Albertina Sisulu Executive Leadership Programme in Health

Excellence, Innovation, Transformation

Final Report - Global Development Alliance: AID-674-A-13-00002

Project Title: South African Executive Leadership Program in Health (SAELPH)

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A partnership of

University of Fort Hare
Together in Excellence

HARVARD T.H. CHAN SCHOOL OF PUBLIC HEALTH

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Acronyms

ASELPH: The Albertina Sisulu Executive Leadership Program in Health

COO: Chief Operations Officer

DDG: Deputy-Director General

DG: Director General

DOH: Department of Health

HSPH: Harvard T.H. Chan School of Public Health

HWSETA: Health and Welfare Sector Education and Training Authority

HOD: Head of Department

MOA: Memorandum of Agreement

NDOH: National Department of Health

NHI: National Health Insurance Initiative

PHASA: Public Health Association of South Africa

SAELPH: South African Executive Leadership Program in Health (later to be called ASELPH)

SA Partners: South Africa Partners

SC: Steering Committee

SMT: Strategic Management Team

ELMA: The ELMA South Africa Foundation

UFH: University of Fort Hare

UP: University of Pretoria

1. Executive Summary

The South African Executive Leadership Program in Health renamed the Albertina Sisulu Executive Leadership Program in Health (ASELPH) is an innovative partnership among the South Africa National Department of Health, the University of Pretoria, the University of Fort Hare, Harvard T.H. Chan School of Public Health, and South Africa Partners. The overall goal is to "strengthen the NDOH's ability to meet its health transformation challenges, particularly at District level". ASELPH aims to achieve a sustainable and perceivable impact on health sector reform through skills transfer and capacity building in health management and leadership. ASELPH achieves these goals by developing a critical mass of next-generation change-agents that are capable of translating policy into actionable programs that improve health outcomes in a complex and ever-changing environment.

ASELPH accomplishments address the three aims identified by USAID as indicated below.

AIM 1: IMPROVE SERVICE DELIVERY IN THE HEALTH SYSTEM TO ACHIEVE EQUITABLE, HIGH-QUALITY PUBLIC HEALTH CARE SERVICES ACCESSIBLE TO ALL SOUTH AFRICANS

As a consequence of the partnership, ASELPH established the Masters in Public Health degree program at the University of Fort Hare and a Post Graduate Diploma in Public Health at the University of Pretoria for district health managers and leaders to gain competency in health care management. The Harvard School of Public Health provided guidance and mentorship on the curriculum and pedagogy. Beginning in 2013 each university has offered their respective curriculum to four ASELPH cohorts. A total of 340 health practitioners were enrolled; 302 are currently active or have graduated - 194 from UP, and 108 from UFH. Enrollees were sourced from all 9 provinces, with the majority sourced from the Eastern Cape, KwaZulu Natal, and Gauteng. A total of 160 health practitioners have graduated with a PGD (134) or a Masters (26). Both universities have developed short learning programmes which are focused on specific areas of need within the health system, and UFH has established a Health Sciences Institute as a vehicle for the delivery of short course programs.

A survey of ASELPH graduates established that the majority, 90.3 percent, are employed in the State sector. The survey also showed that 70.2 percent have current positions either within the district office structures, or within health facilities, such as hospitals, clinics or related entities. The survey also showed that 41.6 percent had secured a new career position since enrolling on or graduating from ASELPH and 78.6 percent of these indicated that they had been promoted. Results from monitoring and evaluation indicate a significant improvement in the management and leadership competencies of ASELPH graduates in line with the needs of the NDOH.

There was significant effort in the establishment of an ASELPH mentorship process, to support and encourage fellows to manage their own learning to maximize their potential, develop their skills, and improve their performance. In addition, the establishment of an ASELPH alumni association has received attention to ensure that fellows are able to stay connected with the fellowship and contribute to ASELPH after graduation, by assisting with writing cases, teaching modules, or acting as mentors for new cohorts of ASELPH fellows.

AIM 2: BUILD CAPACITY IN THE FIELD OF HEALTH EXECUTIVE TRAINING

The partners, with significant input from HSPH, worked collaboratively to develop and offer a unique pedagogy using the Harvard case-study method, and a unique curriculum in response to the health care transformation needs of South Africa, as identified by the NDOH. There was significant one-on-one engagement between South African faculty members, and Harvard faculty to develop capacity to offer the ASELPH curriculum. The ASELPH partners have continued to review and revise the curriculum to maintain relevance and responsiveness to the health system needs. The partners have also modified the approach to training to transition toward blended learning, using e-learning tools, to improve accessibility of the program for health care managers. As a result, at UP contact time has been reduced from five to three days per module. These changes have contributed to reducing travel costs, time and accommodation costs, as well as reduced time out of the office for critical managers within the health sector. These changes have been made with an eye on sustaining a quality executive health leadership training experience.

Harvard has maintained involvement in developing the case-study teaching method. ASELPH has produced 16 South Africa case studies. Three have been approved by Harvard, four have been published in an accredited scientific publication, Emerald Insight, independent of a Harvard review process. The case studies, which reflect a South African health sector reality, are used by UFH and UP in their course delivery. UFH has established a case writing center to help with development of cases and faculty comfortable with the case teaching method.

AIM 3: CONTRIBUTE TOWARDS CRITICAL ENGAGEMENT WITH HEALTH POLICY

ASELPH has contributed to the health policy debates within South Africa, hosting numerous public policy seminars and round table discussions. The policy themes have included National Health Insurance (NHI), Ward-Based Primary Health Care Outreach Team policy, and Ethical Leadership. Policy briefs on the implementation of the NHI and developing the community health worker workforce to implement the Ward-Based Primary Health Care Outreach Team policy have been developed and reviewed with the NDOH, contributing to the refinement of the policies, as well implementation strategies. In addition, ASELPH was asked to conduct a rapid appraisal of Ward Based Outreach Teams on behalf of the NDOH.

CONCLUSION

The ASELPH program has made significant strides in its objectives of training executive leaders for the health system in South Africa. Fellows that have successfully completed the program are widely distributed geographically and across the South African health system; they are beginning to make some demonstrable impact in the areas of their functioning. An independent evaluation of ASELPH concluded that ASELPH is unique in method and content and is an established health executive leadership development program and that the offering. The program is contributing to health system strengthening in South Africa and has the potential to impact significantly going forward. Institutionalization of the PGD and MPH at UP and UFH plays a significant role in program sustainability.

The yet-to-be released USAID funded SPACES-MERL framework for evaluation at the systems level will provide more insights into the impact of ASELPH within the national health system, through the social network analysis, and systems mapping of ASELPH participants, their skills and their role within the health system.

Capacitating two South African universities to offer unique executive leadership programmes aimed at positively impacting the South African health system, is a significant outcome of the USAID support.

2. Background

INTRODUCTION

The South African Executive Leadership Program in Health (SAELPH) (renamed the Albertina Sisulu Executive Leadership Program in Health (ASELPH)) as described in the USAID Program Description for AID-674-A-13-00002, includes the South Africa National Department of Health (NDOH), the University of Pretoria (UP), the University of Fort Hare (UFH), Harvard T.H. Chan School of Public Health (HSPH), and South Africa Partners (SA Partners). The overall goal is to "strengthen the NDOH's ability to meet its health transformation challenges, particularly at District level".

In 2011, Atlantic Philanthropies committed approximately $2,177,000 (R28.3m) over four years to establish the beginnings of ASELPH. In March 2012, The ELMA South Africa Foundation (ELMA) awarded approximately $2,000,000 (R24m). The USAID program description acknowledges Atlantic Philanthropies was instrumental in "allowing the partnership to investigate current health management training capacity in South Africa and to design a program that would address critical gaps in executive health management training – from national office, through the provincial and district levels, down to hospital level as the need arises". USAID committed $2,987,161 (R21.5m) for a four- year period (October 1, 2012 to September 30, 2016) to support SAELPH. USAID then committed $400,000 a year from October 1, 2016 to September 30, 2019 which was matched by ELMA. Subsequently, USAID reduced the commitment from three years to two years, ending on the September 30, 2018.

HISTORICAL CONTEXT OF THE SOUTH AFRICAN HEALTH SYSTEM

South Africa is an upper middle-income country, according to the World Bank[1], that has transitioned from a history of racial segregation based on a policy of apartheid. The final and official transition into democracy occurred in 1994 following the first democratic elections. The South African political history of racial segregation had significant and far-reaching impact on the health system. The provision of health services, like other public services, was designed and implemented according to race with unequal financing and thus inequality in health services for the black majority.

[1] https://data.worldbank.org/country/south-africa

With the advent of democracy, the democratic government inherited a health system divided by race and along tribal lines within the context of the apartheid homeland system. The first health objective of the democratic government was to bring the various departments of health into one unified national health system to serve the entire population irrespective of race and tribal affiliation. Since the democratic transition, the government has committed to improving access to health services and the quality of services by improving and ensuring equitable financing of the health system.

Access to health services has progressively improved in South Africa since 1994. However, the main challenge has been to ensure that the health services are of good quality, result in improved health outcomes, and ultimately improve the health of the population. Although the health system has seen significant improvement in the financial allocation in the last 20 years, the health outcomes have remained worryingly poor. Even with the gains made after democracy, and a high concentration of dedicated and accomplished staff, the NDOH identified daunting human resource challenges that impeded progress in achieving health and health system transformation goals. The challenges relevant to ASELPH were:

- Limited capacity to translate and implement important and far reaching policy initiatives into efficient, well run programs;
- Insufficient innovation and low morale in the health system;
- Critical weaknesses in middle and senior management and serious shortfalls in executive leadership and management skills;
- Chronically over-stretched senior leadership with a limited pipeline of capacitated senior executives; and,
- Insufficient capacity for executive management and leadership training in health, as well as weaknesses in management know-how in policy implementation.

SOUTH AFRICA'S HEALTH SYSTEM TRANSFORMATION AND ASELPH

South African universities have offered a number of health management courses for a number of years, including as part of Masters in Public Health (MPH) programs but also offering advanced-diploma programs. Many health managers have participated in these programs but there is no evidence that the training interventions have made a significant difference in improving the leadership and management competencies of the managers trained.

South Africa has also committed to undertake a fundamental health systems reform and transformation towards implementation of universal health coverage in line with the recommendations of the World Health Organization. South Africa designed the policy on National Health Insurance, which was released in August 2011 and planned to progressively implement the program in three phases over a 14-year period starting in 2015.[2] To successfully implement NHI requires leaders that are uniquely trained in various aspects of the health system to provide the necessary stewardship. The NDOH identified the need for an executive leadership development

[2] Matsoso M P, Fryatt R. National Health Insurance: The first 16 months. South African Medical Journal. 2013 103; 3:156-158 Available at http://www.samj.org.za/index.php/samj/article/view/6601/4920.

program that focuses on explicit competencies and skills required for leaders within the health system.

ASELPH aims to achieve a sustainable and perceivable impact on health sector reform through skills transfer and capacity building in health management and leadership. ASELPH focuses on three overarching goals: 1) to improve service delivery in the health system to achieve equitable, high-quality public health care services accessible to all South Africans; 2) to build capacity in the field of health executive training; and, 3) to contribute towards critical engagement with health policy.

The strong relationship forged between ASELPH and the DOH at both the national and provincial level is critical to the success of this intervention. The collaboration between ASELPH's three academic partners provides a unique opportunity through which to address critical training needs in health management and leadership. This training is an essential element to drive transformative changes in the South African health system. ASELPH supports South Africa's efforts toward sustainable development and its broader democratization and equality goals, through ensuring access to a responsive and just health system.

Dr. Aaron Motsoaledi, the South Africa Minister of Health launched ASELPH in 2013. In his remarks at the launch, Dr. Motsoaledi said of ASELPH that "It marks a milestone in the capacity development of human resources for health. This program is highly significant for the overall performance of the national health system... As the National Health Insurance process is gaining momentum, the Albertina Sisulu Executive Leadership Program in Health has been working with the National Department of Health to engage with senior managers at national, provincial and district level to prepare them with the required leadership and management skills needed to play a central role in the implementation of the NHI."

By harnessing the resources of academia and experts in public health practice, ASELPH advances an applied approach to the developmental challenge of strengthening South Africa's health system, especially its leadership, through building competent and effective district health systems and institutions. ASELPH aims to make a sustainable and perceivable impact on health sector reform through skills transfer and capacity building in health management and leadership among South Africa's health care managers and leaders. ASELPH Fellows are drawn from across the country and include medical professionals (doctors and nurses), hospital and clinical administrators, as well as national, provincial and district managers. ASELPH hoped to develop a critical mass of next-generation change-agents that are capable of translating policy into actionable programs that improve health outcomes in a complex and ever-changing environment.

The aim of the USAID investment in ASELPH as a whole, was to strengthen three key components of health transformation in South Africa:

- *Service Delivery Improvements*, with a focus on developing management and leadership capacity at the district level, and those in national and provincial levels who are responsible for district level services.
- *Human Resource Development*, focusing (although not exclusively) on the National Health Insurance Initiative (NHI) transformation process, and its successful implementation.

- *Excellence in Executive Level Training*, by building capacity at both UP and UFH to establish and deliver executive leadership courses in health, to help create a pipeline of trained senior health manager to address key challenges at all levels of service delivery in South Africa.

In the second co-operative agreement signed with USAID in October 2017, the following areas were prioritized:

- Expansion of the e-learning platform as part of the ASELPH blended learning approach, with a focus on reducing contact time.
- Completion of new case studies with a focus on ensuring that more case studies are signed off by HSPH, and that several case studies are used in each course, tied to the specific competencies and learning objectives of each course.
- UFH Health Sciences Institute to offer short courses dealing with key management strategies needed for the implementation of NHI, for health managers dealing identified by the Eastern Cape DOH.
- Curriculum Review in partnership with the NDOH, to ensure that the needs of the Health Department are met.
- Faculty Development through the adoption of the ASELPH Faculty Competency Framework which seeks to mentor and coach a pool of ASELPH faculty members to deliver the ASELPH program.
- Integration of Monitoring & Evaluation using electronic systems that are carried out by the respective universities for paperless course evaluations, as well as the management of the self-evaluation and 360degree evaluation processes with respect to the ASELPH fellows.
- Alumni network including the hosting of one national alumni event per year, and utilizing alumni in the recruiting and mentoring of current ASELPH fellows.

UNIVERSITIES COLLABORATE TO TRAIN EXECUTIVE LEADERS IN HEALTH

Critical to this report, is an understanding of the transformation in the Faculties of Health Science at both UFH and UP in relation to executive leadership training as ASELPH evolved. The two universities took on different challenges as UFH is a historically disadvantaged black university and UP one of the preeminent universities in South Africa.

University of Fort Hare

Prior to the launch of ASELPH, UFH had a School of Health Sciences located within the Faculty of Science and Agriculture. The school was preceded by a Department of Nursing Sciences and a unit of Public Health. The School of Health Sciences inherited an Advanced Diploma in District Health Management and Leadership that previously offered by UFH's Department of Public Administration, in partnership with the Eastern Cape DOH. This advanced diploma program offered training in District Health Management and Leadership (DHML) and over time involved faculty from Walter Sisulu University and Nelson Mandela Metropolitan University. The Advanced Diploma in DHML was a two-year semi-distance learning program with students from across the Eastern Cape. By 2009, 350 students had participated in the program.

When the partners applied for an executive leadership program to USAID, ELMA and Atlantic Philanthropies, UFH used the Advanced Diploma as motivation for its participation in the program. At that point leaders from the School of Health Sciences were also applying to become a fully-fledged faculty separate from the Faculty of Science and Agriculture. Additional courses and academic programs were applied to include public health, physiotherapy, audiology, speech and language therapy and occupational therapy and the Department of Human Sciences Movement.

The Faculty of Health Science was launched in 2016 with five departments - Public Health, Human Movement, Rehabilitative Sciences, Nursing Sciences and Natural Sciences. ASELPH is among five research centres and units in the Faculty of Health Sciences. The Faculty managed to secure funding from ELMA to purchase and renovate a building that now houses the Faculty. The Faculty has grown in terms of programs, teaching staff, research output, and publications.

University of Pretoria

UP did not have a specific executive leadership development program offering within the School of Health Systems and Public Health. There had always been a Diploma in Health Systems Management (DHSM) as part of the postgraduate diploma offering and a health policy and management track in the MPH, both focusing on generic health systems management aspects, but not on executive leadership. The existence of the DHSM meant that ASELPH could re-engineer this postgraduate diploma and create a second parallel program that specifically focused on executive leadership.

Harvard T.H. Chan School of Public Health

The Harvard T.H. Chan School of Public Health, which, through its International Health Systems Program (IHSP), has been a significant partner since the conceptualizing and launch of ASELPH. The IHSP's training program has strengthened the capacity of health system practitioners from middle- and lower-income countries to improve the performance of their health systems. The programs serve senior officials and policymakers who strive to improve the health of citizens in their countries. IHSP courses blend theoretical and conceptual knowledge with practical tools to accomplish important tasks and hands-on practice in using those tools. Their courses build on research and public health practice throughout the world. Senior officials in the NDOH had attended specific courses at the HSPH in the U.S., but the costs were prohibitively expensive. ASELPH developed out of an expressed need to have "cost-effective, high quality and sustained executive training for health leaders in South Africa, with a curriculum and pedagogical approach specifically tailored to the current needs of their country".

The HSPH courses have been offered to the faculty of UP and UFH, and are the basis for some of the courses and modules that are now part of the ASELPH training programs in both institutions. HSPH committed to capacitating ASELPH to use of the Harvard case method-teaching model for training of senior health managers. The Harvard Business School pioneered this methodology, which engages students more deeply in their learning, and teaches analytical and decision-making skills.[3]

[3] The case method is a teaching approach that uses decision-forcing cases to put students in the role of people who were faced with difficult decisions at some point in the past. It developed during the course of the twentieth-

ASELPH Executive Fellowship

The centerpiece of the ASELPH program is the ASELPH Executive Fellowship. ASELPH Executive Fellows enroll in either a Master's Degree in Public Health at UFH or a Postgraduate Diploma in Health Systems Management – Executive Leadership at UP. ASELPH and its South African academic partners developed these postgraduate academic programs with the extensive support of HSPH and their faculty, who offered their expertise and hands-on guidance. A unique feature of ASELPH's academic programs is the use of specially developed South African case studies, using the Harvard case study teaching approach, which stimulate robust discussion and vitally needed problem-solving skills for the country's pressing and emerging health challenges.

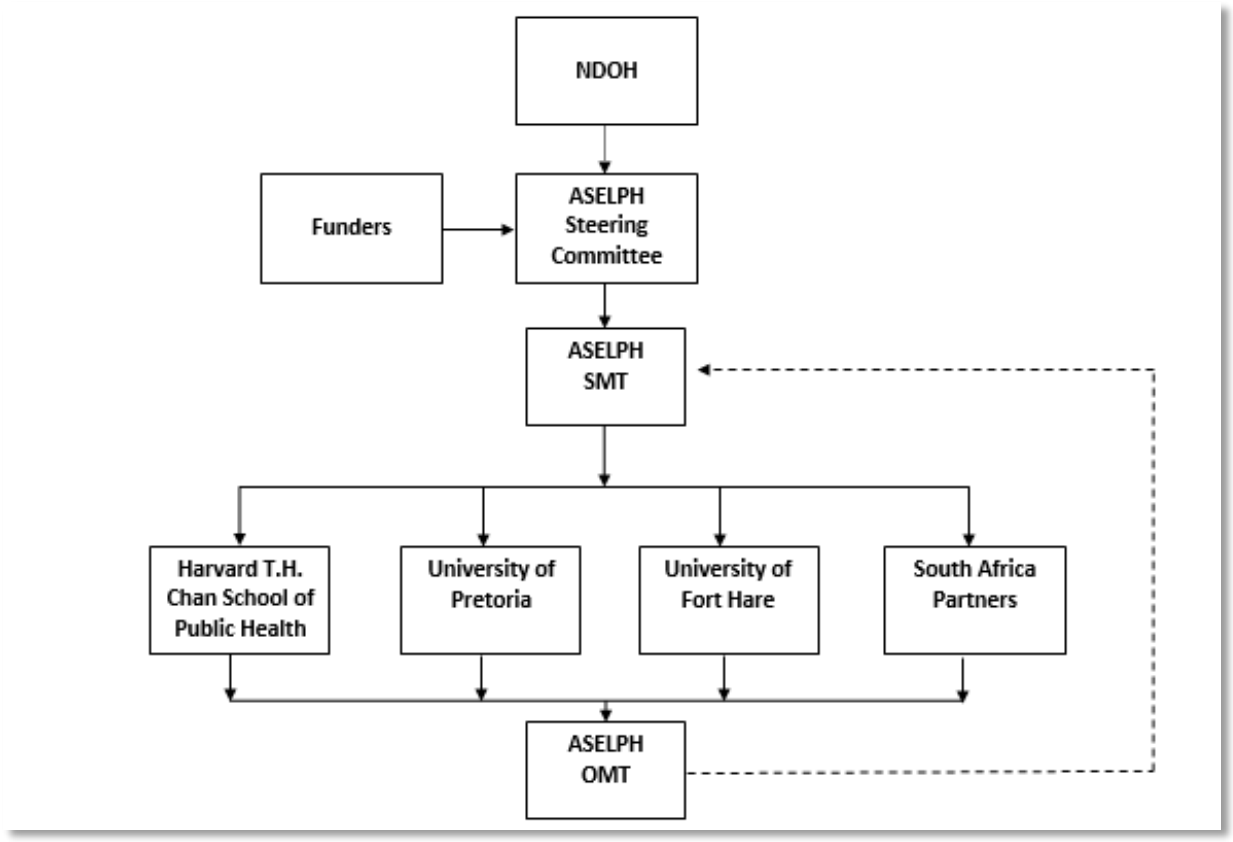
ASELPH GOVERNANCE

To underpin the working relationship, all partners - NDOH, UP, UFH, HSPH, and SA Partners - signed two MOAs. The MOAs cover the periods 2013 to 2017 and 2018 to 2022 (Appendix 1).

