to the City Manager.

The second, a provincial authority, was the Metro District Health System (MDHS) of the Western Cape Department of Health. At the sub-district level, a sub-structure director led the MDHS. Among others, the sub-structure director worked with deputy directors responsible for support functions such as finance, human resources and supply chain management, but also deputy directors for PHC and comprehensive services. The latter supervised assistant directors for facility-based services, TB/HIV, PMTCT, rehabilitation, and community-based services, who supported facilities in implementing these programmes.

At the district level, the sub-structure director reported to the MDHS Chief Director and his/her team. The MDHS Chief Director was accountable to the Deputy Director-General for the District Health System of the Western Cape provincial government.
Below the sub-district level, managers and frontline staff worked in health facilities. Facility managers fell under the line management of PHC managers who reported to the CoCT Health sub-district manager or MDHS sub-structure director. Historically, health service delivery in local government facilities had been led by nurses and focused on preventative and promotive programmes, as well as basic curative services for children, infectious disease control and environmental health. The provincial government’s services had traditionally been doctor-led and oriented to curative care in hospitals. As of 2016, Mitchells Plain had:

- 8 clinics, managed by CoCT Health and with 8-20 staff members. These clinics provided at least curative care for common childhood illnesses, as well as preventative services such as family planning and HIV testing;
- 6 community day centres, with 24-68 staff members. The centres focused on general curative services for adults;
- 3 community health centres, with 143-180 staff. These facilities offered general curative services for adults, all-day emergency services and obstetric services. The MDHS managed most community day centres and community health centres; and
- 1 district hospital, which was the responsibility of the MDHS.

The CoCT Health sub-district managers and MDHS sub-structure managers were to some extent independently responsible for their respective facilities and programmes, but they also coordinated their efforts. At the sub-district level, officials came together in the Integrated Sub-district Management Team, while the District Executive Committee provided joint oversight at that level. The MDHS also funded CoCT Health to provide certain services through a service-level agreement, which in some respects structured the relationship between the two organisations. Managers also met where they share programme responsibilities, for example concerning the HIV, AIDS, STI and TB (HAST) programme.

The CoCT sub-district and MDHS sub-structure: a brief history

The South African health system has a history, dating back to before the democratic transition of 1994, of severe fragmentation in health service delivery. The CoCT sub-district and MDHS sub-structure emerged from this history. The health management structures of the CoCT were consolidated in 2000 and sub-district managers were historically seen as having a fair degree of decision-making authority. The MDHS was only formally established in the 2008/2009 financial year. Its sub-structure managers have therefore received meaningful, arguably more so than CoCT sub-district managers, decentralized authority over a comparatively short time period.

A further structural complexity was that the local government and provincial structures had different planning processes and financial years. The MDHS had an annual district plan, which was nested within the provincial department of health’s annual plan, which was in turn linked to the Western Cape province’s 5-year strategic plan. The provincial financial year began in April. The CoCT had its own business plan, which was informed by the cross-sectoral Integrated Development Plan. The Mitchells Plain sub-district therefore received health service delivery targets through the planning processes of both CoCT Health and the MDHS. Local government’s financial year started in July.
Tension and conflict linked to complex structures and processes

The complex governance structures and processes occasionally contributed to conflict between sub-district health system actors. The HAST programme was a key example.

Sub-district HAST programme staff liaised with their co-workers in finance, supply chain management and health information, and gave technical support to facility managers, health workers and community-based organisations, who delivered HAST services to clients.

The CoCT Health sub-district had two HAST coordinators, who reported to an operational and PHC manager. The latter was a line manager to the facility managers, but also provided technical support to them with the HAST coordinators. The MDHS sub-structure had a HAST medical officer and programme staff working on TB and PMTCT. Above them was a HAST manager, and above the HAST manager was a programme manager. The HAST staff and programme manager gave technical support to the operational manager and the facility managers, while the operational manager was the line manager of the facility managers.

The creation of the MDHS’ HAST manager post caused tensions between the organisations. Key obstacles to achieving the HAST programme’s vision included conflict in communication, a perceived lack of respect for organisational lines of authority, and conflict over access to planning and monitoring information held by the respective organisations. These problems were linked to perceptions about the personalities and power of certain actors involved in the conflict and were therefore characterised by the presence of suspicion and mistrust.

