Crises, Routines and Innovations: The complexities and possibilities of sub-district management

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Districts and sub-districts are crucial to the functioning of the district health system and the successful implementation of health sector reforms, which have been at the centre of public debate in the past few years. While policy intentions and service challenges are much debated, little systematic discussion is held about the internal operations and functioning of sub-districts and districts. These dynamics will strongly influence the implementation of the reforms proposed.

This chapter discusses the complexities and challenges of managing a sub-district, using as a case study the Cape Town sub-district of Mitchell’s Plain. Drawing on debates in systems thinking and management theory, the role of districts and sub-districts at the interface between strategic policy direction and operational service implementation is discussed. The chapter uses experience from an action learning project in Mitchell’s Plain to present examples of innovation aimed at strengthening leadership and routine management functions. We argue that routine management in an environment of stress, constraints and uncertainty requires that managers be resilient, reflective, and continuously able to learn, analyse and adapt. Management and leadership development programmes should focus on developing these capabilities (within and beyond the classroom), in addition to developing technical skills and capacities.

Routine management in an environment of stress, constraints and uncertainty requires that managers be resilient, reflective, and continuously able to learn, analyse and adapt. These are the characteristics of good leaders.
Introduction

The district is the cornerstone of South Africa’s health system. Since 1995 a series of policies and interventions have contributed to shaping the South African District Health System (DHS) in its present form. These policies and interventions have ranged from establishing district boundaries to clarifying the relative roles of provincial and local government in delegating authority and drawing up district health planning processes.1-4 The 2011 proposals for both Primary Health Care (PHC) re-engineering5 and National Health Insurance (NHI)6 reaffirm the foundational role of the DHS within the health system and as the vehicle through which PHC will be delivered. A core objective of the NHI pilot sites is the development of innovative ideas about how to strengthen the DHS.

Alongside structural and organisational innovations and interventions have been discussions and concerns about standards and the performance of the DHS. Politicians, officials, media and researchers have frequently pointed to uneven and often poor access to and quality of health services throughout the country. The Health Systems Trust’s annual District Health Barometer provides publicly available data on key indicators of structure and performance across all health districts in the country, which reflect vast unevenness in performance. One of government’s responses to its growing concern with quality and performance has been the move towards the establishment of an Office of Health Standards Compliance which will audit standards of care, from patient rights to infrastructure and clinical support in health facilities.

But while poor quality and inequitable access to health services are acknowledged, in contrast, little information is formally available about the dynamics, opportunities and challenges of routine operations in a South African health district (although the 2001 South African Health Review did air the voices of district managers).7 Yet change in the organisational culture of the South African health system is recognised as a key requirement for implementing current policy priorities and improving performance and quality of care.8,9

Understanding health system capacity and complexity

Literature from outside the health sector also highlights the importance of daily practices and routines to an organisation’s collective capacity; i.e.:

that combination of attributes that enables a system to perform, deliver value, establish relationships and to renew itself ... the abilities that allow systems – individuals, groups, organisations, groups of organisations – to be able to do something with some sort of intention and with some sort of effectiveness and at some sort of scale over time.10

As summarised in Figure 1, organisational capacity rests on three interacting dimensions: the hardware of infrastructure, technology and funding levels; the tangible software of knowledge, skills and processes of decision making; and the intangible software of relationships, communication practices, values and norms. The intangible features are particularly important in shaping the behaviours of those working in the organisation and underpin its “power to perform”. Organisational practices and routines are located in the software dimensions, but are shaped by the organisational hardware.

In the health literature the particular importance of the intangible capabilities of systems (and the time and patience it takes to build strong and resilient systems) has been highlighted in the 2011 publication Good Health at Low Cost – 25 years on.12 This publication reports on an assessment of the health systems of five countries (Bangladesh, Ethiopia, Kyrgyzstan, Tamil Nadu (India), Thailand) that have achieved better health outcomes than neighbouring countries with similar incomes. Beyond policy actions around human resources, healthcare financing and drug supply, government leadership and vision and organisational software were found to be important in sustaining health system resilience to withstand shocks and secure good health at low cost.

Figure 1: Organisational capacity to function as a resilient, strategic and autonomous entity

Intangible software: capabilities to commit and engage; adapt and self-renew; balance diversity and coherence through:

- Values and norms
- Relationships
- Communication
- Power

Tangible software

- Management knowledge and skills
- Organisational systems and procedures

Hardware

- Infrastructure
- Technology
- Finances

Source: Adapted from Aragón, 2010.11
Such shocks included the changing health demands associated with epidemiological and demographic transition, new drugs and technology, wider economic crisis – and the quite frequent waves of health reform initiatives in every setting.\textsuperscript{13,14} The key features of successful health systems identified in this study are summarised in Box 1 below.