To achieve its collaborative objectives, the partners developed a functional governance structure as shown in Figure 1.

century from its origins in the casebook method of teaching law pioneered by Harvard legal scholar Christopher C. Langdell. In sharp contrast to many other teaching methods, the case method requires that instructors refrain from providing their own opinions about the decisions in question. Rather, the chief task of instructors who use the case method is asking students to devise and defend solutions to the problems at of each case.

Figure 1: ASELPH governance structure



The roles and responsibilities of each partner are as follows:

- *NDOH* provides leadership for the integration of ASELPH into the long-term goals of South African health management improvement. Connection to ASELPH is managed through the office of the Director General, and delegated initially to the Deputy Director General responsible for Human Resources and then to the Chief Operations Officer (COO) of the Department, Dr Gail Andrews, when the HR responsibility was shifted to her.
- *Steering Committee* made up of representatives from NDOH, selected provinces, the ASELPH implementing partners, funders, the Sisulu family, and outside experts as determined by NDOH; monitors progress, provide strategic input, and reports to NDOH. The Committee meets two times per year and is chaired by the COO.
- *Strategic Management Team (SMT)* – The SMT consists of the university Principal Investigators (PI) and program managers from each of the four implementing partners (UP, UFH, HSPH, and SA Partners). The SMT is responsible for *inter alia* proposing strategy, developing and monitoring the work plan, fundraising, budgets, and fulfilment of overall strategic objectives. The Chair rotates between the Principal Investigators of UP and UFH. SA Partners provides administrative leadership. Meets every other week by transatlantic teleconference calls.
- *Operations Management Team (OMT)* – The OMT consists of program managers, ASELPH faculty members and administrative staff from each of the four implementing partners. The OMT is responsible for implementing the work plan, managing the institutional budgets,

and the fulfilment of specific agreed to operational objectives. The Chair rotates between UP and UFH. Meets every two weeks by transatlantic teleconference calls.

The PIs at UP and UFH engage on a regular basis with the NDOH through the office of the DG and COO. The DG has retained a keen interest in ASELPH and the PIs have continued to meet with her and seek her guidance. In addition, the PIs have established a working relationship with all the NDOH DDGs and the heads of department of the Provincial Departments of Health. The ASELPH provincial representatives have come to form an important link between ASELPH and the provinces and endeavor to create seamless interaction and engagement in relation to candidate matters as well as other areas of mutual interest.

3. ASELPH Activities

RECRUITING AND ENROLLING FELLOWS

UP and UFH endeavor to work closely with the Provincial Departments of Health to identify potential candidates for ASELPH. The human resource directorates within the provincial structures serve as the universities' point of contact and both universities endeavored to enroll fellows from multiple provinces. Two factors have had an impact recruitment of fellows: the physical geography of the respective institutions (Gauteng and Eastern Cape) and the entry requirements to the PGD at UP against that of the MPH at UFH.

UFH faculty visit provinces to market ASELPH and to clarify the entry requirements for the programme. From the beginning UFH engaged provincial heads of department for the recruitment processes which was developed and approved by the UFH Senate. Human resources directors and staff, including bursary officers, work collaboratively through the process, deciding on which candidates should be selected and funded. UFH selects applicants based on the university entry requirements to the MPH degree.

UP advertises for applications in the provinces, and in conjunction with the Provincial Departments of Health. ASELPH faculty members participate in shortlisting, interviewing, and selecting the final candidates.

These methods of recruitment have proven to be very effective in that appropriate candidates for executive leadership development are selected based on their current professional and strategic responsibilities in the health system, opportunity for career progression in health leadership, and commitment to the public service and making a positive contribution.

Between 2013 and 2018, a total of 340 health leaders were inducted into four cohorts at UFH and four cohorts at UP. However 38 (11.2 percent) enrollees withdrew from the program for various reasons including personal issues, poor health, and one death. As of September 2018, a total of 302 were deemed to be, or have been, "active participants", with 194 enrolled at UP, and 108 at UFH. All provinces have been represented with the Eastern Cape, Gauteng, and KwaZulu Natal supplying 65.2 percent of the fellows. (Table 1)

Table 1: ASELPH enrollment by province, 2013 – 2018

Province	UP	UFH	Total (percent)
Gauteng	54	5	59 (19.5)
Eastern Cape	16	77	93 (30.8)
KwaZulu Natal	27	18	45 (14.9)
Limpopo	19	0	19 (6.3)
North West	20	1	21 (7.0)
Free State	24	2	26 (8.6)
Northern Cape	12	2	14 (4.6)
Mpumalanga	16	2	18 (6.0)
Western Cape	0	1	1 (0.3)
National Office	6	0	6 (2.0)
Total	**194**	**108**	**302 (100)**

From the onset of ASELPH, provincial representatives identified by the NDOH participated on the Steering Committee. Initially these representatives were selected by the NDOH from the provincial HOD level. However, in more recent years, the representatives were selected from Chief-Director and DDG level within the provinces, as they are more in tune with the needs of health managers. In 2017, the three provincial representatives established a national committee of provincial representatives which has significantly improved strategic recruitment of fellows as they represent well-informed departmental officials who help identify appropriate candidates. UP took advantage of this connection in their recruitment drive for the fourth UP cohort in September 2018. Eight of the nine provinces are represented in this cohort of 56 ASELPH fellows.

At the beginning of the project, the fees for ASELPH fellows were subsidized by project funding and the universities. However, due to the financial demands on the universities as a result of the Fees Must Fall movement[4], as well as funders' recommendation that ASELPH secure alternative sources of funding for the fees, both UP and UFH applied to and successfully received funding from the Health and Welfare Sector Education and Training Authority (HWSETA). The support of the NDOH in endorsing the applications to HWSETA, assisted in the universities' success in being approved for the funding. However, the outcome of the application process often took some time. In 2017, UP did not receive an affirmative response from HWSETA for its fourth cohort, which was due to start at the beginning of 2018. For this reason, Cohort 4 was only able to start in September 2018.

ACADEMIC PROGRAM

At the beginning of the ASELPH project, UP and UFH held consultation meetings in relation to faculty planning and course development in preparation for course offerings. The planning included preparation of materials, visits to districts and health facilities to interview managers on the proposed curriculum. The development of academic staff involved in the ASELPH program was

[4] For a description of the #FeesMustFall movement see https://en.wikipedia.org/wiki/FeesMustFall

central to ensuring a consistently high-quality academic program and the medium- to long-term sustainability of the program.

The development of the academic program involved HSPH from the onset, to draw on the extensive impactful experience that Harvard had with respect to executive health leadership. Case studies are an important aspect of the pedagogic methodology, in addition to conventional didactic lectures, problem-solving learning approaches and case vignettes. ASELPH academic faculty initially relied on case studies developed and used by Harvard faculty but have since developed a number of South African health systems cases that have been used in the classroom and published in journals.

In the first two years of the project, there was a close working relationship between HSPH faculty and the ASELPH faculty at UFH and UP, which enabled HSPH to offer some of the modules to ASELPH fellows, so that South African faculty could observe and start modelling the approach. To assist with the capacity building, local faculty sat in on the classes, and there was intensive engagement between Harvard, to ensure the transfer to skills. The methodology was then taken on by local faculty with support and mentorship provided by HSPH. Towards the end of the reporting period, Harvard was no longer involved in the direct delivery of the any of the courses, but remained actively involved in faculty development and contributed to seminars and round table discussions, as well as providing opportunities for ASELPH faculty members to take part in case study writing courses at the HSPH.

ASELPH Masters in Public Health at the University of Fort Hare

From the beginning of the project, UFH set out to offer a Masters in Public Health (MPH). The curriculum includes a series of core courses and electives, and also involves completion of a research project that is submitted as a dissertation. The ASELPH courses offered by UFH can be found in Table 2. Between May 2014 and March 2018, a total of 129 health managers enrolled on the UFH MPH program.

Table 2. ASELPH MPH course offerings at the University of Fort Hare

Course Code	Course Title
PUG800E	Executive Leadership in Health, Complex Problem Solving, Ethics and Values in Health Care, Negotiating Coherence and Coordination.
HRS821E(EPI)	Health Research: Epidemiology
HRS821E(AEP)	Health Research: Advanced Epidemiology
HRS821E(BIO)	Health Research: Biostatistics
ISP111E	Introduction to Public Administration and Learning in Public Health.
	Centralisation, Decentralisation, NHI, PHC Re-engineering
OSH101E	Organisational Strategy in Health, Strategic Economics and Finance Management
PUP800E	Public Health Policy Transformation, Governance & Legislation
HRS812E	Quality Improvement Modalities (Strategies) in Health System, Health Informatics, Monitoring & Evaluation
REM800E	Research Methodology
HRH101E	Strategic Human Resource, Labour Relations & Management Performance
SMO101E	Strategic Marketing and Communications

Table 2. ASELPH MPH course offerings at the University of Fort Hare

Course Code	Course Title
HSM821E(CUH)	Hospital Management and Leadership: Critical Units in Hospital
HSM821E(HOM)	Hospital Management and Leadership: Hospital Operations Management
HSM821E(HSC)	Hospital Management and Leadership: Hospital Specific Competencies

ASELPH Post Graduate Diploma in Public Health at University of Fort Hare

UFH has also developed a post-graduate diploma in public health, which has been approved by the university's internal structures and by the Department of Higher Education and Training. Accreditation by the Council of Higher Education is currently being sought.

ASELPH Post Graduate Diploma in Public Health (Executive Leadership) at the University of Pretoria

UP has focused on offering a 1200 learning-hours PGD in Health Services Management in Executive Leadership to health practitioners. The curriculum includes a series of core courses and electives, and also involves a research project. The ASELPH courses offered by UP can be found in Table 3. Between October 2014 and September 2018, a total of 211 health managers enrolled on the UP PGD program.

Table 3. ASELPH course offerings at the University of Pretoria

Course Code	Course Title
AHM771	Executive Leadership Research Project
CCC770	Complex Problem-Solving and Negotiating, Coherence and Coordination
EOC770	Ethics and Values in Healthcare, Organisational Behaviour Change and Strategy in Health
HPF770	Health System and Transformation Policy (includes political analysis, strategy & finance options)
HRM771	Strategic Human Resources and Management Performance
HSR770	(District) Health Systems (and Hospital) Re-engineering (includes public sector and centralisation / decentralisation)
LHE770	Executive Leadership for Health (to include responsible leadership)
MEH 771	Health Informatics, Monitoring and Evaluation
PHM770	Learning in Public Health (special)
PPS770	Policy Practice Seminar
QIM771	Implementation of Quality Improvement Modalities (Strategies) in Health Systems
SFM 770	Financial Management in Health
SMH770	Strategic marketing (and communication) in health

Short courses learning program at UFH and UP

Representatives of the ASELPH SC, as well as Provincial Departments of Health requested that both universities make available short courses on specific topics in healthcare management. This request was in response to focused needs within hospitals, or within certain health districts. UFH committed significant time and resources to establish the Health Sciences Institute (HSI) in 2017, as the mechanism to deliver the short courses. The goal of the HSI is to improve population health

outcomes in South Africa through training of senior and middle managers on health leadership and systems reform, by providing accredited short courses that cover their competency requirement within the health system.

UP has developed the *Albertina Sisulu Centenary Short Course Program in Health Leadership and Management*. The focus areas include:

- Certificate Course in District Health Systems Management; 20-day contact session course
- Short Course for Hospital Board Members; 6-day contact session course
- A series of eight credit bearing focused short courses; 3-day contact session course

These courses have been marketed through provincial human resources managers for 2019.

The accredited short course offerings at both UFH and UP are provided in Appendix 2.

CURRICULUM REVIEW

The ASELPH curriculum has been developed over a number of years, with the input of HSPH, UP and UFH faculty. In addition, the ASELPH SC and the NDOH have recommended changes over the years to ensure that the curriculum reflects the goals of the department to improve service delivery at a district level. Over and above this, UP and UFH have conducted internal reviews to refine their respective offering to ASELPH fellows and have called on external reviewers to make input into the ASELPH curriculum. In 2017, ASELPH asked the NDOH to participate in a formal review of the curriculum to ensure that the offering was in line with the NDOH's vision for ASELPH. In turn, the NDOH asked ASELPH to conduct a joint internal review involving the three university partners and to share the recommendations with the NDOH for comment.

This joint curriculum review process was conducted early in 2018, highlighting the following key areas:

- Identifying all core and adjunct courses and cases offered at UFH and UP as part of the PGD and MPH programs
- Indexing all core courses offered and organizing them by pedagogic objective and competency
- Registering all original and new cases and indexing them according to courses, competencies and thematic area
- Appraising core, managerial and leadership competencies
- Reviewing the delivery method and relevance to ASELPH mission, vision and values
- Integrating the case review mechanism into broader curriculum refresh process.

Once consensus between HSPH, UFH, UP, and SA Partners was reached, collective recommendations were produced (see Appendix 3). The areas covered included: competencies; courses; cases; and pedagogy & delivery.

The DOH reviewed the recommendations and provided the following:

- ASELPH fellowship should grow, being a widely recognized professional training for leadership in public health.
- Emphasize active, student/self-directed learning, problem-solving, and gaining of skills essential to provide strategic leadership in South Africa health system.

- Structure to critically explore issues and challenges affecting health service delivery, leadership and management issues and identifying and solving challenges facing health system.
- Curriculum should afford fellows to explore in-depth areas relevant to their personal career goals and the country's priorities.
- Time spent on contact learning could be reduced from 12 weeks to six weeks, by adding an on-line interactive platform and holding conventional in-class time one week every second month.

These recommendations reinforced the value of ASELPH and the direction that the ASELPH partners were taking to strengthen the programme.

CASE STUDY DEVELOPMENT

ASELPH uses the case-based method developed at Harvard University. Case content is guided by the strategic objectives and needs of the NDOH while also respecting feedback from ASELPH course evaluations in which fellows identified the need for local South African cases. The ASELPH teams committed to developing the relevant case studies to use in teaching the respective ASELPH courses. The ASELPH case study development process focuses on a number of different thematic cases in health system reform, leadership, and health care management which will form core teaching tools in many ASELPH courses in the future.

The case study writing and review mechanism demonstrates the interactive nature of the process and the coaching provided to authors by more experienced case writers. The case review process includes five distinct phases with clear objectives, timelines, and responsibilities. The Guide for Developing an ASELPH Case (see Appendix 4) describes the objective frameworks that underpin each stage.

The five principal stages in the case review process are:

1. *Case authoring* – ASELPH faculty and fellows develop and write cases.
2. *SA Partners review* – SA Partners conducts a preliminary review that evaluates cases against a checklist of minimum case features as an initial quality assurance step. Authors address findings before proceeding to the next stage.
3. *Harvard review* – HSPH faculty conduct a comprehensive review, assisted by the SA Partners preliminary review, and provide suggestions for improving cases. During this academic review, the reviewer evaluates both the theoretical and empirical foundations of the case, and its orientation toward both content and pedagogic objectives against global health trends and other competing social science discourses.
4. *Author review* – Case authors review both the preliminary (SA Partners) and comprehensive (HSPH) suggestions and revise the case studies. In preparation for a final Harvard review, case authors respond to the specific reviewer recommendations. Authors submit the revised case studies and a point-by-point response to the reviewer recommendations describing how the recommendations were used or explaining the reasons for not agreeing with the comments or recommendations.

5. *Case finalized* – HSPH evaluates cases based on its own internal case framework which approves cases for teaching at Harvard. UFH and UP have similar internal evaluation frameworks but also emphasize "piloting" cases (in-class testing) as a crucial step towards case finalization. The process for finalization therefore includes an opportunity to use cases in the classroom during the case development process, before final review.

The ASELPH teams from UFH and UP have produced 16 case studies that have entered the review process. Three have been approved by HSPH. (See Appendix 5) Four have been published in *Emerald Insight*, an accredited scientific journal, independent of the Harvard review process. The remaining cases are in the review process, as detailed in Table 4.

Table 4: ASELPH case studies approved and under review

Case Title	University	Authors	Status
Compensating for the shortage of doctors: the case for clinical health associates in South Africa	UFH	Meecham, Maphalala	H
Labour relations in Amajuba District in South Africa	UFH	D Seekoe	A
Clinical governance dilemma around communication and litigation within the health sector	UFH	Tshabalala, Maphalala	H
Piloting National Health Insurance in OR Tambo District	UFH	E Seekoe, Maphalala	F
Re-engineering primary health care: Operational challenges in the health services through a ward-based outreach team lens	UFH, UP	Jinabhai, Thomas, Chaponda	F
Addressing operational constraints through contextual leadership at a KwaZulu Natal public hospital	UFH, UP	Zungu, Mathu, Scheepers	P, H
South African health decentralization: requiring contextually intelligent leaders	UP	Meyer, Thomas, Smith, Scheepers	P, F
Juggling complex systems within a metropolitan health district	UP	Scheepers, Thomas, Meyer	P, H
Contextual leadership of a multi-partner approach to health care innovation	UP	Meyer, Scheepers	P, H
2020 in South African Health Centre	UP	Buch	A
Overcoming barriers to delivering comprehensive primary health care and ward-based outreach teams	UP	Thomas, Chaponda	A
The importance of health data, information and statistics for health planning at district health level	UP	Makola	A
Reforms in financing and budget allocation to improve health system operational efficiency within provincial health services	UP	Makola	A
Capacity for development and implementation of clinical practice guidelines at PHC and hospital facilities	UP	Makola	A
Understanding leadership styles	UP	Thomas, Van der berg-Cloete	A
Addressing the issues of "Not enough Health Workers". Nursing production pipeline: A South African provincial DOH case study.	UP	Thomas	A

Note: A = author revising after SA Partners and/or Harvard reviews; F = case finalized (Harvard sign off); H = Harvard reviewing; P= published

As part of its commitment to producing cases for the ASELPH program, UFH launched a Case Teaching Centre in May 2018. The aim is to produce cases that deal with the reality of hospitals and clinics in underdeveloped regions of the country. Faculty and MPH students at UFH are developing 11 additional case studies on a variety of issues relevant to the South African health system that will undergo review in 2019.

E-LEARNING

E-learning provides fellows with learning opportunities in the form of blended learning. The purpose of developing the blended learning approach was to decrease the on-campus contact time and reduce time taken away from Fellows' professional positions to participate in ASELPH. NDOH expressed concern about the amount of time that health leaders were not at work, thereby causing pressure on an already stressed system. The blended learning substitutes remote delivery of course content using technology for those hours. The ASELPH partners debated the potential impact of a reduced amount of contact time on the quality and value of the ASELPH offerings. The intrinsic value of in-person peer interactions from a diversity of provinces and from diverse areas within the health sector, was deemed important in terms of personal and professional development. The ASELPH partners deliberated on a model that would maintain the essence of ASELPH and also respond to the concerns of the NDOH.

The transition to the blended curriculum was slow due to the need to ensure that quality was maintained. At UP, the blended model was phased in starting with Cohort 2 and refined for Cohort 3, enabling Cohort 4 to be exposed to an expanded e-learning component, with a more diverse use of e-learning modalities. The classic model at UP consisted of a face-to-face module for five days (40 hours) offered once a month for the period of the course, with pre-reading (20 hours) and a post module assignment (40 hours). For Cohort 4, face-to face time is reduced to three days from five. Two modules run straight after one another - Monday to Wednesday for the first one; Thursday to Saturday for the second one - and the face-to-face contact sessions is offered once every two or three months. In addition, a month before the contact sessions, ASELPH Fellows receive additional readings and assignments to complete before the contact sessions. The time to complete these assignments makes up the two days that are not on campus. ASELPH has responded to the needs of the NDOH for less time away from work and there is also the added advantage of a reduction in travel and accommodation over the period of the ASELPH course.

UFH faculty plan to meet in December 2018 to discuss e-learning innovation. It is anticipated that beginning in 2019, UFH will require fellows to attend three days of contact time, with the other two days delivered through the e-learning platform, *Blackboard*. This will involve recorded lessons, live online lectures through *Skype* or *Zoom* with assignments that students have to complete before they attend classes the following week.

UP uses *ClickUP,* a well-established e-learning online platform. *ClickUP* allows faculty to upload module information, presentations, documents, tests, and other electronic materials (readings and articles) for the students to access and make group announcements. The platform also allows students to submit their class group work, assignments, take part in surveys, and give feedback to

faculty on modules. Faculty grade online. In addition, the e-learning platform has largely enabled UP to provide paperless modules.

UFH uses a well-known Learning Management System platform across the university, namely *Blackboard*, which allows faculty to add resources for students to access online. The Department of Public Health also has its own e-learning specialist who trains the lecturers on implementing e-learning in their teaching practices. Regular training sessions take place either face-to-face or via video recordings for lecturers who are not on campus.

DEVELOPMENT OF MENTORSHIP MODEL

One of the foundational elements of the ASELPH program is the strategic involvement of a mentor, in the professional development of ASELPH fellows. The mentoring process was established to support and encourage fellows to manage their own learning in order that they maximize their potential, develop their skills, improve their performance and become the professional health workers they want to be. Mentorship is therefore an important strategy for developing leadership competencies for emerging public health leaders.

Both UP and UFH started their mentorship journey with their respective cohorts independently of one another. However, through a process of continuous evaluation to ensure that it achieves the objective of mentorship in executive leadership training, ASELPH is reviewing the individual university mentoring processes and will develop a joint vision for ASELPH mentorship.

In the early part of the project, the fellows were expected to identify potential mentors and approach them to check for their availability. Universities now help identify mentors - including previous graduates of the ASELPH programme - that are listed on a database. This strategy ensures that fellows have access to mentors that have direct knowledge and understanding of ASELPH and know what is required to successfully complete the program. In addition, the universities convened mentorship workshops to ensure that there is a uniform understanding between the mentors and mentees of the objective of the mentorship program.