To address the conflict, the sub-district created a task team. The task team was comprised of five operational and programme managers responsible for supervising the HAST programme staff and was facilitated by two researchers who, as part of a wider project, had a long-term collaborative relationship with the Mitchells Plain sub-district. Drawing on engagements with their sub-district managers, the idea was that the task team would negotiate a division of HAST responsibilities between the CoCT and MDHS authorities.

The problems initially came to a head in a joint CoCT Health-MDHS management meeting. The task team began with a review of written submissions to this joint meeting and the meeting’s minutes. This was a chance for the task team to reflect on how they understood the problem and what needed to be fixed. To give a similar opportunity to the bigger HAST team, the task team held a two-day workshop for all the HAST managers and programme staff to explore the nature of the problem, the reasons for it, and possible solutions.

This workshop revealed that the respective HAST teams did not understand each other’s job descriptions and positions within the CoCT Health and MDHS hierarchies. They had wrongly assumed that the jobs, processes and structures in their organisations were essentially the same. Deeper discussions around job descriptions and organograms changed participants’ understandings about acceptable lines of communication, how different lines of authority worked, and the processes for implementing policy and delivering services.
A key workshop learning was that the MDHS had a shorter policy implementation pathway and thus often faster implementation. MDHS district managers met monthly with their provincial line managers. Decisions in these meetings were binding, so that the MDHS was immediately mandated to implement them. In contrast, CoCT Health had to approach the City of Cape Town if a policy change required additional funding and engage with MDHS for additional funding in case of any changes to the activities in their service-level agreement. Divergent understandings about what could be expected from different actors and whether CoCT Health was acting in line with the service-level agreement or not, was therefore related to misaligned organisational processes, not obstructive personalities or exercises of power. Aligning all these organisational structures and processes was beyond the authority of those involved in the task team process, so different solutions had to be considered.

After the workshop, HAST programme staff were still intent on drafting standard operating procedures, to be endorsed by the CoCT Executive Director for Health and Chief Director of the MDHS, to stipulate rules for working together; rules they hoped would remove all uncertainty from these relationships. However, upon further reflection, the task team recognised that technical knowledge and skills were only one part of HAST staff’s job and that, in fact, they could only be effective if they had strong relationship skills that allowed them to work with other actors on all levels, both within and across their organisations.

Building on this insight, the task team concluded that the solution was not fixed rules for communication and collaboration. They wanted roles and relationships across CoCT Health and MDHS to develop naturally, based on changing contexts and needs. Instead of standard operating procedures, which would cement current roles and relationships, they opted to provide more support to collaborative relationships and communication between all the HAST staff, which they thought essential to maintaining working relationships and ensuring that all tasks and responsibilities were fulfilled. They therefore decided that:

- All HAST staff could communicate openly, regardless of lines of authority;
- It was desirable to work together to plan joint campaigns;
- Support could be offered across organisational boundaries; and
- They would plan together informally, but formal planning and information-sharing would take place in the Integrated Sub-district Management Team.

These understandings and decisions presented the task team with a dilemma because it had strayed from its perceived mandate of simply dividing responsibilities between CoCT Health and MDHS staff. In response, the task team arranged a joint meeting with their sub-district managers in which it was confirmed that the division of responsibilities through standard operating procedures was, in fact, not the only possible solution and that they had the authority to determine how the HAST work in the sub-district would be organised.

Following this clarification of their authority, the task team called a final workshop of all HAST programme staff in which they presented their understanding and proposed solution, and implemented participatory methods through which participants developed trust-building and hierarchy-neutralising principles for working together. Reframing the conflict away from personal power struggles to organisational misalignment enabled the CoCT
Health and MDHS staff to be more trusting of each other and to work together on a solution. Once the HAST managers in the task team became aware of the centrality of relationship skills, communication and collaboration, they affirmed it through their words, but also valued and role-modelled it in workshops and their daily management practice.

In their collective dialogue about the future, the HAST staff decided to base their collaboration on the principles of participation by all, respect for diversity, respectful communication, information sharing, collaboration, problem solving, acknowledging organisational differences, passion and commitment in teamwork, and persistence.

After months of creating spaces for dialogue, collaborative learning, developing common understandings, and reframing understandings of problems and solutions, the Integrated Sub-district Management Team approved the final set of documents spelling out roles and responsibilities, principles for collaboration and lines of communication.