**Box 1: Key features of successful health systems**

- A health system has been found to be successful when it:
  - has vision and long-term strategies;
  - takes into account the constraints imposed by path dependency;
  - builds consensus at societal level;
  - allows flexibility and autonomy in decision making;
  - is resilient and learns from experiences, which it feeds back into the policy cycle;
  - receives support from the broader governance and socio-economic context in the country and is in harmony with cultural and popular preferences;
  - achieves synergies among sectors and actors; and
  - demonstrates openness to dialogue and collaboration between public and private sectors with effective government oversight.

**Source:** Balabanova et al., 2011.\textsuperscript{12}

Worldwide, these and similar experiences are leading health system practitioners and scholars to look to complexity theory and systems-thinking approaches to aid their understanding of what health systems are, how they operate and how to strengthen them. Adams and de Savigny noted in 2012:

Health systems are complex. Failing to take this complexity into account will continue to hinder efforts to achieve better and more equitable health outcomes. Understanding and working with complexity requires ... dynamic and holistic approaches that appreciate the multifaceted and interconnected relationships among health system components, as well as the views, interest and power of its different actors and stakeholders.\textsuperscript{15}

From this perspective health system strengthening is about building a learning culture and promoting collaboration across disciplines, sectors and organisations. Importantly, strengthening health systems involves developing leaders distributed across the system, who work to transform existing routines and practices.\textsuperscript{16}

These understandings of collective capacity and systems suggest that strengthening the South African DHS requires better understanding of what a South African health district looks like from the inside – what the daily routines and challenges of district managers are and what opportunities they contain for strengthening the DHS software.

**A case study in sub-district functioning and innovation**

This chapter addresses these issues by presenting a case study of one urban sub-district as a stimulus for reflection elsewhere in the health system. Although not all provinces have yet established sub-districts, Naledi et al.\textsuperscript{7} note the critical importance of stronger sub-district management in PHC strengthening. We also suggest that the experience presented here can stimulate debate about broader district functioning. Whilst the specifics of this sub-district will clearly be just that, specific to its context, many of its critical features are likely to be more widely shared – importantly, the location of districts and sub-districts at the interface between strategic policy direction and operational service implementation. Early reviewers of this chapter, have confirmed that this particular experience is reflected in other areas of the country. Management commonly requires: working within multiple lines of authority and managing multiple demands and many sets of actors; seeking to lead and supporting others to lead; and challenging organisational cultures whilst being subject to continuing uncertainty and change in structural arrangements and delegations.

Some of the experiences from this case study indicate the possibility of innovating within this complexity, of initiating the processes of software change that are essential for implementing policy reforms and achieving service delivery improvements.\textsuperscript{9,17} We present them to encourage a wider sharing of experience about the processes of positive change that are already occurring, mostly unnoticed, within the South African health system. In addition, we argue that stimulating and generating positive organisational change is a key task of managers and leaders, which requires new understandings of the managerial/leadership role and new approaches to health system research. The case study reported on in this chapter, has been developed as part of a wider action learning project partnership between health services and academic groups – the DIALHS project\textsuperscript{\textsuperscript{a}} – that seeks to understand and improve health system governance. Through collaborative action learning and reflective practice the case study draws on a combination of managerial tacit knowledge and scholarly understandings, brought together through a series of conversations and engagements among the authors.

This is a case study of the Mitchell’s Plain sub-district in Cape Town. Health service delivery in Mitchell’s Plain is under the dual authority of the Metro District Health System (MDHS) of the Western Cape Department of Health and the City of Cape Town (CoCT) health department.

Box 2 provides more details about the sub-district, which is a relatively low-income community (with 83 informal settlements). The community has a relatively poor health status and health problems that reflect the South African quadruple burden of disease. Although the Mitchell’s Plain 2010/11 PHC utilisation rate was not as high as in other areas in Cape Town, the MDHS as a whole managed a ten-fold headcount increase between 1994/5 and 2011/12 – reflecting the combination of a growing population and disease burden, and improved access. Relative to population and headcount levels, Mitchell’s Plain is under-resourced compared to other Cape Town sub-districts. Clinics in Mitchell’s Plain on average each serve a population of over 64 000 (the target for urban areas is 24 000). Daily workload averages in 2010/11 were 40 patients per medical officer in Community Health Centres (CHCs) and 50 patients per professional nurse in clinics and CHCs. Despite the challenges, a range of service indicators point to a strong health service performance in the sub-district. It also has a TB cure rate of 88%, immunisation coverage of 93% and 56% of antenatal care (ANC) visits occur before 20 weeks.

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\textsuperscript{a} The District Innovation and Action Learning for Health System Development (DIALHS) project is a partnership between the City of Cape Town and the Western Cape Department of Health and the Universities of Cape Town and the Western Cape funded by the Atlantic Philanthropies.
Box 2: Mitchell’s Plain health system profileb

Population: In 2010/11, the population was estimated at 510,267, 88% of which do not belong to a medical aid scheme.

Health status: Just over half (5.5%) of the children under-five present with failure to thrive. The infant mortality rate is 14 per 1,000 live births and there is a high incidence of diarrhoeal cases and other illnesses related to poverty. The tuberculosis (TB) incidence is 687 per 100,000 and the sub-district carries a quadruple burden of disease, with a co-infection rate of TB and HIV of 50% and non-communicable diseases, mental ill health and violence putting serious strain on services. Substance abuse affects most households.