The underlying purpose of ASELPH mentorship, includes:

- *Relationship-building*: to encourage the development of professional relationships among leaders at different stages of leadership within the public health system in South Africa;
- *Knowledge-transfer*: to provide a mechanism of sharing of skills, knowledge and experience among managers and leaders within South Africa's health system;
- *Institutional support within higher education institutions teaching public health*: to provide academic institutional support for the transfer of leadership experience and skills from established leaders in the health system to the next generation of health systems' leaders and mangers;
- *Critical mass of leaders*: to harness the strengths of mentorship to create a change movement of leaders and managers within South Africa's public health system that will drive healthcare transformation.

ASELPH CONTRIBUTION TO NATIONAL HEALTH POLICY

ASELPH conducts policy seminars and round tables as a component of the academic offering, and as a contribution to public discourse on health-related issues. UP and UFH both host policy seminars, in partnership with the NDOH. ASELPH and the NDOH co-create the content of the seminars and roundtables.

ASELPH facilitated several policy seminars between 2012 and 2018. From 2012 to 2016, the policy seminars focused on the National Health Insurance (NHI) before and after the release of the first version of the NHI White Paper in December 2015. In 2017, the policy seminars focused on the Community Health Worker (CHW) program as it relates to Ward Based Outreach Teams, with a goal to develop a uniform and standardized implementation plan in the 52 health districts. In 2018, Dr Gail Andrews asked ASELPH to focus the policy seminar theme on Ethical Leadership in Health.

The outcomes of the three broad themes are as follows:

- *NHI Policy (2012 – 2016)* - ASELPH facilitated policy seminars and round table discussions about the NHI to provide a multi-stakeholder forum the opportunity to discuss and debate how to address outstanding issues related to the implementation of NHI. As the seminars and debates occurred, background issues of how to best design the health system using primary health care as the foundation; affordability, and the definition of benefits were evident. ASELPH provided a forum to discuss the evolution of the policy and accompanying legislation that reinforced the right to health care and the formation of the delivery system; payment methods; and services, such as drugs, to be covered. Unanswered questions about financing (both private and public), how to address the decentralized responsibility for health care, merging of the public and private systems, and the need for national legislation to establish the specifics of policies such as the benefits package and eligibility. Development of pilot projects was also discussed. Harvard's global experience was brought into the deliberations.
- *Community Health Worker Policy (2017)* - ASELPH worked in partnership with Ms Jeanette Hunter, the DDG Primary Health Care in the NDOH, and her team. The purpose of this series of workshops was to assist the NDOH secure the inputs of a broad diversity of stakeholders in the development of the implementation plan for the Ward Based Primary Health Care Outreach Team policy. Stakeholders included NGOs involved with community health workers, national and provincial representatives from the NDOH, health activists, as well as academics. ASELPH facilitated discussion and processing of the following topics: 1) Unpacking the WBPHC Policy and Strategy - implications for implementation; 2) Unpacking the Policy's Implementation Plan - identifying the blind spots; and 3) Training for Community Health Workers and their supervisors – Where are we? What is the way forward? ASELPH produced a policy document for the NDOH as a result of these activities. (Appendix 6)
- *Ethical Leadership (2018-2019)* - ASELPH worked in partnership with Dr Gail Andrews, the NDOH COO. A number of seminars and roundtables were hosted in 2018, which will continue into 2019. The public seminars are intended to contribute to the debate around ethical leadership within the health sector, whilst the Ethical Leadership Round Tables are

aimed at focused sectors within the DOH, to raise the issue and identify solutions to dealing with ethical issues in the work place.

In 2018 UFH hosted a public seminar, *Ethics and the Quality of Health Services*. The representatives of the DOH, including Dr Gail Andrews, as well as three ethicists: Prof Dan Wikler, from HSPH; Prof Ames Dhai, university Witwatersrand's Steve Biko Centre for Bioethics; and Dr Chris Allsobrook, UFH's Centre for Leadership Ethics in Africa addressed the event.

During the annual PHASA conference, UFH also hosted a round table *Ethical Leadership Focusing on Professionalism & Conflicts of Interest* for hospital CEOs and District Managers Mr Gavin Steel, Chief Director for Human Resources in the NDOH, and Professor Dan Wikler of HSPH addressed the audience.

In 2019, ASELPH plans to produce several deliverables for the NDOH related to ethical leadership including a short course on ethical leadership and a case study.

ASELPH COMPETENCY FRAMEWORK FOR FELLOWS

An element of ASELPH that is unique within the South African academic context is the competency framework that was developed for ASELPH fellows by the ASELPH team. The 14 competencies are listed in Table 5.

Table 5: ASELPH competencies

Competency	Description
People Management and Empowering Environment	Must be able to manage and encourage people in a collaborative environment, advocate for team work, optimize their outputs and effectively manage relationships in order to achieve organizational goals.
Self-Management	Must be able to recognize one's learning style, personal attributes, professional development needs, be good with time management and taking initiative.
Honesty and Integrity	Must be committed to honesty and integrity, build and displays high standards of ethical and moral conduct, apply self-corrective measures and be reliable and accountable.
Client Orientation and Customer focus	Must acknowledge customer rights and be committed to a client orientated approach to service delivery according to Batho Pele principles.
Communication	Must be able to use verbal and written communication competently, be committed to the exchange of ideas, sharing of ideas and practices both internal and external communication effectively and consistently.
Resource Management and Allocation	Must be able to manage the human resources, physical resources and materials of the organization in accordance to strategic plans of the organization and within the legal and policy framework.
Financial Management	Must be able to compile and manage budgets, control cash flow, institute risk management and administer tender procurement processes in accordance with generally recognized financial practices in order to ensure the achievement of organizational objectives.
Problem Solving and Analysis	Must be competent at the systematic identification, analysis and resolution of existing and anticipated problems on a timely basis and manage the risk appropriately.

Table 5: ASELPH competencies

Competency	Description
Program and Project Management	Must be able to develop, implement, evaluate and adjust plans to achieve desired objectives, while ensuring the optimal use of resources.
Community/ Partnership Collaboration	Must be able to align the organization's priorities with the needs and values of the community, implement the governance framework and ensure stakeholder involvement and networking.
Knowledge Management	Must be able to promote and share knowledge, information, and lessons learnt, and applying theory into practice.
Strategic Leadership	Must be able to provide vision, give direction and inspire others in order to deliver from an organizational mandate.
Change Management	Must be able to initiate and support organisational transformation and change in order to successfully implement new initiatives and deliver on service delivery commitments.
Service Delivery Innovation (SDI)	Must be competent in process integration, policies and structures across the organization to achieve improved efficiency and effectiveness on SDI and implement new ways of performing tasks and develop the organizational as a whole.

ASELPH fellows participate in a self-assessment of the competencies and their peers and managers complete a 360-degree evaluation to assess whether these competencies have been achieved by the fellows during their engagement with ASELPH.

In 2017, ASELPH partners conducted a strategic review of the 14 leadership competencies and recommended changes to 11 of the 14, as well as a revision in courses to support these changes. The competencies and the recommended changes are:

- Honesty and integrity (ethical considerations) – greater curricular depth required to assist fellows respond to issues of corruption, malpractice, maladministration and basic professional issues within the workplace and inculcating an ethical leadership ethos of responsibility to the citizenry
- Self-management – self-mastery, reflection, self-understanding and personal development to be strengthened. Great emphasis on the "softer" management issues, such as interpersonal skills and empathetic management techniques rather than on the "hard" intellectual components.
- Communication – develop a module that focuses on basic writing skills, comprehension and analysis based on practical, everyday needs of managers.
- Client orientation – entrench the principles of Batho Pele by making it a continual theme in the teaching cases, class discussions and assignments.
- Project management – greater emphasis must be made to include specific policy priorities within the curriculum (e.g. WBOT) and ensure adequate understanding and analysis of such policies and their implementation challenges.
- Financial management – this is a constant theme throughout the course. Address specific needs more thoroughly, for example the handling of financial spreadsheets and health accounts.
- Community partnership/collaboration – this area requires greater attention and to be refocused in light of the principles of *Batho Pele*. Specific curricular content to be included

that provide a pragmatic overview of how fellows can increase the quality of local participation in health affairs and include case studies from different countries.

- Change management – greater emphasis to be placed on effecting strategic leadership and how managers at all levels can facilitate the strategic goals of their organizations.
- Data and technology – to be a more constant theme throughout the curriculum. Must address the salient contemporary themes issues of social media, using data effectively, cyber-security, innovative health delivery platforms. Prepare fellows to read and anticipate how science and technology will influence health in South Africa.
- Implementation science – greater emphasis to be placed on using data to inform implementation challenges and how to monitor the effectiveness of their programs at the local level.
- Clinical governance – further curricular depth required for fellows to pragmatically apply ASELPH skills to the area of clinical governance.

The ASELPH team began implementing the curriculum review recommendations in August 2018.

MONITORING & EVALUATION

Monitoring and Evaluation (M&E) of the ASELPH program is an important process to ensure that there is continuous improvement in the quality of the offering. The M&E process used in the ASELPH program includes course evaluations by the fellows, reflective essays, self and 360-degree assessments of fellows' competencies, and the impact of ASELPH on the national health system as a whole.

ASELPH course evaluations

The purpose of the daily ASELPH course evaluations is to ensure immediate and responsive improvement of course offerings, the refinement of course delivery methods, and to provide the SMT with an objective overview of each ASELPH course that is offered.

UP captures the daily evaluation of lectures electronically using *Qualtrics.* The UP Program Manager oversees the process. UFH uses *Survey Monkey*. UFH's e-learning specialist manages the process. After each module, a report is generated and shared with the SMT, providing an overview of the experience by ASELPH fellows of the particular module. Areas of concern are highlighted and used by the respective universities to improve their delivery of the modules.

In October 2017, ASELPH conducted an independent review of the course evaluations produced from 2012 to 2017 (Appendix 7). The purpose of the review was to identify trends, indicate key messages from the evaluations and answer the question: *are we getting better?* The report concludes:

> "*The picture that emerges from the comparison of the various courses and cohorts is one of consistency in self-reported learning outcomes. On the whole, there hasn't been a great deal of improvement or regression, but there hasn't needed to be. Students consistently report being happy with the courses and the presentation of content. Overwhelmingly, there is positive feedback on course organisation and management.*

> *There are some interesting, noteworthy trends which do emerge from the data, but these only serve to underscore the consistency in outcomes throughout the years. The most notable of these trends is the students' response to group discussions. Group discussions score consistently amongst the most well-received aspects of all the courses. Students report that the opportunity to discuss the topics with the lecturers and their fellow students is an invaluable and irreplaceable facet of the learning process. …The importance of this form of engagement with the course material cannot be understated."*

The ASELPH fellows' responses to group discussions was considered when the issue of reducing face-to-face time was deliberated by partners.

ASELPH self-evaluations

To evaluate whether ASELPH fellows have acquired or developed the 14 ASELPH competencies ASELPH uses a fellow self-assessment process and 360-degree process involving peers, supervisors and subordinates. (Figure 2).

Figure 2: Fellow self-assessment and 360-degree review process

We provide a brief description of the results of this process in Section 4.

ALUMNI ACTIVITY

Having an engaged and coordinated alumni group is critical for the ongoing sustainability and impact of the ASELPH program. The ideal is to have a network of similarly trained and inspired health workers in South Africa to take on the baton of health activism, in order to facilitate health

transformation. In addition, an alumni association enables the health leaders to continue to support and mentor each other in their day-to-day work.

Each university began their alumni engagement working with their alumni independently, ensuring that alumni involve themselves in an array of ASELPH activities. These includes writing case-studies, participating as emerging faculty members, acting as mentors to new ASELPH fellows and, where applicable, helping identify new ASELPH recruits. In the past three years UP has successfully hosted a modest annual event for their alumni. UFH successfully launched the KwaZulu Natal alumni chapter in 2017.

In early 2018 ASELPH leadership resolved that as more ASELPH fellows graduate and represent all nine provinces, provincial chapters of ASELPH should be convened rather than basing alumni chapters on university affiliations. ASELPH has created an ASELPH database of active and graduated fellows to assist with this process.

4. Results and outcomes

This section describes the results and accomplishments that have been realized in the project period as a result of the activities detailed above. We organize the results according to the three overarching aims of the USAID investment as detailed in the introduction, as well as the seven focus areas that were agreed to in the co-operative agreement with USAID of October 2017. We also provide a summary of The Public Health Agency's 2016 evaluation of ASELPH.

SERVICE DELIVERY IMPROVEMENTS – DEVELOPING MANAGEMENT AND LEADERSHIP CAPACITY (USAID AIM 1)

ASELPH enrollment and graduation: increasing the number of trained mangers and leaders

Over the period from 2013 to 2018, UP and UFH enrolled a total of 340 health managers into their ASELPH programs and 302 (88.8 percent) maintained their academic engagement. Table 4 and Table 5 provide summaries of enrolled fellows by cohort at UFH and UP, respectively.

Table 4: Status of UFH enrollees on the ASELPH MPH, as of October 2018

Enrollment date	Number enrolled	Number maintained	Number graduated
Cohort 1: May 2014	51	46	26
Cohort 2: June 2015	27	21	pending
Cohort 3: May 2017	32	23	Not yet eligible
Cohort 4: March 2018	19	18	Net yet eligible
Total	**129**	**108**	**26**

By September, 30 2018, a total of 46 ASELPH MPH fellows from Cohort 1 and 21 from Cohort 2 completed the required course work at UFH. A total of 26 fellows from Cohort 1 successfully submitted, and passed their dissertations, and graduated in October 2018. This signifies a 63 percent pass rate for Cohort 1. The balance of Cohort 1 and Cohort 2 are expected to graduate in May 2019 as UFH has resolved institutional obstacles that prevented an earlier graduation date for the first and second cohorts.

Table 5: Status of UP enrollees on the ASELPH PGD, as of October 2018

Enrollment date	Number enrolled	Number maintained	Number graduated
Cohort 1: October 2013	57	54	53
Cohort 2: April 2015	45	39	35
Cohort 3: September 2016	51	49	46
Cohort 4: September 2018	58	56	not yet eligible
Total	**211**	**197**	**134**

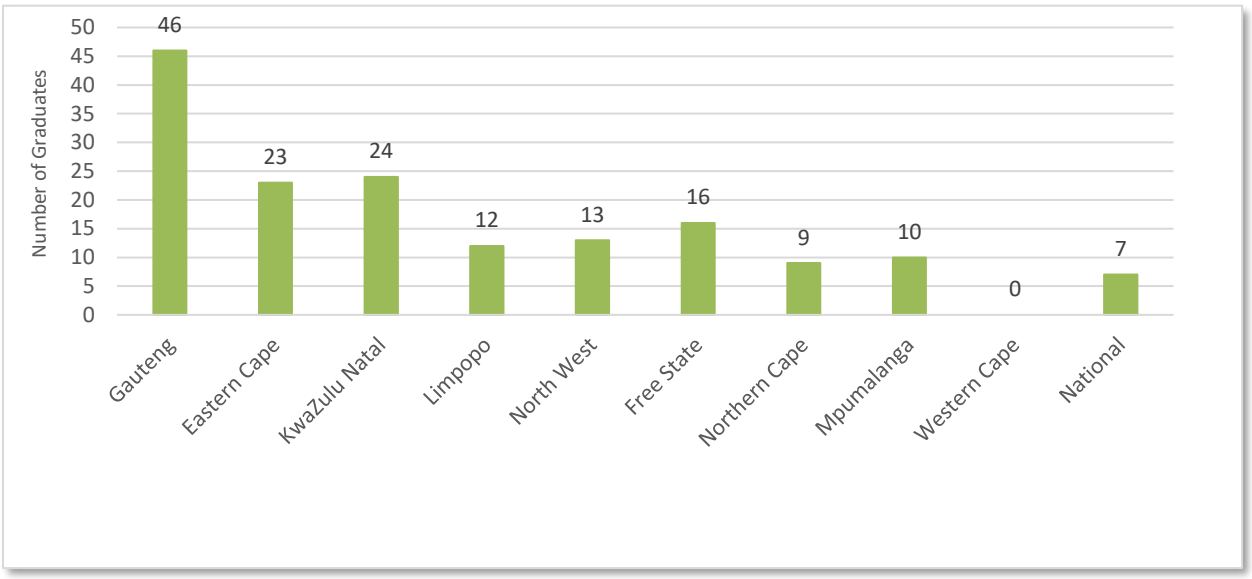
By September, 30 2018, a total of 134 ASELPH UP fellows from Cohort 1, Cohort 2 and Cohort 3 had graduated with a PGD in Executive Leadership, reflecting a 94.4 percent graduation rate among those who had maintained enrollment and were eligible for graduation and an overall 87.6 percent graduation rate among those who enrolled and would have been eligible for graduation (Table 5).

The comprehensive lists of enrolled fellows and the most recent details of their role within the South African health system are available in Appendix 8.

Box 1 - Dr Rolene Wagner obtained an MBChB (UCT) in 1996. She has worked in both in the public and private sectors as a Medical Officer at Community Health Centres in both the Eastern Cape and Western Cape Provinces, Director Complex and Regional Hospitals, and General Practitioner at Medicross. Dr Wagner returned to the public sector, as CEO of the Frere Hospital, a 900-bed academic tertiary hospital in East London. As an important contributing member of UFH's ASELPH 2014 Cohort 1, she graduated with a Masters in Public Health in September 2018. Together with her team, she has spearheaded the turnaround strategy at the Frere Hospital. The services at Frere are measurably more patient-centered; are safer with better patient outcomes and of a standard that has improved overall patient satisfaction. In 2018 she received the KwaZulu Natal Doctors in Healthcare Discovery Emerging Leader Award and the Frere Hospital received the International Hospital Federation's top Dr Kwang Tae Kim Grand Award, for its turnaround quality improvement project.

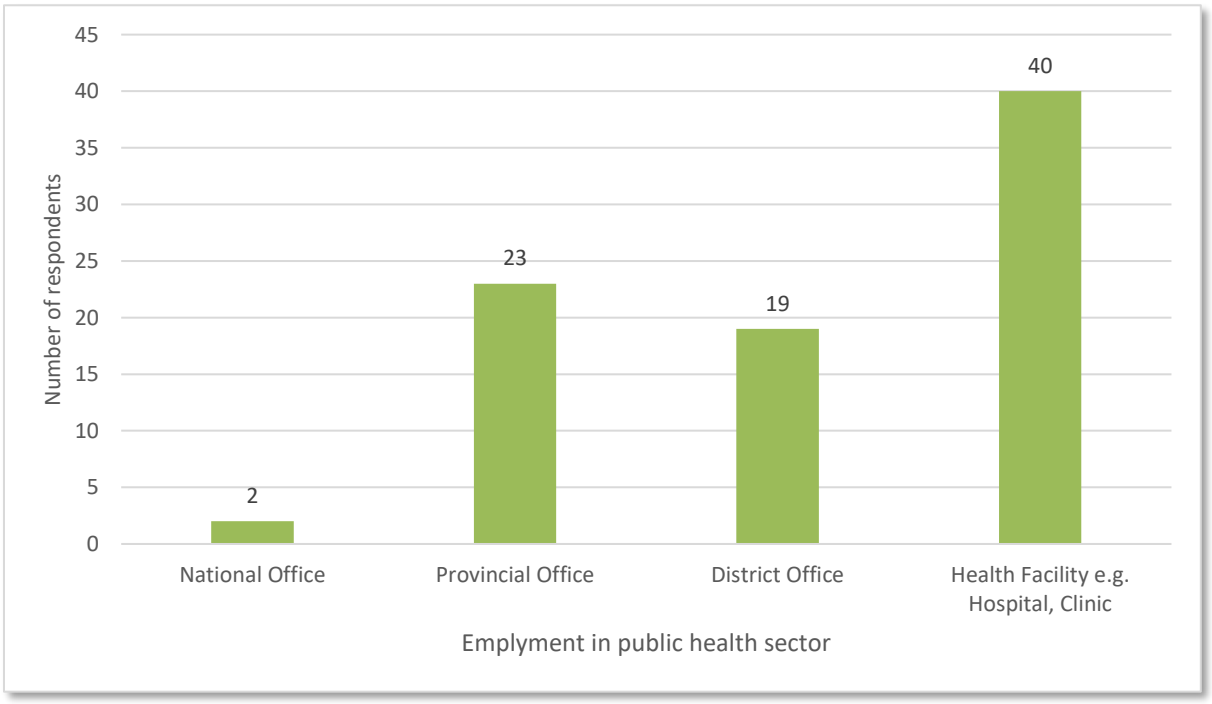
By October 2018, a total of 160 health practitioners from within the South African health sector had graduated with either a PGD from UP (134), or an MPH from UFH (26). The full list of graduates is available in Appendix 9. Of the 160 graduates, 93 (58.1 percent) come from Gauteng, Eastern Cape, and KwaZulu Natal provinces as shown in Figure 3. A profile of one graduate is presented in Box 1.

Figure 3: Distribution of ASELPH graduates by province and National Department of Health



A recent survey of ASELPH graduates produced a 64.4 percent response rate. A majority, 90.3 percent of respondents are employed in the State sector. The survey also revealed that 59 of the 84 (70.2 percent) graduates who responded hold positions either within district office structures or within health facilities, such as hospitals, clinics or related entities (Figure 4). This concentration of graduates in the districts or health facilities indicates the potential impact that the graduates have the potential to impact on the health system at district level.

Figure 4: Distribution of ASELPH graduates within the Department of Health structures



Outcome of ASELPH fellows' self-assessment and 360-degree review of competencies

The real impact of the ASELPH program on the health system will be seen in the influence that ASELPH fellows will have as they execute what they have learned, in the work place. This impact will be seen over a period of time once a critical mass of health practitioners take part in transformative executive leadership. ASELPH has gone some way to deliver appropriately trained health professionals, and has started assessing the impact that these professionals may have on the health system.