The task team met again 8 months after the final workshop. They judged the intervention to have been fruitful, as evidenced by examples of CoCT Health and MDHS HAST staff working well together to plan a joint campaign, support training and give technical support to health facilities across the organisations. The HAST programme collaboration also spurred wider collaboration between CoCT Health and the MDHS in the sub-district, for example in the area of child health.

The pivotal role of management at the sub-district level
Within this complex health system architecture, CoCT sub-district and MDHS sub-structure managers occupied a focal position from where health system stakeholders’ demands and the strategic direction and operational plans of national, provincial and local government had to be brought together and translated for facility managers and frontline health workers into processes, understandings, tasks and instructions that would lead to efficient health system functioning and the meeting of service delivery targets.

By virtue of their position and responsibilities, sub-district managers interacted with and managed a wide range of actors. This happened through many formal and informal meetings and interactions. In fact, sub-district managers spent much of their time on crises and service delivery problems caused by others’ inaction, lack of pro-active management, skills deficits, or negative behaviours such as unplanned absenteeism or theft.

Sub-district managers, first, “managed down”, i.e. managed their teams and the staff who reported to them. In Mitchells Plain this included the following routines and processes, which were complemented by ad hoc meetings and interactions as needed:

- Once a month, the CoCT sub-district manager and PHC coordinator met individually with each facility manager. They also conducted monthly supervision visits to each PHC facility;
- The MDHS’ Deputy Director of PHC also conducted monthly visits to PHC facilities;
• The MDHS sub-structure managers participated in the quarterly performance appraisal of staff who reported to them; and
• The CoCT sub-district manager, head of environmental health, programme managers and programme coordinator also participated in performance appraisal meetings.

Second, sub-district managers “managed up” when they formally met with and accounted to their line managers, for example in regular meetings with the MDHS Chief Director and CoCT Executive Director for Health to discuss items such as budgets; in many ad hoc meetings with district-level managers, when reporting was more informal; and when they met provincial or local politicians on their visits to the sub-district. Beyond reporting and accounting, “managing up” included advocacy by sub-district managers to bring the needs and priorities of Mitchells Plain to the attention of higher levels of the health system.

Third, sub-district managers “managed out”. Regarding health services, this included participating in the Integrated Sub-district Management Team; meetings about programmes where CoCT Health and MDHS shared responsibility, for example the HAST programme; and engaging with service users and clinic committees. In the wider health system, sub-district managers also participated in the City of Cape Town’s Multi-Sectoral Actions Teams and processes such as the Integrated Development Plan.

Of course, sub-district managers could not do everything themselves: in their attempt to meet service delivery targets and put in place a generally well-functioning health system, they had to work with and through other health system actors, notably facility managers. This has not always worked as well as was hoped.

A hierarchical, autocratic, procedural mind-set. Sub-district managers felt that facility managers and their staff often upheld autocratic and procedural attitudes towards patients; attitudes that ran counter to the notions of PHC and a population health orientation, which required sharing power with patients and the community.

On their part, facility managers and frontline staff often felt on the receiving end of a top-down, autocratic, procedure- and compliance-driven system. An example was the annual service delivery targets. During strategic planning processes, these targets were set centrally and cascaded down. For the MDHS, provincial targets were passed down the hierarchy and disaggregated at each level until each frontline staff member received targets. CoCT Health also disaggregated its targets, but only to the facility manager level. Target achievement was then monitored and evaluated through regular so-called Plan-Do-Review meetings.

Higher-level managers saw these targets and monitoring processes as providing stability, clear expectations, and standard frameworks for facility managers and frontline staff to work within, but many facility managers and frontline staff saw them as disempowering, as disciplinary tools, and as instruments that enabled micro-managing by their managers.
Such working practices, and resistance to them, stemmed from the history of the South African health system and government bureaucracy, which had long been characterised by autocratic hierarchy, the importance of rules and procedures for their own sake, and the routine use of hierarchical communication practices such as standard operating procedures and formal memoranda to convey instructions to lower system levels.