Government health services
The following services are provided to the population by the government:
- community-based service platform managed through MDHS and environmental health services managed through CoCT;
- nine CoCT clinics staffed by nurses;
- four CHCs (3 MDHS, 1 CoCT), with medical and nursing staff; 1 offering 24-hour services, 3 offering 8-hour services; and
- one Level 1 hospital with 188 beds, which is currently being decommissioned. A new Level 1 hospital with a future capacity of 220 beds is under construction, to be opened in 2013.

Financing 2011/2012: 
- R358 per uninsured head (district average of R533; national average of R514)
- An average of R147.40 is spent on each PHC visit; the district average is R147.40; while the national average is R176.

Government health service performance indicators:
- The total headcount for PHC facilities was 9.9 million in 2010/11.
- The 2010/11 PHC utilisation rate stood at 2.85 per uninsured head (district average of 3.7; national average of 2.3).
- In 2011/12 88% facilities were supervised monthly (district average 56%; national average of 68.8% in 2010/11).


The complexity of the sub-district health system

Figure 2 shows the organisational complexity of the sub-district and how it is situated within municipal and provincial district structures. As Mitchell’s Plain is located in a metropolitan area, provincial and local government have dual, overarching responsibility. Managers from the MDHS sub-structure and from the CoCT sub-district independently manage the services that fall under their jurisdiction. They also coordinate services, through the Integrated sub-district Management Team (ISDMT), in areas agreed within the annually renewed service level agreement (SLA). In addition, as elsewhere in the country, these managerial teams are jointly and separately responsible for: Level 1 hospitals and PHC facilities; specific health programmes (e.g. environmental health and TB/HIV); contracts with non-profit organisations (NPOs) that support community health workers (CHWs); and a range of support services (e.g. finance, supply chain and health information). The Mitchell’s Plain managers are answerable to the MDHS Chief Director and to the Executive Director of Health, CoCT, respectively. At district level, the district executive (DEX) provides joint oversight of services. Programme managers at CoCT and provincial level, such as TB/HIV managers, also provide some support to the sub-district. The MDHS Chief Director is, finally, responsible to the Deputy Director-General for the DHHS at provincial level, and the Executive Director for Health to the City Manager.

Although they work within a complex hierarchical structure, local managers now hold substantial delegated decision-making power. Both city sub-district and provincial sub-structure managers, for example, have the authority to move posts between facilities within the sub-district, aided by relevant guidelines and tools and working within existing salary budgets. In the City structures drugs are procured via the Central Medicine Depot (CMD) by the sub-district pharmacist within an allocated budget. Additional funds need to be advocated to the district executive, e.g. when antiretroviral services are introduced in a new clinic. The increased pharmaceutical needs are then included in future planning. In the MDHS, however, each facility has a pharmaceutical budget and each pharmacist, together with the facility manager, is responsible for the management of this budget and for procurement from the CMD. Finally, in the provincial structure the securing of the budget for capital equipment is a centralised process, while procurement of equipment is a sub-structure function. Similarly, in the City, purchasing equipment is decentralised to the sub-district and procurement is based on the needs of facilities. The challenge, however, is that the budget for capital equipment is always insufficient.

Organisational complexity has historical and cultural dimensions in every setting. The South African health system has a particular history of severe health service fragmentation and inequity. Today only two authorities manage health services within Cape Town. However, different histories and cultures continue to influence interactions among the sub-district actors. These include differences in their past service responsibilities. For example, local government has always focused on preventive and promotive services, basic curative services for children, and infectious disease control while provincial government has focused on hospital curative care. Local government has also followed a nurse-led service model while the province has used a doctor-led model.

Management structures in the two authorities have, moreover, evolved at different paces. The MDHS is a very new structure, as it was only formalised during the 2008/09 financial year, in line with the National Health Act (Act 61 of 2003), with new managers appointed to Mitchell’s Plain in 2008. In contrast, CoCT health management structures were consolidated in 2000 and the Mitchell’s Plain sub-district manager has been in the post since 2005. At the same time, although CoCT sub-district managers were previously seen as having a fair degree of decentralised decision-making authority, MDHS sub-structure managers have in a fairly short period of time been given perhaps greater levels of decentralised authority.

However, organisational histories and cultures are slow to change and South African state bureaucracies come out of a history of autocratic hierarchy and deference, which complicate and
Figure 2: Lines of authority in the Cape Town Metropolitan Health District

AD – Assistant Director;  
CBS – Community Based Services;  
DD – Deputy Director;  
DEX – District Executive;  
EHP – Environmental Health Practitioners;  
FM – Facility Manager;  
HIO – Health Information Officer;  
HR – Human Resources;  
ISDMT – Integrated Sub-district Management Team;  
MSAT – Multi-Sectoral Action Teams;  
PMTCT – Prevention of mother-to-child transmission;  
SD – Sub-district;  
SS – Sub-structure;  
STI – Sexually Transmitted Infection.