As described above, ASELPH has endorsed an evaluation process for ASELPH fellows that includes a self-assessment and 360-degree review, to assess whether ASELPH fellows have gained competency in the 14 ASELPH competencies. Appendix 10 contains a summary of the results of the self-assessments and 360-degree reviews for the UFH and UP cohorts.

Box 2 - "ASELPH changes attitudes. It helped me grow from being a medical practitioner to become a manager. It taught me how to become firm when necessary, and to adopt a problem-solving approach … I began to understand the significance of how the work environment and context influences performance."

Dr S Tshabalala
CEO Prince Mshiyeni Memorial Hospital, KZN

A study undertaken by a UP faculty member has provided validation of the methodology used to assess fellows' competencies. The second cohort of UP fellows served as a study sample for research to assess whether the part-time ASELPH executive leadership program, based on competencies, and using the case studies as a core methodology, successfully enhances the leadership performance of public health service leaders and managers in South Africa. The study used a mixed-method, quasi-experimental study design, with pre-and post-assessments by the fellows and a 360-degree assessment by their supervisors, peers and subordinates (assessors). The research determined fellows' improvement at the workplace in the 14 competencies and on a subset of 56 performance indicators. In spite of the small sample size, the ASELPH fellows showed statistically significant improvement in 11 of the 14 competencies and 46 of the 56 performance indicators. The effectiveness of the ASELPH Fellowship was further affirmed by the qualitative information shared by their assessors. [5]

[5] Personal communication from Prof Eric Buch, University of Pretoria.

The unique features of the ASELPH Fellowship such as the values framework, development of generic leadership competencies, case-based teaching, e-learning, round-table conference-style classrooms, group-work, networking, mentorship and workplace-linked assignments were identified as factors underpinning the success of ASELPH. In addition, the research also found that the ASELPH faculty's depth of expertise and experience of the South African health system also contributes to the quality and relevance of learning. Areas to be improved included the balance between class and online learning, more South African case studies, and mentorship in the workplace.

Box 3 - Examples of assessors' comments from 360-degree reviews

- "He has got the best interest of the facility at heart. He has taken a bigger role in ensuring that the team jells. He has been pivotal to ensure that Management Team comprised of Head of Administration, Head of Nursing and Head of Clinical work together in utmost harmony. "
- "The participant is a driven person who has done well in starting a new Directorate with no guidance at all. She manages because she engages other managers on issues that will take the Nursing Directorate to greater heights. Among documents she has drafted is the Draft Nursing Strategy for KZN and three policies. She has also written a Nurse Manager's handbook. She motivates others to work hard and reach their full potential. I have also heard from other colleagues speaking highly of her. The manner in which she speaks to her colleagues is motivating."

HUMAN RESOURCE DEVELOPMENT TO SUPPORT TRANSFORMATION (USAID AIM 2)

Impact of the ASELPH program on career paths within the health sector

ASELPH has made a contribution to the human resource development needs of the NDOH by supporting South African health practitioners by providing career advancement opportunities. In addition the policy debates has helped to clarify several areas of human resources need and strategies for implementation (such as CHW). The targeted offerings of short learning programs in support of the national department's goals also supports human resource development.

In the recent survey of ASELPH graduates, 42 (41.6 percent) indicated that they had a new career position since enrolling in or graduating from ASELPH. Among the 42 health practitioners with new positions, 33 (78.6 percent) indicated that they had been promoted.

The survey also asked graduates to provide, "one word that describes the impact of the ASELPH program on your career within the health sector". The word cloud below indicates that Leadership, Empowerment, Confidence and Transformation were the areas of personal impact on the ASELPH fellows.

Short learning program offering at UFH, through the Health Sciences Institute, and at UP

As part of its commitment to human resource development within the Department of Health, ASELPH began work on the development of short-learning programs. To date the HSI at UFH has run eight courses. Two for middle and senior managers in the Eastern Cape DOH and one for managers/supervisors from Livingstone Hospital in Port Elizabeth. The five other courses were health skills programmes for senior managers. The Eastern Cape DOH has not prioritized the training of the senior managers but has rather prioritized technical skills training such as emergency medical services and life support systems that are urgently needed in the hospitals.

In addition, the HSI has successfully competed in a national tender from the Office of Health Standards Compliance. The tender seeks to train the national health inspectors in fulfilling their processes of accreditation for the hospitals and clinics in South Africa. The HSI has also submitted nine other tender bids, including a joint international bid.

The Gauteng DOH has identified the UP Certificate in Health Service Management and the short course in ethical leadership as a provincial need and submitted a request to HWSETA for funding. UP plans to continue marketing the short learning program in 2019.

Contributing to the national policy debate and implementation

The policy seminars and round tables that were organized in partnership with the NDOH focusing on NHI, Community Health Workers, and Ethical Leadership, performed a dual role of human resource development for the NDOH, as health practitioners from ASELPH and beyond were active as both participants and presenters. They assisted the NDOH to address some of the critical issues that confront the department to offer quality health care to South African citizens. A policy brief on the Ward Based Primary Health Care Outreach Teams was produced based on the three seminar reports which ASELPH developed (Appendix 6). ASELPH also produced a report based on findings from a rapid appraisal of the Ward Based Outreach Team (WBOT) model in National Health Insurance (NHI) pilot sites in seven provinces.[6] Recognized for its expertise on community health workers, ASELPH also contributed to a report on the role of community health workers in supporting the early childhood workforce. [7]

[6] CC Jinabhai, TS Marcus and A Chaponda. Rapid Appraisal of Ward Based Outreach Teams. Pretoria: Minuteman Press Lynnwood. October 2015. ISBN 978-0-620-68852-9

[7] Supporting the Early Childhood Workforce at Scale. Community Health Workers and the Expansion of First 1000 Days Services in South Africa. Washington, DC. Results for Development Institute. 2018

EXCELLENCE IN EXECUTIVE LEVEL TRAINING: BUILDING CAPACITY AT UP AND UFH (USAID AIM 3)

With the support of USAID, ASELPH has made significant inroads into offering a quality executive leadership program to health professionals in South Africa. The quality teaching that was achieved is underpinned by quality development of faculty members at both UP and UFH.

Building capacity: ASELPH faculty development and faculty competencies

Box 4 - "Since ASELPH … I am more participative, and endeavour to engage managers in the district … Whereas we used to work in parallel structures, I have tried to build teamwork … I learnt new concepts, as well as how to take action using those concepts. I feel that I am now able to manage the complex issues that arise within a District Health system."

Ms Linah Maepa
District Executive Manager: Sekhukhune, Limpopo

HSPH faculty members worked closely with the local South African faculty in mentoring and developing capacity and skills to teach using the case-study method. UP and UFH combined their ASELPH experiences and their university competency frameworks to develop an ASELPH faculty competency framework, which was endorsed by HSPH.

The faculty development process is an ongoing initiative within ASELPH. The PI at UP has developed a faculty development plan template that all members of faculty use to identify areas in which they need support; the plan is then discussed and agreed upon. This plan involved each member of faculty identifying specific areas in which they needed further development. This resulted in faculty members going through significant development over the years. The development activities included attendance of workshops and conferences in line with the areas of interest related to ASELPH responsibilities. It also included case study writing and teaching, e-learning, research, active classrooms, and were subject to peer review.

As part of the development of capacity faculty members have presented their work in both local and international conferences over the years. A number of presentations were made by ASELPH faculty and alumni at the annual PHASA conferences. A presentation was made on the experience of ASELPH as a leadership development program at the American Public Health Association Conference in Denver, USA in 2016 and the Global Forum on Human Resources for Health in Ireland in November 2017.

Case study development

One of the areas of capacity building of faculty members in ASELPH, was the involvement of faculty in the development of South African case studies. Both UP and UFH engaged faculty in the case study writing process. UFH has engaged ASELPH fellows and graduates, as health practitioners, to be case writing. The involvement of ASELPH fellows in case writing proved challenging due to their work commitments. This resulted in a core group of faculty members at the universities doing most of the writing, using themes suggested by the fellows.

UFH and UP faculty members benefited from attending case study writing workshops at HSPH and at UP's Gordon Institute of Business Sciences, and have translated their learnings into the development of case studies relevant to South Africa for the ASELPH curriculum. Faculty who participated in the case writing workshops are mentoring their faculty colleagues in the case development process.

The development of local case studies is not only an important development process for the ASELPH faculty teams in South Africa, but also impacts positively on the learning experience of the ASELPH fellows. The development of locally relevant cases is responsive to the NDOH and the ASELPH fellows.

ASELPH INDEPENDENT EVALUATION

In 2016, The Public Health Agency conducted an evaluation of ASELPH (Appendix 11). The major findings are summarized below:

1. ASELPH's approach to both teaching and learning is exceptional. The outstanding features cited by participants included the ways in which ASELPH promotes peer learning; the applicability of tools and methods taught to real life situations; and the focus on training executive leadership rather than a generic approach to public health that includes leadership training.

2. There are tremendous benefits from an academic strategy to drive development. ASELPH established an academic program and monitors progress and self-reported changes in leadership competency.

3. Partnership with the National DOH allows ASELPH to fulfill its mandate of responsiveness. The direct engagement of NDOH helps ASELPH to fulfill its mandate of being responsive to DOH's policy imperatives and implementation priorities, making ASELPH more relevant for its fellows.

4. The partnership requires collective ownership and responsibility and the continual strengthening of all partners. The ASELPH academic partners were chosen deliberately for their individual strengths as well as with a long-term goal of equity, utilizing the program to further strengthen a historically disadvantaged university.

5. The careful selection of fellows enhances the overall quality of the learning experience. There is professional diversity in the program, including representation from hospitals, health programs, support systems, human resources, and finance as well as a mix of policy makers and implementers. This diversity enhances the fellows' understanding of the public health system as a whole and also illuminates their own role within it.

6. Support from senior provincial DOH managers is vital and increases ASELPH fellows' opportunities to bring constructive change to their workplaces. However, fellows acknowledge challenges exist to bringing change to their work sites.

7. There is a need to measure faculty development. The South African ASELPH faculty, as well as the fellows, report increased competence and confidence from their involvement in ASELPH. Still, it is important to create a framework and establish criteria for faculty competency.

8. Local research would strengthen case studies. Information gleaned from the applied research conducted by ASELPH fellows could be used to develop new case studies and inform course materials, thereby helping to ensure that the ASELPH curricula remains relevant and up-to-date.

Box 5 - "… even though I was in a management and leadership post, I used to take an operational approach. Since I have been an ASELPH Fellow … I am now able to prioritise and manage time, as well as handle multiple projects and deadlines effectively. The ASELPH approach … helped strengthen my ability to be strategic and make meaningful contributions towards improving South Africa's Health Systems ..."

Mr Montwedi Botsane
Director: Budget Management, Gauteng

5. Conclusions

The ASELPH program has made significant strides in its objectives of training executive leaders for the health system in South Africa. The number of fellows that have successfully completed the program are widely distributed geographically and across the South African health system. Initial indications based on self-assessments and 360-degree reviews and anecdotal evidence suggest that these leaders are beginning to make some demonstrable impact in the areas of their functioning. The yet-to-be released USAID funded SPACES-MERL framework for evaluation at the systems level, will provide more insights into the impact that ASELPH fellows are having within the national health system, through the social network analysis, and systems mapping of ASELPH participants, their skills and their role within the health system.

The strategic partnership between ASELPH and the National and Provincial Departments of Health place the program in a unique position as an academic program that trains emerging leaders within the correct context reflective of the current realities and challenges of the health system in South Africa. More importantly ASELPH prepares them for envisaged NHI health systems reforms that are in various stages of implementation.

The ASELPH program has also made its contribution in terms of providing technical support and assistance to the NDOH in the areas of strategic policy development and implementation. The NHI,

CHW, and Ethical Leadership policy contributions enable the NDOH to implement policies informed by feedback from those responsible for implementation.

ASELPH has drawn useful lessons and experience in the challenges. The inherent complexity of the health system means that it is challenging to demonstrate - with confidence and scientific accuracy - the impact that ASELPH is having on the overall functioning and stewardship of the system. However, having a cohort of change agents is likely to impact positively in the areas where ASELPH fellows are located and this is borne out by the improvements in performance found in the detailed evaluation of the UP second cohort.

As The Public Health Agency concludes, "ASELPH has established itself in the health executive leadership development space. It provides an offering that is unique in method and content. The program is making a contribution to health system strengthening in South Africa and has the potential to impact significantly going forward, particularly if attention is given to the e-learning and post-classroom support components. Institutionalization of the PGD and MPH at UP and UFH plays a significant role in program sustainability. ASELPH should definitely continue and strong efforts should be made to mobilize resources to support the next phase of the program".

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Albertina Sisulu Executive Leadership Programme in Health

Excellence, Innovation, Transformation

Final Report Appendices

Global Development Alliance: AID-674-A-13-00002

Project Title: South African Executive Leadership Program in Health (SAELPH)

Reporting Period: Full project period (October 1, 2012 – September 30, 2018)

A partnership of

University of Pretoria

University of Fort Hare
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Appendices

Appendix 1: MOAs

Appendix 2: ASELPH short courses

Appendix 3: Curriculum review recommendations

Appendix 4: Guide for Developing an ASELPH Case

Appendix 5: ASELPH Cases

Appendix 6: Ward Based Primary Health Care Outreach Teams Policy Brief

Appendix 7 Course evaluation report

Appendix 8: ASELPH Cohorts

Appendix 9: ASELPH Graduates

Appendix 10 UFH and UP fellows assessment

Appendix 11: ASELPH Evaluation

Appendix 1: MOAs

MEMORANDUM OF AGREEMENT

entered into between

The National Department of Health
herein represented by **Ms Precious Matsoso** in her capacity as
the **Director General of the National Department of Health** duly authorized thereto
(hereinafter referred to as the "NDOH")

AND

The University of Pretoria
herein represented by **Prof Cheryl M de la Rey** in her capacity as
Vice-Chancellor and Principal duly authorized thereto
(hereinafter referred to as "UP")

AND

The University of Fort Hare

herein represented by **Dr. Mvuyo Tom** in his capacity as

Vice Chancellor duly authorized thereto

(hereinafter referred to as "UFH")

AND

The President and Fellows of Harvard College through Its School of Public Health

herein represented by **Jorge I. Dominguez** in his capacity as

Vice Provost for International Affairs duly authorized thereto

(hereinafter referred to as "HSPH")

AND

South Africa Partners

Herein representetd by **Mary Tiseo** in her capacity as

Executive Director duly authorized thereto

(hereinafter referred to as "SAP")

(collectively referred to as "the Parties/ Partners")

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1. BACKGROUND

WHEREAS the National Department of Health has a need to build the required skills, competencies and experience among existing and emerging national, provincial and local government managers;

AND WHEREAS the Parties have investigated current health management training capacity in South Africa and have designed the South African Executive Leadership Program in Health (SAELPH) to address critical gaps in executive health management training on the abovementioned three levels and to contribute to the goals of the Health Minister's Health Management Development Plan for the country;

AND WHEREAS SAELPH aims to increase capacity and quality of leadership of the health systems in South Africa by bringing together teaching and health leadership experience from a variety of organisations to learn, teach and share aspects of leadership practised globally;

AND WHEREAS the University of Pretoria, through its School of Health Systems and Public Health has grown its capacity to deliver high quality multi-disciplinary education, research consultancy and advocacy and has contributed in addressing public health challenges facing South Africa and Africa;

AND WHEREAS the University of Fort Hare strives to provide high quality multi-disciplinary health science programs that meet the needs of rural and resources constrained environments and has been involved in various partnerships and donor-funded projects with international donors and the South African Government;

AND WHEREAS the President and Fellows of Harvard College through Its School of Public Health has a tradition of scholarship and research in international health, marked by longstanding commitments to improvement of health in developing countries and the health status of people living in transitional economies;

AND WHEREAS South Africa Partners has a long history of supporting partnership development between the United States and South Africa and has worked to build health infrastructure in South Africa since 2000;

AND WHEREAS University of Pretoria, the University of Fort Hare, the Presidents and Fellows of Harvard College through its School of Public Health and South Africa Partners, united and motivated by the strong social values of equity and "health for all" underlying the SAELPH-programme, wish to participate in the development and implementation of the programme to build in-country health and management capacity.

NOW, THEREFORE, DESIRING TO ESTABLISH A MUTUALLY BENEFICIAL RELATIONSHIP, THE PARTIES WISH TO COLLABORATE AS FOLLOWS:

2. DEFINITIONS

2.1 In this MOA, unless inconsistent with the context, the following expressions and/or words bear the meanings set out below and derivative expressions and words will have a corresponding meaning:

2.1.1 "**NDOH**" means the National Department of Health;

2.1.2 "**UP**" means the Faculty of Health Sciences, University of Pretoria, a higher education institution and juristic person established in terms of the Higher Education Act 101 of 1997, as amended, with its registered address at Lynnwood Road, Hillcrest, Pretoria, 0001, herein duly represented by Professor Cheryl de la Rey, Vice-Chancellor and Principal;

2.1.3 **"UFH"** means the University of Fort Hare, a university duly established under the Higher Education Act No 101 of 1997 as amended, herein represented by Dr Mvuyo Tom, duly authorised thereto and acting by virtue of delegated authority;

2.1.4 "**HSPH**" means the President and Fellows of Harvard College, through Its School of Public Health a Massachusetts non-profit educational corporation under 501(c)(3) of the Federal Tax Code with a principal place of business at 677 Huntington Avenue, Boston, MA 02115;

2.1.5 "**SAP**" means South Africa Partners, Inc., acting through the organization's headquarters in Boston, Massachusetts led by Mary Tiseo, Executive Director, and its South Africa office in East London, represented by Ms. Tabisa Bata, Program Manager;

2.1.6 "**Agreement**" means this Memorandum of Agreement concluded between the NDOH, UP, UFH, HSPH and SAP;

2.1.7 **"Parties/Partners"** shall mean NDOH, UP, UFH, HSPH and SAP; and **"Party"** shall mean any one of them, as indicated by the context;

2.1.8 **"Implementing Partners"** shall mean UP, UFH, HSPH, and SAP;

2.1.9 "**Partner Institutions**" shall mean UP, UFH and HSPH;

2.1.10 "**SAELPH**" means the South African Executive Leadership Program in Health;

2.1.11 "**Program**" means the SAELPH program;

2.1.12 "**representatives**" mean the representatives appointed by the Parties to liaise and make decisions, where necessary, to ensure that each Party complies with this Agreement;

2.1.13 "**Signature Date**" means the date of the last Party signing this Agreement; and

2.1.14 "**Period**" means the duration of this Agreement as cited in clause 14.

3. INTERPRETATION

3.1 In this Agreement, unless the context requires otherwise:

3.1.1 Headings are used for convenience only and shall not be used in the interpretation of the Agreement;

3.1.2 When any number of days is prescribed in this Agreement, same shall be reckoned as calendar days exclusively of the first and inclusively of the last day unless that day falls on a Saturday, Sunday or public holiday, in which case the day shall be the next succeeding calendar day which is not a Saturday, Sunday or public holiday;

3.1.3 Where figures are referred to in numerals and in words, if there is any conflict between the two, the words shall prevail.

4. PURPOSE

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4.1 The Parties undertake to co-operate in the development and implementation of the SAELPH-program with the view to strengthen the South African public health system through the work described below, provided that each Party shall have only the specific responsibilities set forth in this MOA or in other related written agreements entered into by that Party.

4.1.1 **Service Delivery Improvements**

The management and leadership capability of current and emerging executive leadership at district level within the South African Public Health System and those executives at provincial and national level responsible for district level services, will be targeted.

4.1.2 **Human Resource Capacity Development**

The selection and training of executive level management for the National Health Insurance Initiative transformation process is intended.

4.1.3 **Excellence in Executive level Training**

The building of critical capacity at the UP and UFH in collaboration with the HSPH to establish standards and to deliver courses that will meet the country's long-term goal of a highly trained and effective pipeline for senior health managers that are capable of successfully addressing key challenges at all levels of service delivery within the country is envisaged.

4.2 The Parties agree that a Steering Committee be instituted to give direction for the Program. The Steering Committee shall have only the responsibilities specifically stated in this MOA.

5. PRINCIPLES GUIDING THE COLLABORATION OF THE PARTIES

5.1 Collaboration between the Parties shall be based on acceptance of equal status. The Parties shall seek not only to learn and gain from the co-operation but also seek to contribute actively thereto.

5.2 The collaboration is guided by a spirit of active learning, building of faculty capacity and strengthening of institutional systems and processes.

5.3 The Parties being very conscious of the urgency of executive leadership and management development, shall however seek to balance the urgency of delivery with ensuring excellence and development of long term capacity.

6. THE STEERING COMMITTEE

6.1 The Steering Committee (hereafter "the SC") will be organized as described below.

6.1.1 The SC will be constituted as follows:

- 6.1.1.1 DDG: AHSC & HR , NDOH (Chairperson) or his/her representative
- 6.1.1.2 HODs (Free State, KZN and Western Cape) or his/her representative
- 6.1.1.3 UFH (Vice Chancellor or his/her representative)
- 6.1.1.4 UP (Dean or his/her representative)
- 6.1.1.5 HSPH (Principle Investigator or his/her representative)
- 6.1.1.6 3 Health Experts appointed by the Director-General: Health
- 6.1.1.7 DOH Senior Executive: DDG: PHC , NDOH or his/her representative
- 6.1.1.8 One representative from each Funder providing more than 20% of budget
- 6.1.1.9 2 Sisulu Family Representatives designated by the Sisulu Family
- 6.1.1.10 Secretariat – Project Managers (UP, UFH and SAP) with no voting rights

6.1.2 The SC shall have the power to co-opt additional expertise from the private or public sector.

6.1.3 The DDG: AHSC & HR shall act as Chairperson of the Steering Committee and secretariat services will be provided by the three Program Managers of UP, UFH and SAP.