Not seeing the bigger, community picture. As a rule, facility managers understood their jobs to be about managing services in facilities, managing the people delivering the services and meeting facilities’ targets. With this mind-set, their daily practice included involvement in:

- Human resource issues (e.g. could a staff member get permission for unplanned leave, were staff members taking too much leave, which staff members could go on training and when?).
- Assessing and solving problems related to the allocation of tasks and productivity of staff, the workload, and patient flow.
- The management of drugs, equipment and medical supplies.
- Controlling expenditure on selected items.
- Meetings with their managers.
- Collecting and submitting data to higher levels of the health system, as well as thinking about whether this data was complete and correct, and how it could be improved.
- Thinking about how the coverage and quality of priority programmes could be improved.
- Auditing patient records to assess quality of care.
- Dealing with patient complaints.

Indeed, managing people and relationships was the foremost demand on facility managers across all components of their job. They felt that this, and how they managed and presented themselves to others, was their most difficult challenge.

In smaller clinics, the facility manager (and perhaps a second-in-charge) did all the managerial work. In larger facilities such as community health centres, additional staff had specific tasks (e.g. a pharmacist for managing drugs) and management was centred in collective structures such as management committees. Many managers often also got involved in service delivery, especially when there was a shortage of staff. This state of affairs – the clinic focus and manager involvement in service delivery - defied the expectations of sub-district managers and was a source of frustration and complaint.

Instead of the inward focus on facility functioning, sub-district managers wanted facility managers to adopt a more outward focus to make the organising idea of their practice “the health of the population”, not just “the health of the facility’s patients”. Sub-district managers thought that facility managers did not always understand communities’ needs and access challenges, and the importance of community-based programmes. They wanted to see facility managers generate and use more data to better understand and engage with communities. Facility managers spent a lot of time addressing patient complaints, but few saw community engagement as a central aspect of their job.

Lack of pro-active decisions and actions. For sub-district managers, facility managers’ widespread involvement in service delivery was a sign that the latter were not pro-active
Managers’ facility focus and lack of pro-activeness were driven by a number of factors:

- Their training as nurses, which meant they often saw themselves first-and-foremost as nurses, valued their clinical expertise and got more job satisfaction from clinical work than management.
- The provision of very limited support when nurses were first appointed as managers, so that the nursing role remained the preferred and most comfortable one.
- The importance of service delivery targets, which often measured facility activity, and the top-down processes and culture around these.
- The significant increase over time in the number of patients coming to facilities, which limited the opportunities for activities such as home visits.
- Professional hierarchies, which sometimes made it difficult for nurses to hold doctors or older/more experienced colleagues to account.
- The hierarchical culture of the South African bureaucracy and, since the 1994 democratic transition, years of centrally-directed policy and organizational change, which led to change fatigue.

Defying the trend, some Mitchells Plain managers were more confident in their role; pro-active in managing relationships, conflict, and staff misconduct; and able to cope with staff shortages and support others, without doing the work themselves. They had made a more complete identity transition from “nurse” to “leader”, shaped by traits such as persistence and positive attitudes developed earlier in life, interest in management and personal aspirations to occupy leadership positions, and prior managerial experience that helped prepare them for their current jobs.

This perceived lack of pro-activeness also had other dimensions, including preferring to wait for written instructions from above before acting, not being persistent in dealing with facility problems, not being keen to accept new decision-making authority, and presenting new programmes as “instructions from above”, rather than being positive about them.

Some proactive programme planning occurred in the sub-district Plan-Do-Review meetings, but in their daily practice facility managers mostly reacted to demands from staff or clients to immediately solve problems related to issues such as congestion, delays and complaints. They intended to be proactive in planning annual vacation leave and training, but these schedules could change at the last-minute as new courses became available or staff took sick leave. The management of service inputs such as pharmaceuticals, which was embedded in monthly routines, was more proactive, but managers still spent a lot of time dealing with issues such unfilled orders and faulty equipment.

Various changes were implemented to address these weaknesses and frustrations. These efforts were supported by researchers from two universities who, as part of an action-learning project initiated in 2010, partnered with the Mitchells Plain sub-district.

Changes to the Plan-Do-Review meetings
Plan-Do-Review meetings were held at different health system levels. Managers would meet to assess their performance against targets, identify challenges and develop action plans to respond to challenges.
Typical practice: a description of a district-level Plan-Do-Review meeting

“A set of over 20 indicators were reviewed systematically. Taking one indicator at a time the district performance since the start of the financial year was assessed against its target. If it was not meeting the target, then time was spent reviewing the performance against the previous year’s performance for the quarter, and looking at trends over time. In addition any sub-district that was not meeting the district performance average was asked to explain their situation and how they were addressing the problem.