**Glossary:**  
Line management function  
Support function  
Collaboration
delay moves to encourage initiative, innovation and distributed leadership. Many of the findings of the Local Government and Health Consortium, which reviewed the DHS in the early 2000s, are still relevant today, despite substantial de-facto decentralisation of decision-making powers: “People at every level, but particularly front line managers and providers, feel that they work in isolation from others at their own level, and face a top heavy and rigid management hierarchy that imposes multiple and often conflicting demands.”

Health staff in the sub-district are often passive in their decision making and tend to wait for direction from above. At the same time, they experience managerial direction from higher levels as instructional and authoritative. The common use of bureaucratic procedures such as standard operating procedures and formal memos to guide the actions of lower-level staff adds to their experience of hierarchy and supports a compliance culture. As discussed later, these patterns represent a significant challenge for sub-district managers.

The complexity of sub-district management

Within these complex organisational health system structures, and given delegated authority, sub-district managers occupy a pivotal position: the point where strategic direction has to be translated into daily system functioning and service delivery. From this position they have to mediate between, translate and integrate national, provincial and local service plans and initiatives; take responsibility for meeting delivery targets; and manage the operational efficiency of the PHC system.

What does this mean for their routine managerial reality? This work provides three core insights, which are discussed in the sections below:

➢ Sub-district and managers routinely manage a mix of expected and unexpected demands, activities, and larger and smaller crises that occur at the front line of service delivery;
➢ They manage an intricate network of role players; and
➢ They engage in multiple formal and informal planning and management processes, either through meetings or through individual interactions with staff. (See Box 3)

Managing behind the front line of service delivery

Like all managers, sub-district managers simultaneously have to translate strategic policy decisions into operational directions and have to account for operational performance in relation to strategic policy objectives and targets. Their daily practice is also composed of both routines and crises; they spend an inordinate amount of time dealing with service delivery dysfunctionality, very often generated by a lack of proactive management at lower levels of the system. From the sub-district managers’ perspective, facility and operational managers are often “unable to see the big picture” and some seem unable or unwilling to manage and see themselves as responsible and accountable for implementing policies.

Three typical and recurring examples of managing behind the front line are:

➢ efforts to enable and encourage facility managers to conduct daily assessments of clinic staffing needs relative to patient load and allocate staff to service these needs;
➢ encouraging facility managers to follow up and deal proactively with patient complaints (see Box 4); and
➢ addressing poor staff performance in such action.

In all cases the sub-district management challenge lies in enabling and encouraging facility managers to develop a proactive management role. Proactive management involves guiding or instructing facility staff, delegating tasks, and holding staff to account. Such proactive management is hampered by challenging working environments (which include very high patient numbers, staff shortages and abusive patients) and challenges of existing organisational culture, particularly nurses’ reluctance to hold doctors and older colleagues to account. Many facility managers are seen either as being invisible in the facility (and thus not guiding and supervising their staff) or as spending too much time delivering services instead of fulfilling their management roles.
Dealing with staff discipline, which includes dealing with theft and abuse of government resources, is another key feature of routine sub-district managerial practice. Although they vary in degrees of severity and formality, disciplinary processes are time- and energy consuming. They require numerous meetings and often conflictual engagements with relevant staff. Sub-district managers are also, ultimately, held responsible for patient complaints that originate at facility level. As shown in Box 4 responding personally to patients or following up on other managers tasked with dealing with complaints is time consuming. Having the experience and confidence to navigate the complexity of HR procedures and personal relationships is vital for sub-district managers.

Managing multiple actors

The central task in navigating the structural complexity of sub-districts described earlier is engagement with the multiple actors that inhabit these structures. (See Figure 3.)

Sub-district managers not only routinely engage with their teams and the staff who report to them, as described above ("managing down"), but also "manage up." They do this through their formal lines of reporting and accounting to district level and by informal reporting and accounting through frequent, ad hoc meetings with district managers and politicians (e.g. when the member of executive council (MEC) or mayoral health committee member visits the sub-district). Managing up also includes advocacy for local priorities and needs within district planning and management processes and for resources to meet service delivery imperatives brought down the system from higher levels. These imperatives can be annual service delivery targets or centrally led campaigns, such as the 2010 HCT campaign, or unforeseen health ‘events’, such as the 2010 measles outbreak in Cape Town.

In addition, sub-district managers also “manage out” through multiple engagements with structures and processes beyond the health sector. These include engaging and ensuring the functionality of clinic committees; participating in civil society structures such as the City’s Multi-sectoral Action Teams (MSATs); and participating in, receiving instructions from and accounting to Integrated Development Plan (IDP) processes and public consultations. Engagement also takes place with colleagues and structures from the parallel authority, through the ISDMT, and in programme areas where the authorities share responsibility (e.g. the HIV, AIDS, STI and TB (HAST) programme).
Managing meetings and planning processes

The final set of managerial routines in Mitchell’s Plain, as in other sub-districts, encompasses a range of formal and informal, regular and ad hoc meetings and planning processes.