6.1.4 The SC shall meet at least twice a year and the quorum for a meeting shall be 50% (fifty percent) of all members (or their proxies) plus one, who have to be present at the commencement of the meeting or teleconference. Inter-sessional consultation may take place electronically or telephonically on an ad hoc basis. The Secretariat shall give at least 14 (fourteen) days written notice of meetings, unless the next meeting's date was decided during the preceding meeting.

6.1.5 Decisions shall be taken by a simple majority of members present.

6.1.6 Each Party reserves the right to withdraw any of its members from the SC and to replace such member at any time by giving written notice thereof to the other Parties.

6.1.7 The SC will support the achievement of the following goals:

6.1.7.1 to establish and maintain a critical mass of knowledge, skills, competencies and leadership among current and emerging national, provincial, and district health leadership in South Africa;

6.1.7.2 to improve the translation of NDOH policy into successful implementation strategies;

6.1.7.3 to further the NDOH's goal of promoting and maintaining quality service delivery at the district level;

6.1.7.4 to build capacity among South African faculty at the University of Pretoria and the University of Fort Hare so they are capable of building successful training programs for executive health management leadership and offering that training in future;

6.1.7.5 to review the strategic roles and responsibilities of the collaborating parties; and

6.2 The Implementing Partners (section 7) will be responsible for matters on an operational level.

7. THE IMPLEMENTING PARTNERS

7.1 The implementing parties are the following:

7.1.1 The University of Pretoria (UP)

7.1.2 The University of Fort Hare (UFH)

7.1.3 President and Fellows of Harvard College through Its School of Public Health (HSPH)

7.1.4 South Africa Partners (SAP)

7.2 The implementing partners are collaborating with respect to the overall development and implementation of the program according to the work plan by means of a sub-committee system. To help the program reaches its goals and objectives and make a positive contribution toward building executive level health management training in South Africa, the partners have agreed to an operational structure. This structure has been designed to maximize output, with the goals of ensuring that the integrity of the program is maintain over

the course of its lifetime, and that it meets the needs of the NDOH. Each committee or team will be tasked to carry out specific activities and meet specific targets tied to the annual work plan, which will be submitted to the SC for review. The operational structure is as follows:

7.2.1 The **Policy and Direction Committee,** for which the Chair will rotate at every alternate meeting, will be responsible for the overall direction of the program and will be constituted as follows:

- 7.2.1.1 Co-Chairs: Vice Chancellor, UFH and Dean, Faculty of Health Sciences, UP
- 7.2.1.2 Secretariat: Executive Director, SAP

7.2.2 The **Strategy Committee,** for which the Chair will rotate between the Dean, UP and the Vice Chancellor, UFH every alternate meeting, will be responsible for the strategic direction of the program and will be constituted as follows:

- 7.2.2.1 Dean, Faculty of Health Sciences, UP
- 7.2.2.2 Vice Chancellor, UFH
- 7.2.2.3 Program Manager, HSPH
- 7.2.2.4 Executive Director, SAP
- 7.2.2.5 Program Manager, UP
- 7.2.2.6 Program Manager, UFH
- 7.2.2.7 Secretariat (SAP)

7.2.3 The **Operations Committee** will be responsible for day-to-day operations of the program, and will be constituted as follows:

- 7.2.3.1 Program Manager, UP
- 7.2.3.2 Program Manager, UFH
- 7.2.3.3 Training and Education Coordinator, HSPH
- 7.2.3.4 Deputy Director, SAP
- 7.2.3.5 Program Manager, SAP
- 7.2.3.6 Secretariat: SAP
- 7.2.3.7 The UP Program Manager will act as Chair for years 1 and 2 and the UFH Program Manager will act as Chair for years 3 and 4

7.2.4 **Course and Event Teams** will be responsible for developing and implementing Courses, Policy Seminars and Policy Round Tables, with the two distinct responsibilities:

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7.2.4.1 Development of the Courses, Policy Seminars and Policy Round Tables

7.2.4.2 Planning and offerings of Courses, Policy Seminars and Policy Round Tables

7.2.4.3 The teams will be constituted as follows:

7.2.4.3.1 Course Academic Lead, UP

7.2.4.3.2 Course Academic Lead, UFH

7.2.4.3.3 Course Academic Lead, HSPH

7.2.4.3.4 Program Manager, SAP

7.2.5 **Technical Teams** will be responsible for implementing specific activities on behalf of the program.

7.2.5.1 There will be three teams, each responsible for a discrete technical activity.

7.2.5.2 The three technical teams are as follows:

7.2.5.2.1 Finance

7.2.5.2.2 Communications

7.2.5.2.3 Monitoring & Evaluation

7.2.5.3 Each team will be constituted as follows:

7.2.5.3.1 Technical representative, UP

7.2.5.3.2 Technical representative, UFH

7.2.5.3.3 Technical representative, HSPH

7.2.5.3.4 Representative, SAP

7.2.6 The **Overall Program Manager** will be responsible for leading the implementation effort on behalf of the partners. This position will be held by the Program Manager at UP during years 1 and 2 of the program and will transfer to the Program Manager at UFH during years 3 and 4 of the program.

7.3 The quorum of meetings, which may also occur electronically or telephonically, shall fifty percent of the members plus one, except in the case of the Policy and Direction Committee, which requires the participation of both the Dean, Faculty of Health, UP and the Vice Chancellor, UFH.

7.4 The meeting schedules of the Committees and Teams are as follows:

7.4.1 Policy and Direction Committee – meets every other month

7.4.2 Strategy Committee – meets monthly

7.4.3 Operations Committee – meets weekly

7.4.4 Course and Event Teams – according to the Work Plan activities

7.4.5 Technical Teams – according to the Work Plan activities

7.5 Decisions shall be taken by a simple majority of the members present at a meeting or the members participating in an electronic or telephone conference as the case may be, assuming that a quorum has been reached.

7.6 The Policy & Direction Committee, the Strategy Committee and the Operations Committee, in consultation with SAP on matters related to the adherence of reporting and other requirements of the Program funders, will have the following functions, subject to the rules and the regulations of the partner Institutions as well as the internal policies and procedures of the Parties:

7.6.1 to implement the vision of the SC;

7.6.2 to oversee the implementation of the day to day technical operations of SAELPH at UP, UFH and HSPH;

7.6.3 to conduct preparatory research for Round Table and Policy Seminars;

7.6.4 to develop Annual Plans for review;

7.6.5 to submit quarterly site reports on progress of a project;

7.6.6 to take decisions with regard to projects and future work to be done in respect of the program;

7.6.7 to approve material deviation from the parameters laid down in projects;

7.6.8 to work with SAP to approve costs that exceed the estimated costs for a project and otherwise to comply with the reporting and other requirements of Program funders; and

7.6.9 to focus each year on annual work plans drafted by the Institutions and SAP in consultation with NDOH, reviewing and approving an annual set of objectives, activities and responsibilities.

8. RESPONSIBILITIES OF THE PARTIES

8.1 Each Party has a distinct and important role to play in achieving the long-term goals and expected impact of the program as outlined in the annual work plans.

8.2 The Parties will work closely with the Steering Committee to assure that the program's design and content is optimal for the selected goals and suitably located in the South African context.

8.3 The partner Institutions will share the responsibility of facilitating program activities, developing and presenting training courses and conducting additional research with the view to prioritize training needs and identify priority content areas to be developed, the results of which may affect the curriculum process. Assessment will be revised as required and repeated in subsequent years.

8.4 The Parties agree that in respect of each program activity (e.g., Policy development and implementation, Round Tables, Policy Seminars, Applied Research projects, Major Training programs, Study Tours and any other executive development activities) on which the Steering Committee decides, each Party's obligations and responsibilities will have to be determined and agreed to by that Party and will be subject to the availability of funds.

8.5 A sustainability plan in respect of the development, beyond the program period, of existing and new programs in health leadership will be a priority for the duration of the program, subject to the financial capacity and other needs for sustainability and subject further to annual review and refinement.

8.6 An on-going and in-depth evaluation process that will inform program improvement and measure impact over the first four years of the program's implementation, as outlined in the Monitoring and Evaluation framework led by SAP.

8.7 Any discrimination in the program as to participants on the basis of race, color, gender, sexual orientation, national or ethnic origin, religion, age, disability or political belief shall be grounds for termination by any party.

9. TEACHING AND RESEARCH

9.1 Training courses will, from the first year, be run alternatively by UP and UFH.

9.2 HSPH faculty and faculty members of UP or UFH will jointly teach courses decided upon, and agreed to by each Party with the South African teaching role increasing each year.

9.3 Contact sessions as well as on-going e-learning support and interaction between faculty and participants will be used.

9.4 The number and diversity of the teaching activities will increase each year, provided that HSPH faculty involvement will continuously be reduced to effect complete transition to UP and UFH of all courses by the fourth year, with the view to enable the South African Institutions to continue running the program on its own.

9.5 The use of innovative and modern teaching methods being vital, HSPH faculty and staff will lead workshops on the Case teaching method, which will include case development as well as teaching options and skills. The details of these workshops are to be agreed to separately in writing.

9.6 The discussions on and implementation of e-learning will be jointly led by the partner Institutions.

9.7 In respect of informal training, a joint certificate from UP and UFH on behalf of the SAELPH program may be awarded to participants completing a required number of courses offered in terms of the program. Each institution has the responsibility to ensure accreditation and internal approval of the course before endorsing a joint certificate. The logos of the institutions may not be used on such certificates unless written confirmation of accreditation and approval has been received by the respective institutions.

9.8 The presentation of training courses in respect of formal qualifications jointly offered by UP and UFH will be subject to a separate agreement in writing between the two South African Institutions and will have to comply with the relevant Statutory provisions laid down in this regard, external and internal regulations on quality assurance as well as the internal policies and procedures of the Institutions.

9.9 Faculty members will be recruited from the partner Institutions for collaborative research projects. Research topics, strategies and methods will be determined by the participating faculty, subject to the requirement that these will all inform the teaching programs.

9.10 It is a goal of the program to encourage the development of course material, teaching material and teaching methodologies as well as the preparation of articles and research reports for publication.

10. PUBLICITY, MARKETING AND BRANDING

10.1 Marketing of program activities or joint projects will be the responsibility of the SAP.

10.2 The development of information brochures and advertising material shall be managed by SAP in consultation with the Partner Institutions with due consideration of the Institutions' internal policies and procedures in this regard. Co-branding rules shall apply where and if applicable.

10.3 Branding opportunities as well as the use of the Parties' emblems, trademarks and names shall be subject to the relevant Party's guidelines on Corporate Identity. Except as otherwise provided in this agreement, no Party, whether herein defined or not, shall use the name, likeness, logos, trademarks, service marks, internet domain names, trade names, or other source identifiers, likenesses, or representations of another Party, or any other marks confusingly similar thereto (collectively "Marks"), in any manner, or for any purpose in connection with this MOA or the Program without the prior written consent of the other Party(ies) on a case-by-case basis, which shall be in accordance with any restrictions required by the other Party(ies). Each Party will establish its process for gaining consent, which will be adhered to by all other Parties. Without limiting the foregoing, neither Party shall use the Institution Marks in any manner which may be injurious to the goodwill associated therewith, or in any other manner that is fraudulent or defamatory, or that otherwise violates any applicable laws, rules or regulations. The Parties herewith may disclose the existence of this agreement and the general nature of the research while accurately representing the relationship(s) herein.

10.4 No Party may in relation to any publication, presentation or promotional materials, identify or include photographs or other images of any facility, property or operation of any other Party without the prior written consent of such other Party.

10.5 No Party may knowingly make or permit to be made any inaccurate statement concerning any other Party or the Project in any publication or discussion relating to the Program.

11. PROJECT COPYRIGHT AND INTELLECTUAL PROPERTY

11.1 Intellectual Property means all intellectual property, including patents, patent applications, inventions, discoveries and improvements, copyright in documents and courses and academic programmes, data, computer software, drawings, designs, operational analysis, technology and know-how related to the cooperation in terms of this Agreement.

11.2 All Intellectual Property made prior to the date of last signature on this Agreement ('Background Intellectual Property') shall remain the sole property of the Party that discovered and/or created such Background Intellectual Property and who shall have sole rights to such Background Intellectual Property.

11.3 All Intellectual Property as defined in 11.1, resulting from the cooperation within the course and scope of this Agreement ('Foreground Intellectual Property'), shall be owned as follows:

11.3.1 all rights, title and interest in any Intellectual Property made solely by, or created solely by a Party shall vest in and be owned by that Party;

11.3.2 all rights, title and interest in any Intellectual Property made jointly by, or created jointly by more than one Party shall be jointly owned by them. In the event that opportunities arise to commercialise jointly-owned Intellectual Property, the Parties shall enter into an agreement to define the rights and obligations of each Party with regard to such commercialisation.).

11.4 Each Institutional Partner grants to the SAELPH Parties a non-exclusive royalty free license to use and improve its proprietary course material, teaching material, teaching texts, methodologies and computer programmes created or developed in the course and scope of this Agreement ("Program Copyright") for the sole purpose of training and assessment in the current SAELPH program, as well as for training and assessment in any further SAELPH developments after the conclusion of this Agreement, provided that the Parties are at all times duly recognised as the proprietors of the Intellectual Property and Program Copyright. However, modifications to these documents and materials made after the conclusion of the SAELPH program will require Institutional Partner approval in order for an Institutional Partner's logo to appear on the modified document.

11.5 The stipulations of this clause 11 will always be subject to the Intellectual Property Rights from Publicly Financed Research and Development Act, 2008 and to appropriate intellectual property requirements of Program funders.

11.6 Inventors are to be duly recognized by their inclusion as registered inventor(s) in the any patent application(s).

11.7 All improvements and developments to the Foreground Intellectual Property which are developed by a Party independently of the other Party and independently of work under this Agreement shall not be subject to this Agreement and shall be owned by such Party.

12. CONFIDENTIALITY

12.1 Any Party who shall have access to another Party's confidential information, shall adhere to reasonable security procedures at all times.

12.2 The Parties acknowledge that all non-public business, personnel, and personal information is "Confidential Information" if such Confidential Information has or shall come into the possession or knowledge of the receiving Party shall be considered as confidential and proprietary information. All Confidential Information shall be marked as such and if orally given reduced to writing within five (5) days and shared between the Parties involved.

12.3 The Parties agree that such "Confidential Information" shall not be made use of other than for the performance of its obligations under this Agreement and to release such information to its employees or students on a "need to know" basis provided that such employees, students, sub-contractors, or agents undertake to be bound by the confidentiality contained herein. Confidential Information shall in no way prohibit the ability of any Party to publish and/or present meaningfully in regards to this project, subject to provisions in clause 13 below.

12.4 It is recorded that the following information will, for the purpose of this Agreement, not be considered to be "Confidential Information":

12.4.1 information known to the receiving Parties prior to the date that it was received from the other Party; or

12.4.2 information known to the public or generally available to the public prior to the date that it was disclosed by either of the Parties to the other; or

12.4.3 information which becomes known to the public or becomes generally available to the public subsequent to the date that it was disclosed by either of the Parties to the other, other than due to breach in terms of this Agreement by the receiving Party as the case may be, in respect of such information; or

12.4.4 information which the disclosing Party in writing, authorises the other to disclose; or

12.4.5 information that is disclosed by operation of law.

13. PUBLICATIONS

13.1 No Party may use the name of another Party in relation to any publication without having obtained the prior written consent of such other Party and the use of such name will be subject to any conditions attaching to such consent.

13.2 The Parties agree that it is part of the Partner Institutions' core function to disseminate information and to make it available for the purpose of scholarship. They further recognize that the publication of certain technical information may destroy its commercial value. Accordingly, publication shall proceed on the following terms:

13.2.1 The Institutions may publish and disseminate the results of their investigative findings hereunder and shall solely determine the authorship and contents (including scientific conclusions and professional judgements) of any such paper;

13.2.2 The Institution that desires to publish or present its work ("the presenting Party") shall provide the other Parties ("the receiving Parties") with a copy of the paper prepared for publication by it at the earliest practicable time, but in any event not less than 30 (thirty) days prior to its submission to a scientific journal or presentation at a scientific meeting and a reasonably detailed summary or abstract of any other oral or written publication not less than 15 (fifteen) days prior to its submission or presentation.

13.2.3 The receiving Parties will respond within 30 (thirty) days of receipt of the proposed publication and within 15 (fifteen) days for abstracts or presentations. The receiving Parties may comment upon, but shall not be entitled to make any editorial changes to the results and conclusions set forth in the proposed publication. However, if identified by the receiving Parties, any of its Confidential Information that may be contained therein, shall be removed. In addition to this review, the receiving Parties may, at their discretion, direct that the presenting Party delay the publication or presentation for a total period of up to sixty (60) days from the date of receipt of the proposed publication by the receiving Parties to allow the receiving Parties to apply for applicable patent protection. The Parties shall, however, not be entitled to delay the submission and/or examination of thesis or dissertations or the awarding of diplomas or degrees, but shall be entitled to require an undertaking of confidentiality from the examiners.

13.2.4 In the event the receiving Parties do not respond within the time frames indicated in the above clauses, the presenting Party will be free to proceed with the proposed publication.

13.3 The provisions of this clause 13 shall survive the termination of this Agreement indefinitely.

14. COMMENCEMENT AND TERMINATION

14.1 This Agreement shall come into effect after it has been signed by the representatives of all Parties and shall, subject to the provisions providing for earlier termination thereof, continue for a period of 4 (four) years.

14.2 The Parties undertake to consult with one another 3 (three) months prior to the expiry of the period as specified in clause 14.1 above in order to consider the renewal of the Agreement for a further period to be agreed upon, as well as the terms and conditions that will apply.

14.3 Should any Party ("the defaulting Party(ies)") breach any material provision of this Agreement, the Parties experiencing the breach ("the aggrieved Party(ies)") may give the defaulting Party(ies) written notice to rectify such breach within a period of fourteen (14) days of receiving the written notice and on failure to do so, the aggrieved Party(ies) may without prejudice and retaining such other rights as it may have, cancel this Agreement by giving three month's written notice to the defaulting Party(ies).

14.4 Parties to this Agreement may terminate for any reason without penalty on three (3) months advance notice. Every effort shall be made to ensure that termination of this Agreement shall not unduly prejudice any participants in the program and the Parties undertake to cooperate to reach an appropriate understanding in this regard.

15. FINANCIAL RESPONSIBILITIES

15.1 Led by SAP, the Parties will endeavour to secure external funding to further support the program activities and to provide for the on-going collaboration between the Institutions.

15.2 The Parties accept that program activities are subject to the availability of funds and that the Institutions will only be able to deliver in relation to funding provided for this purpose.

15.3 The Parties shall each remain responsible for the erection and maintenance of their own physical facilities.

15.4 The Institutions shall be responsible for providing and extending structures and facilities to carry out their specific responsibilities in terms of this Agreement.

15.5 Participants in courses will be responsible to fund their own travel and accommodation expenses.

15.6 The Parties agree that SAP is responsible for managing the funds received by the Program. This includes entering into contracts on behalf of the Program with funding agencies when necessary and issuing subcontracts to the appropriate Parties when Program funds are contributed through SAP.

15.6.1 The funders of the Program, at the time of the signing of this Agreement, are the Atlantic Philanthropies (AP), the ELMA South Africa Foundation NPC (ELMA), and the United States Agency for International Development (USAID), with other funders anticipated and desired.

15.6.2 Each Party agrees to be responsible for maintaining its own respective accurate and up to date financial records related to the funds each individually receives

under the Program, and it will adhere to the SAELPH Financial Guidelines and to all corresponding Funder regulations and requirements applicable to the Party.

15.6.3 The Parties agree that they will provide SAP with the appropriate program and financial reporting information as described and scheduled in either this MOA or other written documents agreed upon and signed by the Parties solely to fulfil the obligations required by the current and future funders of the Program.

16. LIMITATION OF LIABILITY AND INDEMNITY

16.1 Each Party is responsible for their own negligent acts and omissions to the fullest extent allowed by applicable law.

16.2 In any event, no Party will be liable for any special, incidental or consequential loss, liability, expense or damage pursuant to this Agreement.

17. DISPUTE RESOLUTION

17.1 In the event of a dispute arising between the Parties, in respect of any matter contained in this Agreement –

17.1.1 The aggrieved Party(ies) shall notify the other Party(ies) in writing about the existence and nature of the dispute within a reasonable time of the dispute arising; and

17.1.2 Thereafter the Parties shall negotiate in good faith to settle the dispute in question as expeditiously as possible, which may include subjecting the matter to a mediation process, and if necessary to involve the Deans and Heads of Department of the partner Institutions and the Director-General of the NDOH directly, but in any event within a period of 14 (fourteen) days of the matter being referred to them or such longer time as the Parties may agree upon;

17.2 Should the Parties be unsuccessful in settling such dispute within the aforesaid period or such longer period as the Parties may agree to, the dispute must be resolved through a process of arbitration in terms of the rules of the Arbitration Foundation of South Africa (AFSA). The arbitrator's decision shall be final and binding. The subject matter,

proceedings and decision in an arbitration shall be kept confidential by the Parties, except as necessary to enforce or appeal the decision. The Parties shall each bear their own costs of the arbitration, except that the arbitrator's fees and the costs of the tribunal shall be shared equally by the parties to the arbitration.

17.3 The Arbitrator's decision may, on application to a court of competent jurisdiction by any Party to the dispute, after due notice to the other Parties, be made an Order of Court. A determination that has been made an Order of Court may be enforced in the same manner as any judgement or order of the same effect.

17.4 The above does not preclude a Party from approaching a Court of competent jurisdiction for an interdict, declaratory order or urgent relief arising out of or in connection with this Agreement.