In reviewing the couple year protection rate, the district manager pointed out that the district was generally not doing well. He highlighted the performance of (Sub-district A) which had dropped below the baseline. He said that this indicator was driven by many component parts and that one priority component was contraception services to women under 18, and that this needed to be a particular focus going forward.

The manager of Sub-district A reported that she had done an analysis of this component but that this was now out of date and that she would repeat it. She said that this indicator was proving to be one of the most challenging. She said that her sub-district strategy was one of service integration however, while this was successful in identifying new clients, they are not retaining these new clients in care. On monitoring performance of facilities over time they found that the statistics of some of the better performing facilities had dropped. She reported that further enquiry led them to find that staff didn’t really believe in the strategy and weren’t committed to its implementation.

The district manager seemed satisfied with this report, and then invited the manager of Sub-district B to explain her sub-district’s poor performance in the couple year protection rate.”

Source: Scott and Gilson (2017)

The Plan-Do-Review meetings were linked to the top-down processes of cascading targets to district, sub-district and facility level. They were a source of worry, as facility managers often saw them as venues of criticism for not reaching their targets.

In 2010, the CoCT Health sub-district manager for Mitchells Plain began discussing changes with regular meeting participants. The key changes were decided and implemented in 2011:

- Re-naming the meeting to the Management and Communication meeting;
- A chairing style that de-emphasised didactic and instructional interaction to focus instead on facilitating discussions and debates and challenging participants to improve population health;
- A new seating arrangement, which encouraged small-group discussions and dispersed authority away from the chair of the meeting;
- A new agenda that encouraged joint planning for new initiatives, progress reports on planned activities, the sharing of good practices among facility managers, and a review of selected programmes and other challenges; and
- Careful minute-taking so that activities could be tracked and reported over time.

These changes sought to address the top-down practices linked to this meeting and the perception that it was mainly a disciplinary tool for assessing performance against largely imposed targets. The idea was to move towards more supportive interaction, facility managers sharing good practice, collaborative learning, shared accountability for improvement, and an understanding of targets as opportunities for service improvement, not just top-down and imposed goals. Another objective was to encourage pro-active planning and problem solving by facility managers, including improving their collective
understanding and ownership of new programmes and initiatives, and to build relationships among sub-district staff to enable and strengthen coordination for service improvement.

These changes yielded some early positive results, for example sub-district managers’ perception that some facility managers had taken more ownership of activities and the recording of performance gains in some of the programmes discussed in the meetings.

Key performance area process
In late 2010, the CoCT Health sub-district manager for Mitchells Plain initiated a process in terms of which facility managers, doctors and other managers were asked to develop eight key performance areas (KPAs) within the broad priorities of the City of Cape Town’s Integrated Development Plan and City Health’s annual programme of work; highlighting the outcomes they wanted to achieve, the activities through which the outcomes would become reality, and how the activities and outcomes would be monitored and evaluated.

The idea was that managers would work with their staff to identify the KPAs, that the KPAs would focus on facilities’ local, contextually-relevant needs, and that they would focus action on tackling critical blockages that prevented better health service delivery. The intervention thus sought to stimulate pro-active planning by managers, encourage persistence in tackling service delivery problems, improve managers’ knowledge of planning and the use of information in analysing problems and setting priorities, and increase ownership of priorities and programmes emanating from higher levels of the health system.

The sub-district manager first discussed this innovation in a Plan-Do-Review meeting in late 2010, after which she supported staff individually to develop their KPAs. All presented their KPAs in a later workshop and this was followed by one-on-one quarterly reviews over 2011 to monitor implementation. At the end of 2011, staff gave feedback on one of their KPAs to the renamed Management and Communication meeting and wrote a report on all their KPAs. The innovation thus contained opportunities for discussion, debate and mutual learning about planning and strategies for managing crises or tackling difficult problems. This process was repeated in 2011 for the next financial year, but was focused on only four KPAs.