Regular meetings in “one-on-ones” provide an important space for sub-district managers to engage in depth with their staff, to discuss progress and challenges and to guide and mentor. These meetings are complemented by ad hoc meetings and engagements as the need arises and quarterly supervision visits to all facilities. In this sub-district the CoCT sub-district manager and PHC coordinator meet monthly on a one-on-one basis with all facility managers and conduct monthly supervision visits to all PHC facilities. In the MDHS, the Deputy-Director: PHC also ensures that all PHC facilities are visited monthly. Both authorities use audit tools in their supervision visits, although these are different tools. Supervisors prepare written reports on the basis of the visits.

Within the MDHS, and following provincial frameworks, a performance appraisal system also exists in which each employee, including facility managers, establishes a set of personal performance targets for quarterly review with line managers. These performance targets may lead to development plans in response to poor performance or cash bonuses for excellent performance (shared among all facility staff). In the CoCT, however, performance appraisal procedures currently apply only to sub-district managers, heads of environmental health, programme managers and programme coordinators and do not apply to facility managers.

The sub-district managers also meet regularly and on a personal basis with the MDHS Chief Director and the Executive Director for Health, CoCT, respectively. Budgets are a standing item at these meetings, which provides the opportunity to discuss changes, needs and challenges.

Formal meetings are used to make collective decisions through negotiation, mediation, instruction and persuasion. Joint meetings at different levels allow coordination between authorities within the broad framework of the SLA. Within each line of authority, meetings at different system levels provide opportunities for managers higher up the system to communicate with lower-level managers, hold them accountable for the performance of their services and offer them support and mentorship. Lower-level managers can bring service delivery problems and needs to the attention of higher-level managers at these meetings. The strong emphasis on performance accountability is indicated by the naming of several meetings as “plan, do, review (PDR) meetings”. This name indicates that these meetings are used to review service performance indicators against target levels with the intention of identifying problems that undermine service delivery and of considering appropriate remedies.

These various sub-district meetings are part of wider health planning processes. District health plans and district health expenditure reviews are nationally agreed processes that are aligned with national planning frameworks that emanate from National Treasury and the Department of Health (such as the Medium Term Strategic Framework and the NDoH Strategic Plan). This means that, as in other provinces, the Western Cape’s Annual Performance Plan (APP) is nested within the provincial five-year strategic plan and provides the basis for quarterly performance reports to the NDoH against a combined set of nationally prescribed indicators (and any identified by the PDOH as provincially relevant and aligned with national health system objectives and targets). The annual MDHS District Health Plan links with the provincial APP and identifies priorities and sets performance targets for MDHS services and facilities. Through the SLA targets and priorities are set for those provided jointly with the CoCT.

In Mitchell’s Plain an additional complexity exists, which is working within the planning cycles of two authorities – including the different financial years of local and provincial governments. In parallel to the provincial government, the CoCT develops its own business plan. This plan is informed by the Integrated Development Plan (IDP), developed across sectors and through consultation at local level, and establishes priorities and targets for CoCT services and facilities. Targets that apply to the Mitchell’s Plain sub-district are, therefore, cascaded down the health system through both lines of authority and, as noted, are regularly reviewed in the PDR meetings.

Health planning processes seek to provide forward direction through health system complexity, in pursuit of improved health system performance – focused on future population health needs rather than past service provision. However, as elsewhere in South Africa, in Mitchell’s Plain this forward movement faces two key challenges. First, the link between plans, targets and operational budgets is tenuous as historical budgeting remains the norm across the country (with only year-on-year incremental adjustments linked to inflation). Second, planning processes are implemented within the wider organisational culture of hierarchy and deference. Nationally, the implementation of the Public Finance Management Act (PFMA), for example, is widely understood to be about compliance with specific rules rather than value for money in performance.21 In Mitchell’s Plain, target setting and review in PDR meetings is also quite widely perceived as an instructional and compliance process.

Nonetheless, the annual planning process provides a framework that has brought predictability and standardisation to planning and management across the MDHS. It has also established a joint planning platform for coordination not only of MDHS/CoCT service provision but also between programmes and facilities. Given the very fragmented service provision of the past, this represents a new way of doing business and one that is necessarily and appropriately oriented towards the provision of comprehensive PHC services. The provincial Comprehensive Service Plan of 2010-2020 has helped the Mitchell’s Plain sub-district with the construction of a new district hospital to strengthen the service platform. This has filled a severe key service gap.

Doing business differently

With the planned and actual devolution of authority to sub-districts, South African sub-district management must take on, as central to its work, the functions of managing strategically, guiding innovations and providing direction, and proactively planning for and managing resources to address local needs. “Doing things differently”; problem solving to improve service delivery, making better use of existing resources and translating strategic priorities and direction into operational functioning are the tasks that take up the time of sub-district managers. Yet, as the Mitchell’s Plain experience illustrates, the existing organisational culture, combined with staff not taking ownership of new actions, underpins operational inefficiency, undermines the persistent action necessary to sustain service improvement and prevents the benefits of higher-
level planning filtering down into daily practice. Those at the bottom of every health system have discretionary power and through their daily practices act, mostly inadvertently, to subvert new directions.