18. TOTAL AGREEMENT

18.1 Subject to clause 18.2 below, this Agreement, including any annexures thereto, reflects the whole Agreement between the Parties to the exclusion of other discussions, proposals or undertakings either verbal or written. In the event of any conflict between a provision in the annexure(s) and any term or condition of this Agreement, the latter shall prevail.

18.2 Exceptions to the above are Agreements involving grant funds directed to SAP, but meant for the Program. In these instances, SAP has the right to enter into sub-contracts with the other Parties that are valid beyond the terms of this Agreement (see clause 15.6).

18.3 The Parties agree, should it be necessary, to use reasonable effort to amend this Agreement to bring it in line with the terms of sub-contracts referred to in 15.6. In the event of failure to reach agreement on such amendments and subject to the compliance and fulfilment of irrevocable rights and obligations incurred at that point in time, one or more of the Parties may elect to terminate its involvement as a Party to this agreement in terms of 14.4.

19. AMENDMENT

No addition or amendment of this Agreement is valid unless it is in writing and signed by the authorised representatives of the Parties.

20. REPRESENTATION OR WARRANTY

No Party has given any warranty, created any expectation or made any representation to the other Parties, other than which may be expressly set out in this Agreement.

21. CESSIONS

No rights which any Party may have in terms of this Agreement shall be capable of cession or transfer without the prior written consent of the other Parties, which shall not be unreasonably withheld.

22. SEVERABILITY

In the event that any provision of this Agreement is found to be invalid, unlawful or unenforceable, such provision shall be severable from the remaining terms, which are constituted to be valid, lawful and enforceable.

23. APPLICABLE LAW

This Agreement shall be interpreted and governed in all respects by the Laws of the Republic of South Africa.

24. CONCESSIONS

No indulgence or relaxation, which any Party may allow to the others in regard to the carrying out of the others' obligations in terms of or pursuant to this Agreement shall prejudice these Parties' rights under this Agreement in any manner whatsoever, or be regarded as a waiver of these Parties' rights in terms of this Agreement.

25. NO AGENCY

25.1 This Agreement does not constitute any Party as the agent of legal representative of another Party for any purposes whatsoever and no Party will be entitled to act on behalf of, or to represent or bind another Party unless duly authorised thereto in writing.

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25.2 An exception to the above are Agreements involving grant funds directed to SAP, but meant for the Program. In these instances, SAP has the right to enter into sub-contracts with the other Parties that are valid beyond the terms of this Agreement (see clause 15.6).

26. DOMICILIUM CITANDI ET EXECUTANDI

26.1 The Parties for the purpose of effecting the terms and conditions of this Agreement and whatever matters arise here-from choose as domicilium citandi et executandi the respective addresses set out hereunder:

26.1.1 The National Department of Health: **Ms Precious Matsoso**

Cnr Thabo Sehume and Struben streets
Pretoria
0001
Tel: +27 (0)12 3959150
Fax: +27 (0)12 3958422

26.1.2 The University of Pretoria: **Prof Eric Buch**

Dean: Faculty of Health Sciences
Room 4-3
H W Snyman Building-North
31 Bophelo Road
Gezina
0084
Tel: +27 (0)12 354 2386
Fax: +27 (0)12 329 1351

26.1.3 The University of Fort Hare: **Dr. Mvuyo Tom**

Vice Chancellor
University of Fort Hare
P. O. Box 7426
50 Church Street
East London
Tel: +27 (0)43 704 7000
Fax: +27 (0)43 704 7095

26.1.4 The Harvard School of Public Health: **Frank Urso**

Executive Director for Research Administration
Sponsored Programs/Research Administration
Harvard School of Public Health
Kresge Building, 677 Huntington Ave
Boston, MA 02115
Tel: +1 617 432-8151
Fax: +1 617 432-8160

26.1.5 South Africa Partners: **Mary Tiseo**

Executive Director
South Africa Partners
21 Pearce Street
Berea 5241
East London
Tel: +27 (0)721-2573
Fax: +27 (0)721-2762

or at such other address of which the Party concerned may advise the other Party in writing and shall be deemed to be valid fourteen (14) days after written notice has been given; provided that no street address recorded in this sub-clause shall be changed to a post box or poste restante.

26.2 Any notice given in terms of this Agreement shall be in writing, and: -

26.2.1 If delivered by hand, shall be deemed to have been received by the addressee on the date of delivery, or

26.2.2 If sent by means of prepaid registered post, shall be deemed to have been received by the addressee on the fourteenth (14th) day after the day on which it was posted, except if the contrary is proven in which case the onus of proof shall reside with the addressee.

26.2.3 If sent by facsimile or electronic mail transmission, shall be deemed to have been received on the business day following the day on which it was sent.

26.3 Notwithstanding anything to the contrary contained or implied in this Agreement, any written notice or communication actually received by either Party, including by means of facsimile transmission, shall be deemed to be an adequate service of written notice or communication to such Party in terms of applicable laws.

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27. EXECUTION OF THE AGREEMENT

This Memorandum of Agreement may be executed in counterparts, each of which shall be deemed to be an original, and such signed counterparts shall constitute one and the same document. Facsimile and e-mailed PDF signatures shall be acceptable as evidence of execution of this Memorandum of Agreement, without the need for sending or receiving the original executed document.

SIGNED at Pretoria on 03 MAY 2013.

AS WITNESSES:

1. _____

2. _____

THE NATIONAL DEPARTMENT OF HEALTH

Mrs Precious Matsoso, Director-General NDOH
Name and capacity of signatory warranting that she is duly authorized

SIGNED at PRETORIA on 3 May 2013.

AS WITNESSES:

1. _____

2. _____

THE UNIVERSITY OF PRETORIA

Prof. Cheryl M de la Rey, Vice-Chancellor and Principal
Name and capacity of signatory warranting that she is duly authorized

SIGNED at Johannesberg on 2 May 2013.

AS WITNESSES:

1. _____

2. _____

THE UNIVERSITY OF FORT HARE

Dr Mvuyo Tom, Vice Chancellor
Name and capacity of signatory warranting that he is duly authorized

MT

SIGNED at Cambridge, Mass., USA on 14th of May 2013.

AS WITNESSES:

1. _____

2. _____

PRESIDENT AND FELLOWS OF HARVARD COLLEGE through ITS SCHOOL OF PUBLIC HEALTH

Jorge I. Dominguez, Antonio Madero Professor for the Study of Mexico, Vice Provost for International Affairs
Name and capacity of signatory warranting that he is duly authorized

SIGNED at Boston on 14 of May 2013.

AS WITNESSES:

1. _____

2. _____

HARVARD SCHOOL OF PUBLIC HEALTH

Frank Urso, Executive Director for Research Administration
Name and capacity of signatory warranting that he is duly authorized

SIGNED at Boston on May 8, 2013 2013.

AS WITNESSES:

1. _____

2. _____

SOUTH AFRICA PARTNERS

Mary Tiseo, Executive Director
Name and capacity of signatory warranting that she is duly authorized

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MEMORANDUM OF AGREEMENT

entered into between

The National Department of Health
herein represented by **Ms Precious Matsoso** in her capacity as
the **Director-General of the National Department of Health** duly authorized thereto
(hereinafter referred to as the "NDOH")

AND

The University of Pretoria
herein represented by **Cheryl M de la Rey** in her capacity as
Vice-Chancellor and Principal duly authorized thereto
(hereinafter referred to as "UP")

AND

The University of Fort Hare
herein represented by **Prof Sakhela Buhlungu** in his capacity as
Vice Chancellor duly authorized thereto
(hereinafter referred to as "UFH")
AND

The President and Fellows of Harvard College through its T.H. Chan School of Public Health
herein represented by **Mark Elliott** in his capacity as
Vice Provost for International Affairs duly authorized thereto
(hereinafter referred to as "HSPH")
AND

South Africa Partners
Herein representetd by **Judy Anne Bigby** in her capacity as
Executive Director duly authorized thereto
(hereinafter referred to as "SAP")
(collectively referred to as "the Parties/ Partners")

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1. PREAMBLE

WHEREAS the National Department of Health has a need to build the required skills, competencies and experience among existing and emerging national, provincial and district government managers;

AND WHEREAS the Parties have developed and established the Albertina Sisulu Executive Leadership Programme in Health (ASELPH) to address critical gaps in executive health management training on the abovementioned three spheres and to contribute to the goals of the Health Minister's Health Management Development Plan for the country;

AND WHEREAS ASELPH aims to continue increasing capacity and quality of leadership of the health systems in South Africa by bringing together teaching and health leadership experience from a variety of organisations to learn, teach and share aspects of leadership practised globally;

AND WHEREAS the University of Pretoria, through its Faculty of Health Sciences has grown its capacity to deliver high quality multi-disciplinary education, research consultancy and advocacy and has contributed in addressing public health challenges facing South Africa and Africa;

AND WHEREAS the University of Fort Hare, through its newly established Faculty of Health Sciences, strives to provide high quality multi-disciplinary health science programs that meet the needs of rural and resources constrained environments and, as the previous School of Health Sciences, has been involved in various partnerships and donor-funded projects with international donors and the South African Government;

AND WHEREAS the President and Fellows of Harvard College through Its T.H. Chan School of Public Health has a tradition of scholarship and research in international health, marked by longstanding commitments to improvement of health in developing countries and the health status of people living in transitional economies;

AND WHEREAS South Africa Partners has a long history of supporting partnership development between the United States and South Africa and has worked to build health infrastructure in South Africa since 2000;

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AND WHEREAS University of Pretoria, the University of Fort Hare, the Presidents and Fellows of Harvard College through its T.H. Chan School of Public Health and South Africa Partners, united and motivated by the strong social values of equity and "health for all" underlying the ASELPH programme, wish to continue to participate in the development and implementation of the programme to build in-country health and management capacity.

NOW, THEREFORE, DESIRING TO CONTINUE ENGAGING IN A MUTUALLY BENEFICIAL RELATIONSHIP, THE PARTIES WISH TO COLLABORATE AS FOLLOWS:

2. DEFINITIONS

2.1 In this MOA, unless inconsistent with the context, the following expressions and/or words bear the meanings set out below and derivative expressions and words will have a corresponding meaning:

2.1.1 "**Agreement**" means this Memorandum of Agreement concluded between the NDOH, UP, UFH, HSPH and SAP;

2.1.2 "**ASELPH**" means the Albertina Sisulu Executive Leadership Programme in Health;

2.1.3 "**HSPH**" means the President and Fellows of Harvard College, through Its T.H. Chan School of Public Health a Massachusetts non-profit educational corporation under 501(c)(3) of the Federal Tax Code with a principal place of business at 677 Huntington Avenue, Boston, MA 02115;

2.1.4 **"Implementing Partners"** shall mean UP, UFH, HSPH, and SAP;

2.1.5 "**NDOH**" means the National Department of Health;

2.1.6 **"Parties/Partners"** shall mean NDOH, UP, UFH, HSPH and SAP; and **"Party"** shall mean any one of them, as indicated by the context;

2.1.7 "**Period**" means the duration of this Agreement as cited in clause 14;

2.1.8 "**Program**" means the ASELPH program;

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2.1.9 **"Representatives"** mean the representatives appointed by the Parties to liaise and make decisions, where necessary, to ensure that each Party complies with this Agreement;

2.1.10 "**SAP**" means South Africa Partners, Inc., acting through the organization's headquarters in Boston, Massachusetts led by Dr Judy Bigby, Executive Director, and its South Africa office, represented by Mr Martin Scholtz, Program Manager;

2.1.11 "**Signature Date**" means the date of the last Party signing this Agreement;

2.1.12 "UFH" means the Faculty of Health Sciences, University of Fort Hare, a university duly established under the Higher Education Act No 101 of 1997 as amended, herein represented by the Vice-Chancellor and Principal (Professor Sakhela Buhlungu), duly authorised thereto and acting by virtue of delegated authority; and

2.1.13 "**UP**" means the Faculty of Health Sciences, University of Pretoria, a higher education institution and juristic person established in terms of the Higher Education Act 101 of 1997, as amended, with its registered address at Lynnwood Road, Hillcrest, Pretoria, 0001, herein duly represented by Professor Cheryl de la Rey, Vice-Chancellor and Principal.

3. INTERPRETATION

3.1 In this Agreement, unless the context requires otherwise:

3.1.1 Headings are used for convenience only and shall not be used in the interpretation of the Agreement;

3.1.2 When any number of days is prescribed in this Agreement, same shall be reckoned as calendar days exclusively of the first and inclusively of the last day unless that day falls on a Saturday, Sunday or public holiday, in which case the day shall be the next succeeding calendar day which is not a Saturday, Sunday or public holiday;

3.1.3 Where figures are referred to in numerals and in words, if there is any conflict between the two, the words shall prevail.

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4. PURPOSE

4.1 The Parties undertake to continue to co-operate in the development and implementation of the ASELPH program with the view to strengthen the South African public health system through the work described below, provided that each Party shall have only the specific responsibilities set forth in this MOA or in other related written agreements entered into by that Party.

4.1.1 **Service Delivery Improvements**

The management and leadership capability of current and emerging executive leadership at district level within the South African Public Health System and those executives at provincial and national level responsible for district level services, will be targeted.

4.1.2 **Human Resource Capacity Development**

The selection and training of executive level management for the National Health Insurance Initiative transformation process is intended.

4.1.3 **Excellence in Executive level Training**

The building of critical capacity at the UP and UFH in collaboration with the HSPH to establish standards and to deliver courses that will meet the country's long-term goal of a highly trained and effective pipeline for senior health managers that are capable of successfully addressing key challenges at all levels of service delivery within the country is envisaged.

4.2 The Parties agree that a Steering Committee will continue to give direction for the Program. The Steering Committee shall have only the responsibilities specifically stated in this MOA.

5. PRINCIPLES GUIDING THE COLLABORATION OF THE PARTIES

5.1 Collaboration between the Parties shall be based on acceptance of equal status. The Parties shall seek not only to learn and gain from the co-operation but also seek to contribute actively thereto.

5.2 The collaboration is guided by a spirit of active learning, building of faculty capacity and strengthening of institutional systems and processes.

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5.3 The Parties being very conscious of the urgency of executive leadership and management development shall, however, seek to balance the urgency of delivery with ensuring excellence and development of long term capacity.

6. THE STEERING COMMITTEE

6.1 The Steering Committee (hereafter "the SC") will be organized as described below.

6.1.1 The SC will be constituted as follows:

6.1.1.1 DG: Health (Chairperson) or her/his representative.

6.1.1.2 HODs or his/her representative to be determined by NDOH.

6.1.1.3 UFH (-Dean or her/his representative).

6.1.1.4 UP (Dean or his representative).

6.1.1.5 HSPH (Principal Investigator or his representative).

6.1.1.6 SAP (Executive Director or her representative).

6.1.1.7 3 Health Experts appointed by NDOH.

6.1.1.8 DOH Senior Executive as determined by NDOH.

6.1.1.9 One representative from each Funder providing more than 20% of budget.

6.1.1.10 2 Sisulu Family Representatives designated by the Sisulu Family.

6.1.1.11 Secretariat – Project Managers (UP, UFH and SAP) with no voting rights.

6.1.2 The SC shall have the power to co-opt additional expertise from the private or public sector.

6.1.3 The DG: Health shall designate a Chairperson of the Steering Committee and secretariat services will be provided by the three Program Managers of UP, UFH and SAP.

6.1.4 The SC shall meet at least twice a year and the quorum for a meeting shall be 50% (fifty percent) of all members (or their proxies) plus one, who have to be present at the commencement of the meeting or teleconference. Inter-sessional consultation may take place electronically or telephonically on an ad hoc basis. The Secretariat shall give at least 14 (fourteen) days written notice of meetings, unless the next meeting's date was decided during the preceding meeting.

6.1.5 Decisions shall be taken by a simple majority of members present.

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6.1.6 Each Party reserves the right to withdraw any of its members from the SC and to replace such member at any time by giving written notice thereof to the other Parties.

6.1.7 The SC will support the achievement of the following goals:

6.1.7.1 to empower current and emerging national, provincial and district health leadership in South Africa through the transfer of knowledge, skills and values;

6.1.7.2 to improve NDOH policy implementation strategies;

6.1.7.3 to further the NDOH's goal of promoting and maintaining quality service delivery at the district level;

6.1.7.4 to sustain capacity among University of Pretoria and the University of Fort Hare faculty to deliver high quality executive health management and leadership training in South Africa; and

6.1.7.5 to review the strategic roles and responsibilities of the collaborating parties; and

6.2 The Implementing Partners (section 7) will be responsible for matters on an operational level.

7. THE IMPLEMENTING PARTNERS

7.1 The implementing parties are the following:

7.1.1 The University of Pretoria (UP).

7.1.2 The University of Fort Hare (UFH).

7.1.3 President and Fellows of Harvard College through its T.H. Chan School of Public Health (HSPH).

7.1.4 South Africa Partners (SAP).

7.2 The implementing partners are collaborating with respect to the continued overall development and implementation of the program. To help the program reach its goals and objectives and make a positive contribution toward building executive level health management training in South Africa, the partners have agreed to an operational structure. This structure has been designed to maximize output, with the goals of ensuring that the integrity of the program is maintained over the course of its lifetime, and that it meets the prioritised needs of the NDOH. Each committee or team will be tasked to carry out specific

activities and meet specific targets tied to the annual work plan, which will be submitted to the SC for review. The operational structure is as follows:

7.2.1 The **Co-Directors,** for which the Chair will rotate annually, will be responsible for the overall direction of the program and will be constituted as follows:

7.2.1.1 Co-Chairs: Deans of the respective faculties of health science at UP and UFH; and

7.2.1.2 Secretariat: Executive Director, SAP

7.2.2 The **Strategic Management Team,** to be chaired by one of the Co-Directors, will be responsible for the strategic direction of the program and will be constituted as follows:

7.2.2.1 Dean of the Faculty of Health Sciences, UP or her/his representative;
7.2.2.2 Dean, Faculty of Health Sciences, UFH or her/his representative;
7.2.2.3 Project Director, HSPH;
7.2.2.4 Executive Director, SAP;
7.2.2.5 Program Manager, UP;
7.2.2.6 Program Manager, UFH; and
7.2.2.7 Secretariat (SAP).

7.2.3 The **Operations Committee** will be responsible for day-to-day operations of the program, and will be constituted as follows:

7.2.3.1 Program Manager, UP;
7.2.3.2 Program Manager, UFH;
7.2.3.3 Training and Education Coordinator, HSPH;
7.2.3.4 Deputy Director, SAP;
7.2.3.5 Program Manager, SAP;
7.2.3.6 Secretariat: SAP; and
7.2.3.7 The UP Program Manager and the UFH Program Manager will rotate as Chair annually.

7.2.4 SAP will serve as **Overall Program Manager** responsible for monitoring the implementation effort on behalf of the partners.

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7.3 The quorum of meetings, which may also occur electronically or telephonically, shall be fifty percent of the members plus one.

7.4 Decisions shall be taken by a simple majority of the members present at a meeting or the members participating in an electronic or telephone conference as the case may be, assuming that a quorum has been reached.

7.5 The Co-Directors, the Strategic Management Team and the Operations Committee will have the following functions, subject to the rules and the regulations of the partner Institutions as well as the internal policies and procedures of the Parties:

7.5.1 to implement the vision of the program, as endorsed by the SC;
7.5.2 to oversee the implementation of the day to day technical operations of ASELPH;
7.5.3 to conduct preparatory research for Round Table and Policy Seminars;
7.5.4 to develop Annual Plans for review;
7.5.5 to submit quarterly site reports on progress of a project;
7.5.6 to take decisions with regard to projects and future work to be done in respect of the program;
7.5.7 to approve material deviation from the parameters laid down in projects;
7.5.8 to work with SAP to approve costs that exceed the estimated costs for a project and otherwise to comply with the reporting and other requirements of Program funders; and
7.5.9 to focus each year on annual work plans drafted by the Institutions and SAP in consultation with NDOH, reviewing and approving an annual set of objectives, activities and responsibilities.

8. RESPONSIBILITIES OF THE PARTIES

8.1 Each Party has a distinct and important role to play in achieving the long-term goals and expected impact of the program as outlined in the annual work plans.

8.2 The Parties will work closely with the Steering Committee to assure that the program's design and content is optimal for the selected goals and suitably located in the South African context.

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8.3 The UP, UFH and HSPH will share the responsibility of facilitating academic activities, developing and presenting training courses and conducting additional research with the view to prioritize training needs and identify priority content areas to be developed, the results of which may affect the curriculum process. Assessment will be revised as required and repeated in subsequent years.

8.4 The Parties agree that in respect of each program activity (e.g., Policy development and implementation, Round Tables, Policy Seminars, Applied Research projects, Major Training programs, Study Tours and any other executive development activities) on which the Steering Committee decides, each Party's obligations and responsibilities will have to be determined and agreed to by that Party and will be subject to the availability of funds.

8.5 A sustainability plan in respect of the development, beyond the program period, of existing and new programs in health leadership will be a priority for the duration of the program, subject to the financial capacity and other needs for sustainability and subject further to annual review and refinement.

8.6 An on-going and evaluation process that will inform program improvement and measure impact over phase II of the program's implementation, as outlined in the Monitoring and Evaluation framework led by SAP.

8.7 Any discrimination in the program as to participants on the basis of race, color, gender, sexual orientation, national or ethnic origin, religion, age, disability or political belief shall be grounds for termination by any party.

9. TEACHING AND RESEARCH

9.1 Training courses will, be run at both UP and UFH.

9.2 The three faculty partners will collaborate in the development and delivery of courses.

9.3 Contact sessions as well as on-going e-learning support and interaction between faculty and participants will be used.

9.4 The use of innovative and modern teaching methods being vital, HSPH faculty and staff will continue to play an important role in ensuring the Case teaching method, which will include

case development as well as teaching options and skills, takes root or gains traction at the two South African universities.

