# DEPARTMENT OF HEALTH RESEARCH BRIEF

**Verbal Autopsy with Participatory Action Research (VAPAR)**
**Expanding the knowledge base through partnerships for action on health equity**

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vapar

## **Local PHC decision-making:** significant capacity exists and can be extended through cooperative learning

**RESEARCH:** HOW CAN LOCAL PLANNERS BE INNOVATIVE, EFFICIENT, RESPONSIVE?

- PHC requires staff able to incorporate policy into everyday practice. This requires leadership that enables front line staff to have discretionary power to deal with needs at front line
- This research focussed on understanding how can local planners be innovative, efficient and responsive to local conditions to improve the quality of service delivery.
- We applied 'decision space framework and examined 3 dimensions of the ability to act at facility; district-sub-district and province levels:
  - capacity (what system needs to function, resources and capacity to use them);
  - authority (clarity in roles/ responsibilities that enable staff to take action); and
  - accountability (mechanisms of responsibility within and outside system, i.e. planning, monitoring, reporting and audits, community engagement, clinic committees)

**FINDINGS:** CAPACITY CONSTRAINED BUT INFORMAL STRATEGIES MITIGATE, AUTHORITY CLEAR, CHALLENGES IN ACCOUNTABILITY

- Capacity STRENGTHS → significant informal ingenuity and capacity. System delivering on many of its goals, with areas of high achievement. High level of marked ingenuity and many informal coping strategies built on local relationships
- Authority STRENGTHS → Lines of authority well-defined at all levels, gives power to act through different roles and processes
- Accountability CHALLENGES → External accountability limited to communities. Internal accountability weak in places for individuals and focused more on meeting higher level performance (bureaucratic compliance culture) targets and less on enabling local leadership, resilience, and ingenuity

**RECOMMENDATIONS:** CAPACITY EXISTS AND CAN BE EXTENDED WITH COOPERATIVE LEARNING TO SUPPORT ACCOUNTABILITY WITHIN AND OUTSIDE SYSTEM

- Hierarchical governance - fails to account for significant local innovation, responsiveness and resilience at lower levels
- Cooperative learning can enable and encourage bottom-up, appreciative and reality-based learning and exchange
- Learning platforms provide opportunities for improved communication between district and province, encouraging constructive dialogue on problems and response strategies

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| FRAMEWORK 1 | STRENGTHS | CHALLENGES |
|---|---|---|
| **Capacity:** resources (administrative, technical, organisational, financial and human resources) and capacity to manage<br><br>**Staffing:** control over hiring, payment, performance assessment and management, and motivation<br><br>**Financial:** adequacy, regularity, flexibility, predictability<br><br>**Management:** (planning and management technical skills) staff, medicines and supplies and infrastructure, access to information and ability to use it<br><br>**Leadership:** ability to create and share organisational vision and motivate staff | **Facilities**<br>• significant potential in local management and organization to improve care<br>• Providers highly satisfied with the nature of their work and generally with relationships with colleagues<br>• Strong personal commitment<br>• Responding to shortages, some staff act outside mandated professional scope<br>• Informal strategies: sharing supplies; shortening length of prescriptions; or ordering more supplies than warranted owing to regularly receiving less than is ordered<br><br>**District/sub-district**<br>• Annual planning optimistic about achieving targets while acknowledging reality of under-resourced and dysfunctional system<br>• Province<br>• - | **Facilities**<br>• Staffing insufficient/absent health workers, staff vacancies<br>• Competency gaps (e.g. in IMCI), lack of support, poor motivation, infrequent supervision and trainings<br>• Infrastructure/supplies: Lack of consulting rooms, water outages. Higher throughput than manageable. Overcrowding, long waiting times, delayed/postponed consultations.<br>• Lack of local purchasing autonomy → interrupted medicine supplies<br>• Lack of local maintenance planning. → even minor upkeep expenses difficult to access in centralised budget<br>• Shortages of ambulances. Nurses cannot reach communities to support CHWs<br>• Information: limited information on cause of death, lack of information on critical limiting events<br>• Patient file management problematic, HMIS implementation moved to National level<br>• Strategy: Many initiatives overall destabilising/over-burdening → results manipulated to show progress<br><br>**District/sub-district**<br>• Staffing: staff shortages, high turnover, absenteeism, poor organisational structure, lack of outreach<br>• Hiring recentralised due to poor practices → long delays hiring even basic support staff<br>• Staff concerns re lack of safety: personal protection against attacks and poor working environments<br>• Infrastructure/supplies: Vital equipment unavailable due to budgetary constraints<br>• Centralisation of maintenance budget, expensive and to access and unreliable → maintenance failures<br>• Supply chain management slow and staff competency questioned → delays in procurement<br>• Under-supplied, insufficient and poorly distributed CHCs<br>• Skewed utilisation of health services between PHC and secondary levels<br>• Finance and support services centralised → limited capacity among district officials<br>• No programmes budgets allocated to district and sub-district, decreasing allocations at provincial level<br><br>**Province**<br>• Staffing: appointments often based on personal networks → competency shortfalls. Hiring centralised due to poor practices → hiring freezes, workforce not funded or effectively distributed<br>• Problems with staff morale and capacity, insufficient training<br>• Infrastructure/supplies: tender mark-ups, shortfalls in provision, poor quality, poor storage and stock management practices, equipment not in good working condition<br>• Information: based on DHIS and periodic surveys, gaps from community level<br>• Strategy: poor project management, 'crisis control'<br>• Finance: budgets reallocated without adjusted targets → frustrates service delivery<br>• National Treasury reports misappropriation, Auditor General reported R310M irregular expenditure 2017/18<br>• Resource shortfalls/low spending per capita: initiatives (eg Ideal Clinic) come with no additional funding<br>• Annual budget not aligned with population growth, unequal expenditure across districts/ sub-districts |