Facility managers’ initial feedback was that the process was useful. The sub-district manager felt that skills had been developed, learning had been achieved, and increased ownership of processes and priorities were visible. New leadership processes had supported managers and their staff to make more sense of priorities, targets and plans and to incorporate them into their everyday practices. Over time, the positive impact of this innovation was limited by staff turnover. Newly appointed facility managers received little orientation or support regarding this process and so were unsure of what to do and what exactly it was about.

Community mapping / local knowledge workshops
In late 2010 and early 2011, the researchers working with the Mitchells Plain sub-district managers floated the idea of a community profile to complement the sub-district’s 2011/2012 strategic planning processes. The idea responded to sub-district and facility
managers’ feeling that community participation was important, but that they were sometimes unsure about how to build those relationships; some facility managers’ sense that they didn’t know their communities and if facilities’ services really responded to community needs; and sub-district managers’ frustration about facility managers being focused on patients in facilities, but insufficiently attuned to population health.

The community mapping idea was fleshed out and the activity arranged through a steering committee of community members and health service providers. Involving stakeholders such as nurses, NGOs, police fora, health facility committees and environmental health practitioners, the first community profiling workshop in May 2011 attracted ±70 participants, while the second in August 2011 attracted ±100 participants.

Because of the diversity of communities within Mitchells Plain, participants were divided into four local area groups (LAGs), each with a map of the area. On these maps, they identified issues and places of concern (e.g. substance abuse, drug selling points, illegal waste dumpsites), plotted actual and potential health resources (e.g. government clinics, private doctors, traditional healers, youth centres) and noted under-resourced neighbourhoods. This information stirred immediate actions, such as negotiations with taxi operators to change their routes to make a health facility more accessible, as well as training in hygiene promotion and the provision of hand-washing soap and new drinking water containers to crèches to promote hygiene and combat diarrhoeal disease.

After the profiling workshops, the community and Integrated Sub-district Management Team agreed on their value, for the practical actions taken, but also because relationships had been built and divisions reduced between the facilities and community, and because useful local, contextual information had been generated. Reflecting on the workshops and LAGs, stakeholders felt these processes were made possible by the values and practices of the facilitators, including being flexible and learning from mistakes, managing tensions and power relations by reminding people of what brought them together, and valuing equality by not letting certain participants dominate.

This positive experience led to the idea that the four LAGs should continue functioning. The Integrated Sub-district Management Team approved the LAG concept in September 2011 and by April 2012 terms of reference with their roles and responsibilities had been developed. From June 2012 – June 2014, one of the LAGs met monthly, two LAGs met only once or twice, and the fourth did not meet at all.

A key reason behind the one LAG’s success was the local knowledge of the environmental health practitioner, who helped the group to access government services such as reporting illegal waste dumping and leaking pipes, and motivating for trees to be planted in recreational spaces. In their most notable activity, this group spent months developing a pamphlet with information about health and other social services that they wanted to distribute door-to-door. Some pamphlets were to have a magnet, so that recipients could attach them to their fridges for easy reference. A local business printed the 4200 flyers, the
magnets were bought separately, and in June 2013 the LAG organised a workshop during which the magnets would be attached to the flyers.

On the day of the workshop, a group of new participants arrived and argued that the flyers should be divided equally between them and the longer-serving members of the LAG, as they represented one geographical side of the local area and the longer-serving members the other. After heated discussions, including claims that the newcomers were “stealing” the group, the plan to distribute the flyers in proportion to the number of houses in different areas was abandoned. The meaningful activity and resource represented by the flyer drew in new participants, changed the relationships in the group and brought to the fore existing tensions around the areas where people lived, membership of the health facility committee, and support for political parties that were campaigning in the area around the time.

Beyond challenges posed by issues such as relationships and power, various factors made it difficult for LAGs to work. First, there was little money to support community participation initiatives, whether activities such as printing flyers or basics necessities such as refreshments for participants. Second, in a provincial process in parallel to the LAGs, the District Health Councils Act came into effect in August 2011. In line with this law, the Metro District Health Council was established in May 2012, which meant that funding was withdrawn from the Cape Metro Health Forum, a long-standing but unlegislated structure under which the Mitchells Plain Community Health Forum operated. Without this funding, health facility committees became unfunded and volunteer structures, which in turn affected the LAGs’ functioning because many of their members were health facility committee members angered and disillusioned by this change. Given the limitations around budgets and wider supportive processes, some stakeholders questioned to what extent community participation was really valued relative to other service delivery priorities.