9.5 The discussions on and implementation of e-learning will be jointly led by the partner Institutions.

9.6 In respect of informal training, a joint certificate from UP and UFH on behalf of the ASELPH program may be awarded to participants completing a required number of courses offered in terms of the program. Each institution has the responsibility to ensure accreditation and internal approval of the course before endorsing a joint certificate. The logos of the institutions may not be used on such certificates unless written confirmation of accreditation and approval has been received by the respective institutions.

9.7 Faculty members will be recruited from the partner Institutions for collaborative research projects. Research topics, strategies and methods will be determined by the participating faculty, subject to the requirement that these will all inform the teaching programs.

9.8 It is a goal of the program to encourage the development of course material, teaching material and teaching methodologies as well as the preparation of articles and research reports for publication.

10. PUBLICITY, MARKETING AND BRANDING

10.1 Marketing of program activities or joint projects will be the responsibility of the SAP.

10.2 The development of information brochures and advertising material shall be managed by SAP in consultation with the Partner Institutions with due consideration of the Institutions' internal policies and procedures in this regard. Co-branding rules shall apply where and if applicable.

10.3 Branding opportunities as well as the use of the Parties' emblems, trademarks and names shall be subject to the relevant Party's guidelines on Corporate Identity. Except as otherwise provided in this agreement, no Party, whether herein defined or not, shall use the name, likeness, logos, trademarks, service marks, internet domain names, trade names, or other source identifiers, likenesses, or representations of another Party, or any other marks confusingly similar thereto (collectively "Marks"), in any manner, or for any purpose in

connection with this MOA or the Program without the prior written consent of the other Party(ies) on a case-by-case basis, which shall be in accordance with any restrictions required by the other Party(ies). Each Party will establish its process for gaining consent, which will be adhered to by all other Parties. Without limiting the foregoing, neither Party shall use the Institution Marks in any manner which may be injurious to the goodwill associated therewith, or in any other manner that is fraudulent or defamatory, or that otherwise violates any applicable laws, rules or regulations. The Parties herewith may disclose the existence of this agreement and the general nature of the research while accurately representing the relationship(s) herein.

10.4 No Party may in relation to any publication, presentation or promotional materials, identify or include photographs or other images of any facility, property or operation of any other Party without the prior written consent of such other Party.

10.5 No Party may knowingly make or permit to be made any inaccurate statement concerning any other Party or the Project in any publication or discussion relating to the Program.

11. PROJECT COPYRIGHT AND INTELLECTUAL PROPERTY

11.1 Intellectual Property means all intellectual property, including patents, patent applications, inventions, discoveries and improvements, copyright in documents and courses and academic programmes, data, computer software, drawings, designs, operational analysis, technology and know-how related to the cooperation in terms of this Agreement.

11.2 All Intellectual Property made prior to the date of last signature on this Agreement ('Background Intellectual Property') shall remain the sole property of the Party that discovered and/or created such Background Intellectual Property and who shall have sole rights to such Background Intellectual Property.

11.3 All Intellectual Property as defined in 11.1, resulting from the cooperation within the course and scope of this Agreement ('Foreground Intellectual Property'), shall be owned as follows:

11.3.1 all rights, title and interest in any Intellectual Property made solely by, or created solely by a Party shall vest in and be owned by that Party; and

11.3.2 all rights, title and interest in any Intellectual Property made jointly by, or created jointly by more than one Party shall be jointly owned by them. In the event that opportunities arise to commercialise jointly-owned Intellectual Property, the Parties shall enter into an agreement to define the rights and obligations of each Party with regard to such commercialisation).

11.4 Each Institutional Partner grants to the ASELPH Parties a non-exclusive royalty free license to use and improve its proprietary course material, teaching material, teaching texts, methodologies and computer programmes created or developed in the course and scope of this Agreement ("Program Copyright") for the sole purpose of training and assessment in the current ASELPH program, as well as for training and assessment in any further ASELPH developments after the conclusion of this Agreement, provided that the Parties are at all times duly recognised as the proprietors of the Intellectual Property and Program Copyright. However, modifications to these documents and materials made after the conclusion of the ASELPH program will require Institutional Partner approval in order for an Institutional Partner's logo to appear on the modified document.

11.5 The stipulations of this clause 11 will always be subject to the Intellectual Property Rights from Publicly Financed Research and Development Act, 2008 and to appropriate intellectual property requirements of Program funders.

11.6 Inventors are to be duly recognized by their inclusion as registered inventor(s) in the any patent application(s).

11.7 All improvements and developments to the Foreground Intellectual Property which are developed by a Party independently of the other Party and independently of work under this Agreement shall not be subject to this Agreement and shall be owned by such Party.

12. CONFIDENTIALITY

12.1 Any Party who shall have access to another Party's confidential information, shall adhere to reasonable security procedures at all times.

12.2 The Parties acknowledge that all non-public business, personnel, and personal information is "Confidential Information" if such Confidential Information has or shall come into the possession or knowledge of the receiving Party shall be considered as confidential and

proprietary information. All Confidential Information shall be marked as such and if orally given reduced to writing within five (5) days and shared between the Parties involved.

12.3 The Parties agree that such "Confidential Information" shall not be made use of other than for the performance of its obligations under this Agreement and to release such information to its employees or students on a "need to know" basis provided that such employees, students, sub-contractors, or agents undertake to be bound by the confidentiality contained herein. Confidential Information shall in no way prohibit the ability of any Party to publish and/or present meaningfully in regards to this project, subject to provisions in clause 13 below.

12.4 It is recorded that the following information will, for the purpose of this Agreement, not be considered to be "Confidential Information":

12.4.1 information known to the receiving Parties prior to the date that it was received from the other Party; or

12.4.2 information known to the public or generally available to the public prior to the date that it was disclosed by either of the Parties to the other; or

12.4.3 information which becomes known to the public or becomes generally available to the public subsequent to the date that it was disclosed by either of the Parties to the other, other than due to breach in terms of this Agreement by the receiving Party as the case may be, in respect of such information; or

12.4.4 information which the disclosing Party in writing, authorises the other to disclose; or

12.4.5 information that is disclosed by operation of law.

13. PUBLICATIONS

13.1 No Party may use the name of another Party in relation to any publication without having obtained the prior written consent of such other Party and the use of such name will be subject to any conditions attaching to such consent.

13.2 The Parties agree that it is part of the Partner Institutions' core function to disseminate information and to make it available for the purpose of scholarship. They further recognize that the publication of certain technical information may destroy its commercial value. Accordingly, publication shall proceed on the following terms:

13.2.1 The Institutions may publish and disseminate the results of their investigative findings hereunder and shall solely determine the authorship and contents (including scientific conclusions and professional judgements) of any such paper;

13.2.2 The Institution that desires to publish or present its work ("the presenting Party") shall provide the other Parties ("the receiving Parties") with a copy of the paper prepared for publication by it at the earliest practicable time, but in any event not less than 30 (thirty) days prior to its submission to a scientific journal or presentation at a scientific meeting and a reasonably detailed summary or abstract of any other oral or written publication not less than 15 (fifteen) days prior to its submission or presentation.

13.2.3 The receiving Parties will respond within 30 (thirty) days of receipt of the proposed publication and within 15 (fifteen) days for abstracts or presentations. The receiving Parties may comment upon, but shall not be entitled to make any editorial changes to the results and conclusions set forth in the proposed publication. However, if identified by the receiving Parties, any of its Confidential Information that may be contained therein, shall be removed. In addition to this review, the receiving Parties may, at their discretion, direct that the presenting Party delay the publication or presentation for a total period of up to sixty (60) days from the date of receipt of the proposed publication by the receiving Parties to allow the receiving Parties to apply for applicable patent protection. The Parties shall, however, not be entitled to delay the submission and/or examination of thesis or dissertations or the awarding of diplomas or degrees, but shall be entitled to require an undertaking of confidentiality from the examiners.

13.2.4 In the event the receiving Parties do not respond within the time frames indicated in the above clauses, the presenting Party will be free to proceed with the proposed publication.

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13.3 The provisions of this clause 13 shall survive the termination of this Agreement indefinitely.

14. COMMENCEMENT AND TERMINATION

14.1 This Agreement shall come into effect after it has been signed by the representatives of all Parties and shall, subject to the provisions providing for earlier termination thereof, continue for a period of 4 (four) years.

14.2 The Parties undertake to consult with one another 3 (three) months prior to the expiry of the period as specified in clause 14.1 above in order to consider the renewal of the Agreement for a further period to be agreed upon, as well as the terms and conditions that will apply.

14.3 Should any Party ("the defaulting Party(ies)") breach any material provision of this Agreement, the Parties experiencing the breach ("the aggrieved Party(ies)") may give the defaulting Party(ies) written notice to rectify such breach within a period of fourteen (14) days of receiving the written notice and on failure to do so, the aggrieved Party(ies) may without prejudice and retaining such other rights as it may have, cancel this Agreement by giving three month's written notice to the defaulting Party(ies).

14.4 Parties to this Agreement may terminate for any reason without penalty on three (3) months advance notice. Every effort shall be made to ensure that termination of this Agreement shall not unduly prejudice any participants in the program and the Parties undertake to cooperate to reach an appropriate understanding in this regard.

15. FINANCIAL RESPONSIBILITIES

15.1 Led by SAP, the Parties will endeavour to secure external funding to further support the program activities and to provide for the on-going collaboration between the Institutions.

15.2 The Parties accept that program activities are subject to the availability of funds and that the Institutions will only be able to deliver in relation to funding provided for this purpose. The parties will also ensure sustainability of the programme beyond the period of donor funding.

15.3 The Parties shall each remain responsible for the erection and maintenance of their own physical facilities.

15.4 The Institutions shall be responsible for providing and extending structures and facilities to carry out their specific responsibilities in terms of this Agreement.

15.5 Participants in courses will be responsible to fund their own travel and accommodation expenses.

15.6 The Parties agree that SAP is responsible for managing the funds received by the Program. This includes entering into contracts on behalf of the Program with funding agencies when necessary and issuing subcontracts to the appropriate Parties when Program funds are contributed through SAP.

15.6.1 The funders of the Program, at the time of the signing of this Agreement, are the ELMA South Africa Foundation NPC (ELMA) and the United States Agency for International Development (USAID), with other funders anticipated and desired.

15.6.2 Each Party agrees to be responsible for maintaining its own respective accurate and up to date financial records related to the funds each individually receives under the Program, and it will adhere to the ASELPH Financial Guidelines and to all corresponding Funder regulations and requirements applicable to the Party.

15.6.3 The Parties agree that they will provide SAP with the appropriate program and financial reporting information as described and scheduled in either this MOA or other written documents agreed upon and signed by the Parties solely to fulfil the obligations required by the current and future funders of the Program.

16. LIMITATION OF LIABILITY AND INDEMNITY

16.1 Each Party is responsible for their own negligent acts and omissions to the fullest extent allowed by applicable law.

16.2 In any event, no Party will be liable for any special, incidental or consequential loss, liability, expense or damage pursuant to this Agreement.

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17. DISPUTE RESOLUTION

17.1 In the event of a dispute arising between the Parties, in respect of any matter contained in this Agreement –

17.1.1 The aggrieved Party(ies) shall notify the other Party(ies) in writing about the existence and nature of the dispute within a reasonable time of the dispute arising; and

17.1.2 Thereafter the Parties shall negotiate in good faith to settle the dispute in question as expeditiously as possible, which may include subjecting the matter to a mediation process, and if necessary to involve the Deans and Heads of Department of the partner Institutions and the Director-General of the NDOH directly, but in any event within a period of 14 (fourteen) days of the matter being referred to them or such longer time as the Parties may agree upon;

17.2 Should the Parties be unsuccessful in settling such dispute within the aforesaid period or such longer period as the Parties may agree to, the dispute must be resolved through a process of arbitration in terms of the rules of the Arbitration Foundation of South Africa (AFSA). The arbitrator's decision shall be final and binding. The subject matter, proceedings and decision in an arbitration shall be kept confidential by the Parties, except as necessary to enforce or appeal the decision. The Parties shall each bear their own costs of the arbitration, except that the arbitrator's fees and the costs of the tribunal shall be shared equally by the parties to the arbitration.

17.3 The Arbitrator's decision may, on application to a court of competent jurisdiction by any Party to the dispute, after due notice to the other Parties, be made an Order of Court. A determination that has been made an Order of Court may be enforced in the same manner as any judgement or order of the same effect.

17.4 The above does not preclude a Party from approaching a Court of competent jurisdiction for an interdict, declaratory order or urgent relief arising out of or in connection with this Agreement.

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18. TOTAL AGREEMENT

18.1 Subject to clause 18.2 below, this Agreement, including any annexures thereto, reflects the whole Agreement between the Parties to the exclusion of other discussions, proposals or undertakings either verbal or written. In the event of any conflict between a provision in the annexure(s) and any term or condition of this Agreement, the latter shall prevail.

18.2 Exceptions to the above are Agreements involving grant funds directed to SAP, but meant for the Program. In these instances, SAP has the right to enter into sub-contracts with the other Parties that are valid beyond the terms of this Agreement (see clause 15.6).

18.3 The Parties agree, should it be necessary, to use reasonable effort to amend this Agreement to bring it in line with the terms of sub-contracts referred to in 15.6. In the event of failure to reach agreement on such amendments and subject to the compliance and fulfilment of irrevocable rights and obligations incurred at that point in time, one or more of the Parties may elect to terminate its involvement as a Party to this agreement in terms of 14.4.

19. AMENDMENT

No addition or amendment of this Agreement is valid unless it is in writing and signed by the authorised representatives of the Parties.

20. REPRESENTATION OR WARRANTY

No Party has given any warranty, created any expectation or made any representation to the other Parties, other than which may be expressly set out in this Agreement.

21. CESSIONS

No rights which any Party may have in terms of this Agreement shall be capable of cession or transfer without the prior written consent of the other Parties, which shall not be unreasonably withheld.

22. SEVERABILITY

In the event that any provision of this Agreement is found to be invalid, unlawful or unenforceable, such provision shall be severable from the remaining terms, which are constituted to be valid, lawful and enforceable.

23. APPLICABLE LAW

This Agreement shall be interpreted and governed in all respects by the Laws of the Republic of South Africa.

24. CONCESSIONS

No indulgence or relaxation, which any Party may allow to the others in regard to the carrying out of the others' obligations in terms of or pursuant to this Agreement shall prejudice these Parties' rights under this Agreement in any manner whatsoever, or be regarded as a waiver of these Parties' rights in terms of this Agreement.

25. NO AGENCY

25.1 This Agreement does not constitute any Party as the agent of legal representative of another Party for any purposes whatsoever and no Party will be entitled to act on behalf of, or to represent or bind another Party unless duly authorised thereto in writing.

25.2 An exception to the above are Agreements involving grant funds directed to SAP, but meant for the Program. In these instances, SAP has the right to enter into sub-contracts with the other Parties that are valid beyond the terms of this Agreement (see clause 15.6).

26. DOMICILIUM CITANDI ET EXECUTANDI

26.1 The Parties for the purpose of effecting the terms and conditions of this Agreement and whatever matters arise here-from choose as domicilium citandi et executandi the respective addresses set out hereunder:

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26.1.1 The National Department of Health: **Ms Precious Matsoso**

Cnr Thabo Sehume and Struben streets
Pretoria
0001
Tel: +27 (0)12 3958452
Fax: +27 (0)12 3958422

26.1.2 The University of Pretoria: Prof Tiaan de Jager

Dean: Faculty of Health Sciences
Room 4-3
H W Snyman Building-North
31 Bophelo Road
Gezina
0084
Tel: +27 (0)12 354 2386
Fax: +27 (0)12 329 1351

26.1.3 The University of Fort Hare: **Professor Eunice Seekoe**

Acting Dean : Faculty of Health Sciences
University of Fort Hare
P. O. Box 7426
50 Church Street
East London
Tel: +27 (0)43 704 7000
Fax: +27 (0)43 704 7095

26.1.4 The Harvard School of Public Health: **Frank Urso**

Executive Director for Research Administration
Sponsored Programs/Research Administration
Harvard School of Public Health
Kresge Building, 677 Huntington Ave
Boston, MA 02115
Tel: +1 617 432-8151
Fax: +1 617 432-8160

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26.1.5 South Africa Partners: **Judy Anne Bigby**
Executive Director
South Africa Partners
Apollonia House
40A Bath Avenue,
Rosebank 2196
Johannesburg
Tel: +27 (011)-268-1260
Fax: +27 (086)405-0323

or at such other address of which the Party concerned may advise the other Party in writing and shall be deemed to be valid fourteen (14) days after written notice has been given; provided that no street address recorded in this sub-clause shall be changed to a post box or poste restante.

26.2 Any notice given in terms of this Agreement shall be in writing, and: -

26.2.1 If delivered by hand, shall be deemed to have been received by the addressee on the date of delivery, or

26.2.2 If sent by means of prepaid registered post, shall be deemed to have been received by the addressee on the fourteenth (14th) day after the day on which it was posted, except if the contrary is proven in which case the onus of proof shall reside with the addressee.

26.2.3 If sent by facsimile or electronic mail transmission, shall be deemed to have been received on the business day following the day on which it was sent.

26.3 Notwithstanding anything to the contrary contained or implied in this Agreement, any written notice or communication actually received by either Party, including by means of facsimile transmission, shall be deemed to be an adequate service of written notice or communication to such Party in terms of applicable laws.

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27. EXECUTION OF THE AGREEMENT

This Memorandum of Agreement may be executed in counterparts, each of which shall be deemed to be an original, and such signed counterparts shall constitute one and the same document. Facsimile and e-mail PDF signatures shall be acceptable as evidence of execution if this Memorandum of Agreement, without the need for sending or receiving the original executed document.

SIGNED at PRETORIA on 28th AUGUST 2017.

AS WITNESS:

1. _____

_____
THE NATIONAL DEPARTMENT OF HEALTH

2. _____

Mrs Precious Matsoso, Director-General NDoH
Name and capacity of signatory warranting that she is duly authorized

SIGNED at PRETORIA on 15 December 2017.

AS WITNESSES:

1. _____

_____
THE UNIVERSITY OF PRETORIA

Prof. Cheryl M de la Rey, Vice-Chancellor and Principal
Name and capacity of signatory warranting that she is duly authorized

2. _____

SIGNED at EAST LONDON on 28 SEPTEMBER 2017.

AS WITNESSES:

1. _____

_____
THE UNIVERSITY OF FORT HARE

Prof. Sakhela Buhlungu Vice-chancellor,
Name and capacity of signatory warranting that he is duly authorized

2. _____

SIGNED at Cambridge, Mass on 19 October 2017.

AS WITNESS:

1. _____

2. _____

_____
PRESIDENT AND FELLOWS OF HARVARD COLLEGE through ITS T.H. CHAN SCHOOL OF PUBLIC HEALTH

Mark Elliott, Vice Provost of International Affairs
Name and capacity of signatory warranting that he is duly authorized

SIGNED at Boston, MA USA on October 19, 2017.

AS WITNESS:

1. _____

2. _____

_____
HARVARD T.H. CHAN SCHOOL OF PUBLIC HEALTH

Frank Urso, ~~Executive Director for Research Administration~~ Chief Officer
Name and capacity of signatory warranting that he is duly authorized

SIGNED at Boston, MA USA on 23 October 2017.

AS WITNESS:

1. _____

2. _____

_____
SOUTH AFRICA PARTNERS

Judy Anne Bigby, Executive Director
Name and capacity of signatory warranting that she is duly authorized

Appendix 2: ASELPH Short Courses

Appendix 2 ASELPH short courses

Accredited short courses, University of Fort Hare Health Sciences Institute

Course Title	Course Instructor	Course Description
Hospital Management and Leadership	Prof R Thakathi Mr. J Meecham	This module addresses the essentials of a leadership philosophy and style that encapsulates complex problem solving, the ethics and values of an effective leader in healthcare and matters relating to strategic change and negotiating skills.
Introduction to Public Administration and Learning in Public Health	Prof R Thakathi Dr. Mapindu	The implementation of government policy in health studies prepares public servants for their work. It involves the management of public programs; the study of government decision making, the analysis of the policies themselves, the various inputs that have produced them, and the inputs necessary to produce alternative policies. Public Administration is concerned with the organization of government policies and programs and ensuring the appropriate behavior of officials.
Executive Leadership in Health, Complex Problem Solving, Ethics and Values in Health Care, Negotiating Change and Management	Mr. J Meecham	The leadership module aims to capacitate the existing and emerging executive leaders with the skills they require to operate as competent leaders in their work situations. This course will equip health practitioners to develop their leadership skills and competencies in complex problem solving, ethics and values in health care, conflict management and negotiating coherence.
Public Health Policy Transformation	Prof S Hendricks	This module focusses on the changes in health service delivery particularly the National Health Insurance and the re-engineering of Primary Health Care.
Governance and Legislation	Prof R Thakathi Dr Mapindu	This course provides insight into co-operative and participative government.
Strategic Marketing and Communication	Mr. D Seekoe	The objective of the course is to learn about concepts for strategic marketing to apply them to healthcare organizations. At the end of this module the learners should be enabled to assess customer needs, competitors and the potential of new products and services in the health sector.
Strategic Human Resources, Labor Relations and Performance Management	Mr. D Seekoe	This course will equip health practitioners to develop their skills and competence to help provide South African citizens with a healthy life. The specific purpose is to provide an opportunity for health workers to acquire knowledge and skills regarding Strategic Human Resources, Labor Relations and Performance Management and apply that knowledge to their own health facility.
Organizational Strategy in Health	Prof E Seekoe	This course introduces basic concepts, key issues and relates legislation by focusing on current best practice.
Strategic Economics and Finance Management in Health	Dr Newadi	This course introduces the basic concepts, key issues and principles of the Public Finance Management Act, and relates legislation by focusing on current best practice.
Research Methodology	Prof Maluleke Dr Mapindu	This course gives researchers and prospective researchers an insight into the skills and competencies required to carry out effective quantitative and qualitative research processes.