| FRAMEWORK 2 | STRENGTHS | CHALLENGES |
|---|---|---|
| **Authority:** defined as roles and responsibilities that enable managers and staff to take action | **Facilities**<br>• Key roles are clearly defined. These include, in hospitals, the Chief Executive Officer and Management team, including Clinical Manager and Nursing Manager (the in-charge in hospitals), alongside (mainly in tertiary and regional hospitals) specialist staff, such as hospital-based paediatricians. Within clinics, Operational Managers are in-charge<br>• No supervisory link between district hospitals and CHCs or clinics, which are supervised by PHC supervisors, in sub-district<br><br>**District/sub-district**<br>• District and sub-district roles are clearly defined<br>• District Health Management Team (DHMT) leads service coordination<br>• Primary Health Care Director responsible for a number of programmes<br>• MCWYH coordinator responsible for range of priority programmes<br>• District Clinical Specialist Teams (DCSTs) were established in 2012 should have autonomy to improve clinical governance<br>• Operational support to hospitals and health centres in local areas<br>• PHC Manager supervises implementation of priority initiatives<br>• MCWYH programme coordinator gives technical guidance and supervision to facility staff in areas such as child health<br><br>**Province**<br>• Roles/responsibilities clearly and formally defined and widely understood | **District/sub-district**<br>• Some confusion over mandates especially DCSTs role in routine clinical governance at district and sub-district levels, including the work of PHC coordinators and facility in-charges<br>• Roles clearly defined and understood, however some potential for duplication<br><br>**Province**<br>• Real and stated staffing do not always align and organograms often remain in draft for extended period and/or are outdated<br>• Vacancies for extended periods, staff widely called upon to informally fill vacant positions.<br>• Acting roles often taken on in addition to formal roles and without delegated responsibility or remuneration<br>• Contributes to 'authority vacuums', where staff do not feel empowered to take required decisions<br>• Overstaffing of some senior management positions<br>• Fluidity in roles and responsibilities reported, as well as insecurity for staff, waste and instability |