The existing ways of working are a constant reminder that mind shifts and learning to do things differently take time and require capacity, confidence and trust. Sub-district managers solve crises while simultaneously building the capability and commitment of operational and facility managers so that they can reduce the need for crisis management and improve service delivery.

Against this background, the three conceptualised innovations of the DIALHS project outlined below all aimed to encourage managers to plan ahead, take ownership of their authority and build confidence, either within routine processes or through new initiatives. The innovations aimed at providing constructive accountability among health system actors. All of the innovations have engaged front line staff and all represent adaptations of existing operational routines that aim to change mind-sets and link to larger-scale planning processes. In this sense, they represent “small wins” – changes in routines that are small enough to be accepted and easily implemented, but that have a ripple effect in the system and generate longer-term and larger-scale benefits.

Three of these innovations are outlined in more detail below. Each sought to:

➢ support trust building and relationship development among actors at the front line of the sub-district health system and encourage collaborative and pro-active problem solving to improve operational efficiency; and

➢ develop personal confidence, technical skills and relationships of constructive accountability that can sustain action to improve policy implementation and service delivery.

Whereas two of the innovation ‘cases’ represent changes in routine management practices, the third case is a new initiative, which was aimed at modelling new ways of thinking about planning and management within a stronger population orientation for sub-district healthcare delivery. Of the three, the re-organisation of the monthly PDR meeting as the Management and Communication (M&C) meeting most clearly fits the definition of a small win. However, the facility manager “key performance area (KPA) process” also built on existing planning and HR management processes and even the community profiling initiative built on a history of community/service engagements and drew in existing clinic committee structures.

All three initiatives reflect the critical role of sub-district managers and their teams in galvanising actors in the sub-district and building capacity to improve routines and relationships.
In late 2010, the sub-district manager initiated a discussion about the monthly PDR meeting with those who routinely attend it. The core features of the re-organisation were then decided and implemented in 2011.

In re-naming and re-organising the meeting, the sub-district intended to encourage facility managers to take a more proactive approach to problem solving and forward planning to improve services and operational efficiency. A new name, the M&C meeting, signalled the desire to move away from a confrontational stance that held people accountable for service targets to a new approach that emphasised a supportive engagement, sharing of good practice, collaborative learning and accountability for improved efforts.

Beyond the name, the core changes were:

❖ a different seating arrangement to allow small-group discussion and dispersed authority;
❖ a new agenda structure focused on joint planning for new activities; progress reports on planned activities; sharing of best practices among facility managers; review of selected programmes and other concerns;
❖ a chairing style that facilitated discussion and debate and challenged participants to improve services for population benefit rather than adopting a more didactic and instructional communication style; and
❖ careful minute taking to allow tracking and reporting of action over time.

The sub-district manager initiated the meeting re-organisation because she wanted to tackle the lack of understanding and ownership of new activities among facility managers and the perception that targets were imposed on them rather than an opportunity for service improvement. Her underlying intentions were to develop the meetings as a space to:

a) generate a shared understanding among facility managers about the issues discussed and build their commitment to implementing agreed action; and b) build the relationships among all sub-district staff that enable coordination of service improvement efforts (e.g. between facility managers and sub-district administrative staff or between facility managers and EH staff). She also hoped to provide a role model of a meeting style that facility managers would use in their own staff meetings.

Her assumptions were that opening up the meetings to discussion and with a more problem-solving focus would make them less threatening; support a two-way flow of ideas between sub-district and facility managers; contextualise new activities implemented in facilities for programme and administrative support staff; and generate a sense of shared accountability.

The work carried out in the meetings is backed up by the sub-district manager’s efforts to:

❖ manage down through: special task teams that comprise various sub-district staff planning, which are established to support new activities; monthly facility supervision visits by sub-district managers; and the allocation of environmental health practitioners (EHPs) to facilities;
❖ manage across through: engagement in the ISDMT, or personally with MDHS colleagues where joint strategy or shared support is needed;
❖ manage up through: engagement with MDHS/CoCT district managers to tackle challenges faced in implementation or by securing support (agreement, guidance, resources) for implementation.

Innovation 2: Developing local service-improvement priorities

For the first time, in late 2010 and for the 2010-11 financial year, CoCT facility managers and other staff were asked to develop eight KPAs within the overarching priority areas of the IDP and CoCT Business Plan. The process was then repeated, focused on four KPAs in 2011, for the 2011-12 financial year.

The aim of the new process was to encourage forward planning for service improvement and sustained effort in tackling priority service delivery challenges. This initiative aimed to achieve this by setting clear local objectives and outlining activities, intended outcomes and monitoring and evaluation (M&E) approaches.