Over this time, sub-district managers’ support for population health and pro-active actions by facility managers to meet community need was not limited to the new processes of the profiling workshops and LAGs. They also cultivated the required mind-shift by being mindful of the language they used and role modelling the desired changes, for example affirming the importance of population health in all staff engagements and encouraging facility managers to align their targets with local priorities and respond speedily to patient complaints.
The importance and use of information: a window on the interplay between the old and the new

The Mitchells Plain sub-district valued generating and using formal information. This was evident in the targets set through planning processes, frontline staff’s collection and submission of data, the use of health information system data in Plan-Do-Review meetings, and sub-district managers’ bids to encourage facility managers to use data to understand communities’ needs.

The formal information was therefore bound up with planning processes that facility managers and frontline health workers found top-down and autocratic, as well as meeting practices they experienced as confrontational and disciplinary. In this mixture of authoritarian / enforcement (compliance with rules, standard operating procedures, top-down task enforcement) and transactional / performance (performance frameworks, targets) governance, Mitchells Plain mirrored the wider practices of the South African health system and public sector.

Although important and necessary, this formal information and associated processes could be:

• Counter-productive: e.g. when it bred contextually inappropriate targets, such as challenging targets for male medical circumcision in mainly Muslim communities with already high rates of infant circumcision, or seemingly impossible-to-reach targets, fuelling staff demotivation;
• Less than useful: e.g. gaps in the Human Resource Information System that caused unreliable data on leave usage, thus undermining the ability of facility managers to manage absenteeism and necessitating the development of parallel systems; and
• Distorting: e.g. the system did not routinely measure the regular occurrence of non-urgent clients being asked to return to facilities on other days because of high service demand on a particular day. Consequently, facility managers felt the problem was invisible and of little concern to sub-district managers, thus limiting the support they could expect to deal with it.

In fact, research with facility managers in Mitchells Plain showed that they required more than the formal, routine information of the health information system for their day-to-day jobs. To manage their staff and make locally appropriate and responsive decisions, they also needed informal, rich, local knowledge about community contexts, health facilities or staff. This information could be gathered by, among other things, walking around in facilities to assess the situation, responding to staff questions or patient complaints, and talking informally to staff to learn more about their personal or family circumstances. Facility managers also needed experiential knowledge, which they built up by learning from similar past situations.

While informal, local, and experiential knowledge had not historically enjoyed much support from higher health system levels, sub-district managers in Mitchells Plain have tried to value, generate and use this type of information more. Their attempts included changing the agenda of the Plan-Do-Review meeting to encourage the sharing of good practices among facility managers and the 2011 community profiling workshops – all of which de-emphasised vertical accountability, while reflecting a persuasion / co-production governance mode focused on building shared visions, enabling those lower down in the system to participate in working out how to achieve that vision, and enabling more shared accountability for common goals.

Yet, it wasn’t always possible to reconcile these governance styles and information types. In 2011, the Mitchells Plain sub-district managers asked their research partners to support a planning workshop to plan ahead for more than one year and draw in the information from the May 2011 community profiling workshop. The understandings and information generated in the profiling workshop was useful, but in the end this attempt at planning differently failed because the participants from the health facilities could not see how to translate the local, informal, contextual information and the priorities identified in the profiling workshop into the service delivery targets and activities of the planning template required by the formal planning system. The dominant governance mode and type of information was therefore difficult to change.

A key lesson from this experience was that sub-district managers needed the mind-sets and skills to work with, and to a certain extent hold in creative tension, the values of these different modes of governance so that hierarchical accountability and reporting were respected and spaces were created for much-needed informal and context-specific information, locally responsive planning, and organisational learning. In this, they also needed support from higher-level managers, particularly in the form of time and flexibility to work differently with frontline staff in ways that would support them to do their jobs and achieve health system goals.
Conclusion
This case study illustrates aspects of the day-to-day functioning and challenges of the health system in the Mitchells Plain sub-district. Although they work in a complex and less-than-ideal organizational context, it was beyond the power of the sub-district managers, facility managers and frontline staff to change it. It was also not the only source of their challenges.

Through both routine and new processes, the sub-district therefore sought to utilize other “levers of change” such as building relationships; implementing more open communication; building trust; changing people’s understanding of their jobs; distributing leadership across the system and stimulating collaborative problem-solving and shared, peer accountability for shared goals; and role-modeling change and consciously using language to signal new meaning and the importance of certain goals and understandings.