| FRAMEWORK 3 | STRENGTHS | CHALLENGES |
|---|---|---|
| **Authority:**<br>• Vertical systems within an organisation, such as planning, target setting, supervision, monitoring, reporting and audits,<br>• Community accountability to strength public accountability through direct involvement of clients, users or the general public in health service delivery. formal mechanisms such as health facility committees and hospital boards. | **Facilities**<br>• CEO/hospital management team report to hospital boards. Equivalent is clinic committee at PHC level. Committees should be made up of elected community representatives/health professionals allowing concerns to be heard/addressed<br>• Portfolio Committee report 2017/18 reports constraints to functionality in some hospital boards and that community protests have resulted in the removal of some CEOs, indicating a form of informal accountability claimed by communities<br>• Litigation becoming common, mainly has consequences for provincial budgets more than for facilities or practitioners.<br>• Audits/adverse event reporting/committees part of QA process, committees vary in activity<br><br>**District/sub-district**<br>• Upward accountability - clear (quarterly reviews and annual reports against targets)<br>• Main accountability of the MCWYH programme coordinator is to DHMT, rather than to technical leads at provincial level<br><br>**Province**<br>• Formal structures for planning, budget-setting and performance targets in APP<br>• Range of structures/processes in provinces aligned to national governance<br>• Downward accountability - designed to be bottom-up (district plans feeding provincial plans) however reverse happens in practice (see next column)<br>• Collective responsibility- mechanisms strong | **District/sub-district**<br>• Hospital boards have power including to go to provincial leadership with problems but tend not to/often focused on political priorities → boards can lack capacity<br>• Various mechanisms to support community engagement: complaints systems, satisfaction surveys and waiting times reporting, but not seen as comprehensive<br>• Clinics required to hold Open Days as part of Ideal Clinic initiative, however limited attendance and substance, communities generally already aware of clinic services<br>• HBCs, CHWs and WBPHCOTs visible links communities/ facilities. However, many demands, limited recognition, no additional resources, rapidly expanding mandate<br>• Clients use direct action (protests, media, increasingly social media) rather than formal channels to address grievances. These are problematic, imposing system costs. Do not represent balanced/constructive input from community<br><br>**District/sub-district**<br>• Downward accountability - links to facilities are limited, and vertical communication often depends on personal relationships<br>• Upward accountability - feedback from above tends to be focused on problems, more than identifying, understanding, supporting and enabling local leadership, supervision and innovation (e.g. coping strategies around medication shortages described above)<br><br>**Province**<br>• Downward accountability - provinces set priorities/targets divided between districts → districts lack ownership of targets, district performance/accountability not visible<br>• Budgets supposed to be set bottom up according to plans, in reality set top-down with managers given ceilings to work within<br>• Programme budgets reallocated to shifting priorities (including political), with better-connected managers often protected from variance → undermines accountability<br>• Few consequences for poor management/transgressions, poor response in addressing root causes of poor audit outcomes, and an overall lack of key controls<br>• Individual accountability - rewards and sanctions are selective<br>• Upward accountability - to national level (or technical support from it) limited unless programmes recipients of national conditional grant (for HIV/AIDS, STIs and TB)<br>• Other programmes rely on annual distribution according to provincial APP from 'equitable funds' allocated from national level |

| FRAMEWORK 4 | STRENGTHS | CHALLENGES |
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| **Context:**<br>• Socio-cultural and political factors influence all these relationships, which together affect roles and responsibilities in the health system, its responsiveness and how resources are used | **Facilities**<br>• Constitutional commitment to the right to health and community participation for PHC (National Health Act, 61 of 2003).<br>• Significant pro-poor, equity-oriented reforms include: National Health Insurance PHC Re-engineering including Ward-Based Primary Healthcare Outreach Teams (WBPHCOTs) decentralising PHC to community level;<br>• Ideal Clinic initiative, which provides a national quality framework<br>• National annual performance plans address workforce development and planning with initiatives on affirmative student recruitment, financial incentives, foreign recruitment and compulsory post training service as well as commitments to strengthen the public health workforce through National Health Insurance (NHI) and the National Development Plan (NDP) | **District/sub-district**<br>• Significant gaps exist between policy and implementation<br>• Chronic underinvestment, human resource crises, widespread corruption, poor stewardship and deteriorating infrastructure<br>• 'Quadruple' burden of socially patterned mortality comprising chronic infectious diseases (HIV/AIDS and TB), non–communicable conditions, maternal and child mortality, and mortality owing to injury and violence<br>• The burden of HIV is high and highly unequal. Prevalence in black populations is 40–50 times that of white and in adolescents, risks are eight times higher in females than males<br>• Child poverty rate relatively high and Gini coefficient at 63 is the highest globally, with the majority black population remaining disadvantaged<br>• Provincial unemployment was 35%, with 51% living in poverty<br>• In 2015, life expectancy for males and females was 50 and 53 years respectively, lower than the national average of 60 and 67 years, and under-5 mortality was 41 deaths per 1,000 live births in 2012, which is comparable nationally. |

| FRAMEWORK 5 | STRENGTHS | CHALLENGES |
|---|---|---|
| **Interactions** | • Capacity and authority also need to go in step if resources are to be used well<br>• Bureaucratic accountability mechanisms often constrain the functioning of external accountability mechanisms | • Where resource capacities fall short of what is required for organizational functioning, managers may resort to informal decision-making strategies to fulfil responsibilities and mitigate bureaucratic constraints<br>• Bureaucratic accountability mechanisms often constrain the functioning of external accountability mechanisms/ bureaucratic accountability can crowd out community accountability creating a 'compliance culture' which focuses more on tasks than outcomes. |