For PHC facilities, the key aims of the process were to:

❖ allow managers to set priorities that reflected their clinics’ local needs, while taking account of the overarching strategic planning frameworks and priorities and of their own job descriptions;
❖ focus on tackling critical service delivery challenges, the bottlenecks in the system that prevent the sub-district from implementing agreed on and planned service improvements;
❖ encourage/require managers to identify priorities with their staff – so that the initiative becomes a local initiative from the staff; and
❖ prepare a written document in which the priorities are summarised.

KPA examples include: tackling staff shortages (linked to use of staff!), absenteeism and poor record keeping (all of these are system challenges for any service-improvement effort).

The sub-district manager initially discussed the new approach in the regularly monthly PDR meeting (as it was then still called) in late 2010. She then provided one-on-one mentoring support to facility managers in the development of their KPAs. This support was focused on helping the managers to formulate objectives, think about evaluation and reflect on the implications of these objectives for their management activities. A workshop was then organised for all sub-district staff (facility managers, doctors and all other managers) to present their KPAs to others. Quarterly reviews on a one-on-one basis allowed KPA implementation to be monitored over 2011. At the end of the year managers gave feedback on the implementation of one KPA in the monthly M&C meeting and presented a written report in which they evaluated their progress in meeting all their KPAs. In 2011, the process was repeated but this time focused on only four KPAs and used regular meetings as opportunities for review and reporting.

The sub-district manager initiated the KPA process with the intention of addressing a lack of understanding about planning among facility managers and their lack of ownership of sub-district priorities and related activities.

Her assumptions were that the process would:

❖ develop priorities of relevance to local settings nested within the IDP/Business Plan priority areas and within the wider system processes;
❖ generate a sense of ownership of higher-level priorities and related activities among facility managers and develop local priorities that would support their implementation;
❖ develop managers’ own capacities to use data and information in identifying problems and setting priorities, monitoring achievements, analysing the underlying causes of problems, and preparing written documents; and
❖ encourage managers to engage their own staff in thinking about problems and activities for addressing them, selecting priorities, and using information.

Priorities and feedback on meeting them were discussed in meetings as it was assumed that this would support mutual learning and understanding, generate debate and discussion, and allow opportunities for sharing ideas about how to manage crises and plan ahead. In this way it was hoped to build managerial confidence in coping with crises.

Overall, the KPA process can be seen as a capacity development initiative. It was a form of continuing professional development in that it strengthened managerial capacity to plan ahead and act proactively, and encouraged persistent and sustained effort. It was complemented by the re-organised management and communication meeting.
Across innovations, some early signs of positive impact are summarised in Table 1. However, it is still too early to judge whether they will take root in daily practice and will generate operational efficiency and performance benefits. Contextual pressures played an important role in constraining all Mitchell’s Plain activities in 2012. Unforeseen leadership changes and the dual lines of accountability in Mitchell’s Plain have maintained an uncertainty in the wider sub-district context that acts as a barrier to finding and embedding new ways of doing things. In addition, changing routines and mindsets takes time and more time is needed to nurture, reinforce and track the persistence of the changes discussed here and what their spin-off effects might be. Small wins are small because they do not immediately destabilise the existing situation – the challenge is to identify the leverage point for spreading effects more widely.

Conclusions: lessons for health system development

This case study offers insights into the routines, activities and relationships that represent the complexity of one South African urban sub-district health system. It points a picture of multiple demands, competing priorities and resource constraints, targets and policy directives. It also points to the need to manage and coordinate numerous actors within and outside the system and to the existence of organisational cultures and legacies of deference and hierarchy, which undermine efforts towards decentralisation and innovation. It demonstrates the influence of organisational software over collective capacity and resilience. Managing in this environment is a multifaceted and multi-dimensional task and requires a constant shift in focus, lens and pace.

Although many management models exist, the work of Henry Mintzberg offers explanations and understandings of management that have clear resonance with the experiences presented here and with the wider South African health experience.7,24 Mintzberg’s four facts about managers clearly reflect the Mitchell’s Plain and South African experience. (See Box 6) Describing managing as being about “calculated chaos” and “controlled disorder”, Mintzberg notes that “the pressures of the managerial environment do not encourage the development of reflective planners … This job breeds adaptive information manipulators who prefer the live, concrete situation”. His model of managing encompasses the three roles of managing up, out and down discussed earlier in this chapter. It sees managing as always several steps back from the action – and involved in working through other people to get involved.

Table 1: Preliminary signs of innovation impacts

<table>
<thead>
<tr>
<th>M&amp;C meetings</th>
<th>KPA process</th>
<th>Community profiling</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Positive performance gains in activities discussed in meetings; e.g. isoniazid coverage improvement from 35% to 60%</td>
<td>• Facility managers told the sub-district manager they felt it was very useful and long overdue</td>
<td>In 2011 there was: • Great enthusiasm expressed for the collaborative work among all participants, who often spoke about the benefit of getting to know other health providers and learning more about health services or the communities served</td>
</tr>
<tr>
<td>• Engagement of health promotion officer in supporting facility managers in reproductive health service provision in schools</td>
<td>• Sub-district manager feels that skills have been developed; e.g. in setting objectives; process has been accepted and priorities are increasingly being ‘owned’; improved understanding of how to manage systems and processes to improve outcomes</td>
<td>• Several groups began to take local action and deal with specific local health issues</td>
</tr>
<tr>
<td>• Sub-district perception that some facility managers have taken more ownership of activities and used information to make decisions</td>
<td></td>
<td>• Very importantly, the sub-district’s annual planning was informed by the initiative in terms of format and substance</td>
</tr>
</tbody>
</table>