This case study is based on:

Sample student tasks / assessments

This section contains an example of an examination that can draw on this case study. This is by no means the only way of structuring student engagement and this example can, of course, be adapted to suit different courses and contexts, for example by changing its form (e.g. into an assignment) or the instructions and questions it contains.

Take-home, open book examination

Source: This example is adapted from *Introduction to Health Systems*, a course in the curriculum of the Masters in Public Health of the University of Cape Town, South Africa.

Submission and formatting guidelines

- Because this is a take-home exam, proper academic writing style, and accurate and consistent academic referencing will be expected.
- The writing should be predominantly narrative in style, although tables or diagrams may also be used.
- The entire typed exam response is expected to require between 10-12 pages of response, excluding the reference list and additional appendices.
- In writing up your analysis, please structure your submission around the following headings:
  1) Initial overview description of the case experience and in-depth analysis of the health system and its functioning
  2) Description and analysis of health system improvement actions
  3) System lessons and policy recommendations
  4) References
  5) Appendices

Part 1: Initial overview of the case experience and in-depth analysis of the Mitchells Plain health system and its functioning

In this section, draw on the case report that was provided, the discussion in class, and secondary literature to:

- Outline briefly the structure and key characteristics / nature of the health system in Mitchells Plain in 2010-2014; and
- Highlight 3 key challenges facing the system at this time.

*Use relevant theoretical frameworks or concepts of your choice to describe the nature of the system and its key challenges.*

To prepare for this analysis:

Review and revise your course work and read around the case of focus. In particular, you might want to refer back to the sessions on health system frameworks and experiences of health system development in other countries.
Part 2: Description and analysis of health system improvement actions
Linked to the 3 challenges you identified in part 1:

- Describe the most important actions and processes through which actors sought to improve the health system and address these challenges, including relevant dates and time periods;
- Identify the key agents who had some influence over, or engagement with, the health service and health system improvement processes;
  - Consider how these agents and their relationships influenced the improvement processes, and identify the factors that allowed them to have influence AND if any additional agents came to have influence over time (what influence) and whether the influence of any agents lessened over time (how).
- Analyse the goals of the health service and health system improvement actions, what was achieved or not, and the factors that supported or limited goal achievement.

Part 3: System lessons and policy recommendations (“Lessons from the case for HSS”)
From your analysis of this case experience, identify three key lessons about health system strengthening in general. Justify and explain each of these lessons with reference to your analysis of this particular experience and wider literature about health system strengthening.

To prepare for this analysis: read around other experiences of this type of intervention and health system strengthening more generally, as well as class notes from across the course.

References
List all the sources of information/papers reviewed that you have drawn on to write this response. Use one referencing convention only. Do not include references to materials that have not been used.
Appendices
Whilst you should use some illustrations (diagrams, tables) in the text itself, you may also include additional diagrams or materials not included in the text of your narrative in the appendices. However, anything in the appendices should be actively referenced in the text itself.

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<tr>
<th>Assessment criteria</th>
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<tr>
<td>Clear description of the structure and key characteristics of the health system in Mitchells Plain in 2010-2014. Identification of 3 key challenges facing the system and clear articulation of what the challenges entailed. Clear use of relevant theoretical frameworks and concepts to illuminate the characteristics of the health system and its challenges. At least 1 diagram showing agents and their relationships.</td>
<td>25</td>
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<td>Clear description of the most important health service and system improvement actions, including time periods. Full analysis of the agents involved in these improvement actions and their influence over the improvement efforts. Full analysis of the goals of the improvement actions, whether they were achieved or not, and the factors influencing goal achievement.</td>
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<td>Three lessons about health system strengthening are provided and each is well justified and explained – using broader literature to make your argument.</td>
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<td>You present a clear argument bridging across all parts of the analysis – and providing supportive evidence for your argument. Originality and thoughtfulness (reflexivity) – you present your own ideas about the case, and also show awareness of the strengths and limits of these ideas Appropriate style, adequate reading and references are used to make conclusions (10 refs minimum), spelling and grammar mostly correct, uses appropriate referencing conventions</td>
<td>15</td>
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<td>Total</td>
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