Innovation 3: Generating local knowledge, priorities and action

In early 2011 the sub-district initiated an activity that aimed to strengthen three inter-related planning and management priorities in the sub-district. The first priority was “shifting the lens” of service providers from a patient orientation to a stronger population orientation in health system organisation and functioning, as advocated by provincial and national policy guidelines. The second priority was to move the sub-district’s thinking and vision beyond one-year planning cycles and the third priority was to strengthen relationships between service providers and community representatives. Provincial and district management had recently emphasised the need to address the health of populations rather than patients alone. Yet facility managers had repeatedly expressed uncertainty and frustration that they “did not know the communities they were serving”, did not know how to engage with other role players or access other health resources in communities, and were overwhelmed with the need to service short-term targets instead of being responsive to local priorities and needs.

To explore and practise alternative ways of collaborative planning and prioritising a team consisting of service partners from both city and provincial health authorities, NGOs, statutory clinic committees and civic organisations and community-level partners conceptualised and implemented a series of multi-stakeholder workshops. Nurses, NGO staff, representatives from local community structures such as health committees and police fora, environmental health practitioners (EHPs) and others from a geographically defined local area met in “local area groups” to discuss and map available health resources to needs and gaps. While the physical maps that emanated from these workshops provided useful information, the workshops were more important in that they brought health stakeholders in Mitchell’s Plain into conversation with each other. Discussions led to a number of quite practical and immediate actions, such as negotiations with the local taxi association about the possibility of changing a taxi route to improve access to one facility. The initiative particularly emphasised the importance of EHPs as crucial players in a population-based approach to health planning. And, lastly, at the end of 2011 the local area groups that had been formed were invited to the sub-district’s annual planning event to contribute their ideas and priorities to the development of the 2012 sub-district plan. Apart from small but tangible wins, the initiative succeeded in overcoming or at least lowering perceived barriers between different groups and bringing actors into conversation with each other, thus confirming the importance of building networks, drawing on informal knowledge of multiple actors, and creating fora for engagement outside of established structures.

Despite initial enthusiastic support, the initiative was difficult to sustain in 2012. Work has continued, although haphazardly, in two of the four local groups. Their experience may provide lessons on how to re-energise the process across the whole sub-district. The potential value of this type of innovation is, moreover, receiving attention across the country, with a range of initiatives beginning to demonstrate the value of this type of innovation is, moreover, receiving attention across the country, with a range of initiatives beginning to demonstrate the value of this type of innovation.

The complexities and possibilities of sub-district management 13
things done by using information and by “coaching, motivating, building teams, strengthening culture and so forth.” The model, nonetheless, places managers at its heart and emphasises that the way managers frame their work and how they schedule activities sets the context for the others with whom they work.

Box 6: Facts about managers

❖ Managers work at an unrelenting pace; their activities are typically characterised by brevity, fragmentation, and discontinuity; and they are strongly oriented to action.
❖ Managers tend to favour informal communication media, especially telephone calls, meetings and email.
❖ Managing is as much about lateral relationships among colleagues and associates as it is about hierarchical relationships.
❖ The manager is neither conductor nor puppet: control to the extent possible tends to be covert more than overt, by establishing some obligations to which the manager must later attend and by turning other obligations to the manager’s advantage (effective managers are not those with the greatest degree of freedom but those who use whatever degrees of freedom they can find).

Source: Mintzberg, 2009.23

In this chapter we have discussed the complexity of health sub-districts and districts. We have demonstrated that managers at this level must be able, willing and confident to manage in “calculated chaos”. We have also presented some ideas about the practice of managing in this complexity – of leading change from within the health system. These experiences suggest that it is important to develop the DHS’s daily routines, its software, to nurture the relationships of constructive accountability that support persistent and adaptive problem solving aimed at enhanced service delivery and patient care.

They also suggest that leadership development programmes must, first, help managers “deal with the calculated chaos of managing – its art and craft...” by developing the managerial mind-sets – or competencies – of reflection, analysis, worldliness, collaboration and action. Second, such programmes must allow learning to be carried back into the organisation – by supporting teams of managers in driving organisational change. As Gilson and Daire proposed in 2011, leadership development programmes must, therefore, focus on generating values-based leaders that are able to manage complexity; be provided beyond the classroom and in the workplace; and be sustained through continuous learning.8 They must also work towards changing the system within which people work, even as they develop people as leaders.

Strengthening the South African health system is, in essence, about generating an internal capacity to learn and adapt over time, about building its resilience and responsiveness to meet changing population health needs – for which management and leadership development is a central requirement.

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The complexities and possibilities of sub-district management

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