Course Title	Course Instructor	Course Description
Quality Improvement Modalities (Strategies) in Health System, Health Informatics, Monitoring and Evaluation.	Dr S Mtshali	This course relates the matter of quality in the health service to the health systems, health informatics and the monitoring and evaluation of health service delivery.
Centralisation / Decentralisation: NHI	Prof S Hendricks	This course addresses the issues that will affect or impact the National Health Insurance delivery and the re-engineering of the Primary health Care process.
PHC Re-engineering	Prof. S Hendricks	Specifically addresses the challenges and opportunities provided by the Primary Health Care approach.
Critical Units in Hospital	Prof N Jinabhai	The module serves to acquaint learners with the nature, scope and conceptual component of operations management in the public health sector. It equips the student with theoretical knowledge and practical operational, managerial and supervisory skills for the professional area. Emphasis is placed on understanding real world operations management, in general, and in the public health sector, in areas such as accident, ICU, paediatric and neonatal ICU, theatres and maternity.
Hospital Operations Management	Prof N Jinabhai	This course will acquaint learners with the nature, scope and conceptual component of operations management in the public health setting. The theoretical knowledge is reinforced by practical management and supervisory skills for the professional arena.
Hospital Specific Competencies	Prof N Jinabhai	This module will develop insight into the concepts and values underlying public health equity and relate these to tackling health inequalities within the African context.
Epidemiology	Mr. A Mandeya	To provide an opportunity for health workers to acquire knowledge and skills regarding infectious diseases epidemiology and epidemiological study design; outbreak and frequency investigation; the principles of surveillance and the measurement and evaluation of testing.
Advanced Epidemiology	Mr. A Mandeya	This course will assist participants in the area of infectious disease outbreak investigation and surveillance and will enable them to appraise critically randomized controlled trials.
Pre-Doctoral Program	Prof DT Goon	This course prepares entering PhD students for the basic and fundamental research disciplines so that they can plan, undertake and write their thesis with little difficulty.
Employee Assistance Programs & PILR for Health Workers		This course prepares entering PhD students for the basic and fundamental research disciplines so that they can plan, undertake and write their thesis with little difficulty.
Professional Ethics	Prof S Hendricks Mr. J Meecham	Although a code of ethics may provide ethical direction within which a health worker's practice should be guided, it will not provide solutions for daily ethical dilemmas within work practice. It is often the case that health workers need to access their own integrity and values to make on the spot decisions. This course aims to engender an awareness of the application of the universally held and observed health values and principles in the senior management levels of the health service.

Course Title	Course Instructor	Course Description
Medical Negligence, Malpractice and Health Sector mediation	Prof Du Plessis	This course highlights the law, preventative methods and potential outcomes of cases taken against the Department of Health that are currently costing the department billions of Rands in medical and legal claims.
Supply Chain Management	Mr. D Seekoe	Health is an inherently complex industry and therefore this course looks at components of supply chain of health care and the future scope of SCM along with the present trends. The aim is to remove the inefficiencies, to drive down costs, to ensure on-time delivery. The course examines misaligned activities that hinder the working of the system and considers the redesign of inventory management systems in hospitals along with the aggregation of suppliers and their products through electronic catalogues. Other topics covered are the use of ERP system to address bottlenecks, dealing with inefficient information flow in the system and using RFID to attain inventory visibility and accurate counts at every stage of the supply chain. Supply Utilization Management will be examined to reduce wastages, value mismatch and misuse.
Mentorship	Dr N Mangi	One of the keys to effective leadership in health is mentoring. To be an effective leader and/or mentor there is a need to develop self-knowledge, strategic visions and engage in risk-taking that involves creativity. Communication is central to a positive mentoring relationship and a successful role in a health care leadership positions. The development of good communication skills benefits them in their role as mentor. The aim is that the health profession give to their professions is served by effective mentors to prepare those who will lead health care organizations and institutions into the next decades.

Albertina Sisulu Centenary Short Course Program in Health Leadership and Management, School of Health Systems and Public Health, University of Pretoria

Program	Description
Certificate Course in District Health Systems Management	**Description** This 20 contact day, 240-hour certificate course, successfully run for district level managers from SADC countries, covers all the leadership and management competence as needed to be successful. Participants develop and present a plan for improving the management of their area of responsibility as the examination for the course. This course targets sub-district, program and clinic managers. **Target** Sub-district, program and clinic managers **Subjects covered** • International and national developments in Health Systems and Primary Health Care • Critical priorities and obstacles facing District Health Services • Strategic planning, implementation and operational management • Integrating disease programs: e.g. HIV, TB, Malaria, MCH, IMCI, youth, NCDs • Leadership, people management, teamwork, motivation • The modern manager: A critical thinker, self-motivated, self-development, problem solver, negotiator, advocate, communicator, change manager • District Human Resources planning and development • Quality improvement, Project management • Community participation including the community health worker • Health education and promotion • Financial management, supply systems including drugs • Health information management, monitoring and evaluation, indicators • Analytic visits to Health Services • Preparation and presentation of District Action Plans, Way forward in district management
Focused Short Courses (Credit bearing)	These courses have a 3-day content module followed by participants preparing for improving their role and service, e.g. a quality improvement plan that is presented and discussed as part of a 2-day follow-up module. **Courses include:** • Leadership in ethics and in health • Financial management of health services • Contract management in health • Human resources for health management • Monitoring and evaluation of health services and programs • Quality improvement in health care • Project management in the health sector • Re-engineering primary health care/hospital services
Certificate Course in Hospital Management	This is a 10-15 contact day course offered in 3-day modules in which students prepare a plan for improving their service, leadership, and management and present thie plan for peer and facilitator review. **Target:** Hospital CEOs, Service and Support Managers
Certificate Course in the Foundations of Health Services Management	This is a 10-15 contact day course offered in 3-day modules in which students prepare a plan for improving their service, leadership, and management and present the plan for peer and facilitator review. **Target:** Clinic Managers, Ward Managers, and Heads of Services.

Program	Description
Certificate Course in Ward Based Primary Health Care Outreach Team Leadership.	This is a 10-15 contact day course offered in 3-day modules in which students prepare a plan for improving their service, leadership, and management and present the plan for peer and facilitator review. **Target**: Ward-Based Outreach Team Leaders
Certificate Course in Clinical Management	This is a 10-15 contact day course offered in 3-day modules in which students prepare a plan for improving their service, leadership, and management and present the plan for peer and facilitator review. **Target:** Clinical Managers and Heads of Clinical Departments
Short Course for Hospital Board Members	This 6-day course, which has also been offered as 2- and 4-day courses, prepares hospital board members for their advisory role. **Subjects covered**: • Hospital Boards - A Public Service • Key functions of hospital boards, strategic and operational plans • Board organisation and meetings • Laws rights, ethics, access, equity, quality • Human resources • Financial management, procurement, goods, supplies • Communication, marketing, advocacy, community involvement • Fundraising, donations • Monitoring and evaluation of boards and hospitals

Note: All courses specifically address the unique features of management in the health service and the public sector, going beyond generic management to respond to the challenges of achieving an effective, efficient quality health system. All courses use a problem solving, interactive, active learning style to grow creative thinking and build commitment. Case vignettes and studies are widely used. Exercises bridge the classroom to practice gap and we encourage practical plans and solutions that respond to the context.

Appendix 3: Curriculum Review Recommendations

Albertina Sisulu
Executive Leadership
Programme in Health
Excellence, Innovation, Transformation

ASELPH Curriculum Review: Recommendations

Programme overview

The primary intent of the Albertina Sisulu Executive Leadership Programme in Health (ASELPH) is to transform South Africa's health system. The intervention is to create a critical mass of health leaders that will translate policy into effective health programs. This new cadre of change agents are advocates for public health, creative and passionate individuals that lead with integrity and base their decisions on evidence and best-practice models. Managers face many challenges within a local and global health context that is undergoing rapid change. They must be individually prepared, possess the necessary knowledge, practice ethical leadership and develop interdependent networks of collaboration to drive service delivery. Collectively, they will raise the quality of governance within the state health sector by implementing national health policy at all levels of the system with greater accountability, transparency, and impact.

Part 1: Curriculum review

In order to ensure that we train health managers in a manner that prioritizes the implementation of policy imperatives of the National Department of Health (NDOH), and also reflects local and global public health challenges, the ASELPH curriculum must undergo periodic review. This is the first such effort. This document is organized as follows: first, we outline the current ASELPH curricular approach in terms of competencies, courses, cases and the delivery platform (part 1). Second, we propose changes to the competencies, course content, cases and delivery platform (part 2). We invite the DOH to review our changes and advise on curricular changes.

Competencies

	CORE COMPETENCIES
1	**People Management and Empowering Environment** (encourage and develop in a collaborative environment, advocates teamwork, effectively manage relationships, encourage personal development, delegating duty, maintain a positive attitude, decision making process, and good interpersonal relations)
	Definition: Relates to the manner in which the leader interacts and guides members of the organisation through ensuring that the environment is conducive for staff to develop **Strategic Intent:** To establish a 'values' mirror where one can regularly do a personal reflection on a broad level
2	**Self-Management** (defines & practices personal values, recognizes one's learning style, personal attributes, professional development needs, time management and initiative, emotional intelligence)

	Definition: Mechanism of ensuring continued self-development **Strategic Intent:** To establish a set of values for personal development bearing in mind that one has to lead by example
3	**Honesty and Integrity** (committed, builds and displays high standards of ethical and moral conduct, upholding good governance, applies self-corrective measures, reliable and accountable, professionalism and ethics,)
	Definition: List of fundamental values that guide one in exercising leadership **Strategic Intent:** To establish a set of values for personal development bearing in mind that one has to lead by example
4	**Client Orientation and Customer focus** (acknowledges customer rights, service delivery according to Batho Pele principles, quality improvement)
	Definition: Mechanism of ensuring focus on the core business of the organisation **Strategic Intent:** To establish a guide to ensure adherence to core business by valuing the needs of customers
5	**Communication** (verbal and written communication, exchange of ideas, sharing of ideas and practices, internal and external)
	Definition: To ensure consistency of delivering messages, sharing knowledge and so on **Strategic Intent:** To establish a set of guidelines for adherence to a consistent approach to communicating within the organization
	MANAGERIAL COMPETENCIES
6	**Resource Management and Allocation** (human resources, physical resources and materials)
	Definition: Set of attributes to always be aware of when managing the resource pool of an organisation **Strategic Intent:** To establish a set of attributes that will guide you as a leader in managing or overseeing the rationing and management of resources
7	**Financial Management** (managing budgets in line with the service delegations and recognized financial practices including costing and allocation of expenses)
	Definition: Attributes for management of financial resources in particular **Strategic Intent:** To establish a set of guidelines for appropriate control of financial resources
8	**Problem Solving and Analysis** (identification of issues, organizing issues in systematic form, analysis and resolution of existing and anticipated problems on a timely basis, manage risk appropriately)
	Definition: Ability to identify and/or anticipate, analyze and allocate problems and challenges **Strategic Intent:** To establish a set of attributes that are necessary to resolve identified or anticipated challenges
9	**Programme and Project Management** (strategy, analysis, planning and implementation, monitoring and evaluation from a programme perspective, task allocation, task management)
	Definition: Attributes required for effective management of programmes and projects **Strategic Intent:** To establish a set of attributes required for effective management of projects and programmes
10	**Community/ Partnership Collaboration** (governance, stakeholder involvement and networking)
	Definition: Attributes required to develop, manage and sustain relationships with interested parties **Strategic Intent:** To establish a set of guidelines and values for advancing 'stakeholder ownership' and accountability in joint programmes or projects

11	**Knowledge Management** (translation of data to information and its transformation to knowledge, promoting and sharing of knowledge, information, and lessons learnt, applying theory of practice, understanding administrative law principles)
	Definition: Mechanism of ensuring a conducive learning environment **Strategic Intent:** To establish a set of attributes that are necessary to ensure that the organization values, exploits its data, information and knowledge base
	LEADERSHIP COMPETENCIES
12	**Strategic Leadership** (vision, direction, delivery from an organisational perspective, time management, pursuit of core objectives, decision making ability)
	Definition: Attributes necessary for leading an organisation to success **Strategic Intent:** To establish a set of values and attributes for strategically leading an organisation
13	**Change Management** (organisational transformation, benchmarking, innovation)
	Definition: Processes and approaches to lead and manage change in an organisation **Strategic Intent:** To establish clear paths for ensuring smooth organisational transformation and growth
14	**Service Delivery Innovation (SDI)** (process integration, implement new ways of performing tasks, developing organizations, policy development, policy interpretation, policy analysis, policy implementation; innovation, implementation science, m health, e health,
	Definition: Approaches, mechanisms and applications to improve organization's services **Strategic Intent:** To ensure continued improvement of services to the target population including internal organisational stakeholders

Courses

ASELPH considers most of the competencies as "golden threads" which are to form essential aspects of every module. Fellows develop their competencies through the following courses that are delivered at the University of Fort Hare and Pretoria. Below is a full list of all the course offered by ASELPH at both UP and UFH. All of these courses are to be reviewed and adjusted accordingly to reflect the priorities of the NDOH and outcomes of our discussions.

	UP	Courses for Review	UFH	Courses for Review
1	LHE770	Executive leadership for health (to include responsible leadership)	PUG800E	PUG 800E (Executive Leadership in Health, Complex problem-solving, ethics and values in healthcare, negotiating coherence and coordination)
2	EOC 770	Ethics and values in healthcare, organisational behaviour change and strategy in health	PUP800E - A	Public Health Policy Transformation: Harvard "Flagship" model, Primary Health Care Re-engineering
3	HSR 770	(District) Health systems (and Hospital) re-engineering (incl. Public sector and centralisation/Decentralisation)	PUP800E - B	Decentralization Theory
4	CCC 770	Complex problem-solving and negotiating, coherence and coordination	PUP800E - C	National Health Insurance

5	HPF 770	Health system and transformation policy (include political analysis, strategy and finance options)	OSH101E	Organisational and Marketing Strategy, Economics, Finance Management and Communications in Health
6	SFM 770	Strategic financial management in health	QIM101A	Quality Improvement Modalities (Strategies) in Health Systems, Health Informatics, Monitoring and Evaluation
7	QIM 771	Implementation of quality improvement modalities (strategies) in health system	SMO101E	Strategic Marketing and communication
8	SMH 770	Strategic marketing (and communication) in health	HRH101E	Strategic Human Resources, Labour Relations and Performance Management in Public Health
9	MEH 771	Health informatics, monitoring and evaluation		
10	HRM 771	Strategic human resources and management performance		

Cases:

We have developed the following core teaching cases that allow Fellows to deal with key theoretical concepts in a pragmatic way. These case studies emphasise real-life challenges that commonly arise in the workplace. Below is a table that relates each case a common health reform theme.

		Health system reform theory incl decentrali-zation & health system financing	Governance	Medico-legal	Control of corruption	Leadership & manage-ment theory	Ethics	Human Resources	Implementa-tion science/Heal th care quality	Financial manage-ment	Monitoring and Evaluation
1	Communicating sensitive issues – a clinical governance dilemma around communication and litigation within the health care sector		✓	✓		✓					
2	Compensating for the shortage of doctors: the case for clinical health associates in South Africa	✓						✓			
3	Labour Relations in the Amajuba District		✓				✓				
4	Re-engineering Primary health Care - Operational Challenges in Health Service delivery through a WBOT lens.	✓	✓			✓					
5	Piloting South Africa's National Health Insurance OR Tambo District	✓	✓			✓					
6	2020 in a South African Health Centre	✓									
7	Overcoming barriers to delivering comprehensive PHC at household and community level through WBOTs	✓									
8	Understanding decentralization and decision space analysis	✓									

Pedagogy and delivery

ASELPH's teaching pedagogy comprises 3 components: 1) didactic teaching; 2) teaching cases; 3) E-learning and online management systems. In partnership with our colleagues at Harvard, we have developed a number teaching cases that reflect South African health challenges. These cases are used to engage with theory in a practical manner, allowing Fellows to discuss openly with their colleagues, share lessons learnt and identify common solutions. In addition to didactic teaching, the emphasis during all modules is on individual and collective participation, encouraging communication based on respect, understanding and greater learning. The E-learning course management platform allows Fellows to communicate with one another, share lectures, learn at a distance, exchange course content and submit their assignments.

Part 2: Review recommendations

We are in the process of reviewing the competencies, courses, and cases in order to ensure the methodology remains relevant, quality improved and costs contained. We recommend the following changes to specific competencies:

1. <u>Competencies</u>
    a. Honesty and integrity (Ethical considerations) – greater curricular depth required to assist Fellows respond to issues of corruption, malpractice, maladministration and basic professional issues within the workplace and inculcating an ethical leadership ethos of responsibility to the citizenry.
    b. Self-management – self-mastery, reflection, self-understanding and personal development to be strengthened. Great emphasis on the "softer" management issues, such as interpersonal skills and empathetic management techniques rather than on the "hard" intellectual components.
    c. Communication – develop a module that focuses on basic writing skills, comprehension and analysis based on practical, everyday needs of managers.
    d. Client orientation – entrench the principles of Batho Pele by making it a continual theme in the teaching cases, class discussions and assignments.
    e. Project management – greater emphasis must be made to include specific policy priorities within the curriculum (for e.g. WBOT) and ensure adequate understanding and analysis of such policies and their implementation challenges.
    f. Financial management – this is a constant theme throughout the course. Address specific needs more thoroughly, for example the handling of financial spreadsheets and health accounts.
    g. Community partnership/collaboration – this area requires greater attention and to be refocused in light of the principles of Batho Pele. Specific curricular content

to be included that provide a pragmatic overview of how Fellows can increase the quality of local participation in health affairs and include case studies from different countries.

h. Change management – greater emphasis to be placed on effecting strategic leadership and how managers at all levels can facilitate the strategic goals of their organizations.
i. Data and technology – to be a more constant theme throughout the curriculum. Must address the salient contemporary themes issues of social media, using data effectively, cyber-security, innovative health delivery platforms. Prepare Fellows to read and anticipate how science and technology will influence health in South Africa.
j. Implementation science – greater emphasis to be placed on using data to inform implementation challenges and how to monitor the effectiveness of their programmes at the local level.
k. Clinical governance – further curricular depth required for Fellows to pragmatically apply ASELPH skills to the area of clinical governance.

2. <u>Course content:</u>
    a. National health programmes: emphasis must be placed on strengthening of specific aspects relating to prioritised health programme management, including:
        - HIV/AIDS, TB, and STI strategy
        - Non-Communicable Diseases strategy
        - Ideal Clinic Programme
    b. Structure: there is a need to identify key conceptual golden threads (such as financial, knowledge and project management) of health systems leadership that must permeate through the entire curricular content. This will also inform the scheduling and sequencing of modules to ensure that the theoretical and practical aspects of the modules build on each other in a step-wise manner throughout the training.
    c. Focus on operational issues: the curriculum within the ASELPH program has always been pitched and delivered at a strategic rather than at an operational level. However, experience and feedback from previous cohorts have also indicated the need to address and deliver operational content. This will be achieved through case studies that will be designed to identify, analyse, and adequately deal with some of the operational issues in health systems management.

d. Assessments: greater emphasis to be placed on reducing the workload in relation to module assignments without compromising the learning value derived from the assignment.
e. Research: the research module component should be restructured and encouraged to concentrate more on strategic and health systems operational research directly aligned to the work-related challenges of the fellows rather than abstract research with little relevance for the fellows. Other learning outcomes, such as policy and strategic plan analysis, and literature review from this module will be blended into the other modules.
f. Communication: scientific and academic writing has been highlighted as an area of concern with the majority of fellows still lacking in this area. There is a need to strengthen the curriculum in this area and the suggestion was to develop a Scientific Writing course for students early on in the programme. This point is also empirically supported by the complaints within health services in relation to the quality of documents (submissions, memoranda, reports) produced by managers at various levels.
g. Consolidate courses: there is a need to merge some of the modules and reduce the total number of modules while at the same time make sure that all modules become core and compulsory. These changes will result in shortening the contact time and deliver a comprehensive curriculum. To this end, there is a proposal to structure contact sessions by delivering two modules back to back over a consecutive six-day period, thereby resulting in fellows being away from their workstation for only 6 weeks during the entire programme.

3. <u>Cases</u>

More cases must be developed that allow Fellows to interrogate key theory through contemporary health challenges that are specific to the South African context. These cases must also be informed by global debates in health policy, health system strengthening and leadership theory. We want to develop a case study pipeline that will concentrate on the following 4 key themes:

a. Ethical leadership
b. Governance
c. Medico-legal issues
d. Quality assurance and quality improvement

4. Delivery
    a. E-learning: Strengthening of the e-learning platform and teaching methodologies in order to enhance learning and reduce contact time. The use of blended learning methodologies, that includes both contact sessions and e-learning is envisaged to assist managers enhance skills in using technology while at the same time they can benefit from face to face sessions which remains important in leadership training. The reduction in contact time is an important consideration because: 1) service pressures of removing fellows from their workstations for prolonged periods of time; 2) reduction of the cost of the training programme especially taking into cognisance the overall funding and financial pressures.
    b. Develop a post-training mechanism to ensure the alumni continue to be actively engaged in health leadership development. Some of the pillars of this mechanism include:
        - An alumni network of health leaders to engage actively with developments in the health system.
        - Recruit alumni to be involved in the mentorship programme.
        - Encourage and provide a platform for the alumni to be involved in teaching and development of case studies in the ASELPH programme.
        - Provide support mechanism for those alumni that may wish to enroll for further academic and leadership programmes.

Conclusion

ASELPH aims to strengthen the performance of the South African health system through increasing the level of governance within the public healthcare sector. It is essential that the teaching methodology reflects the key priorities and objectives of the DOH. We invite you to consider our changes and to suggest, in the form of a recommendation list, curricular changes that will align with and assist the DOH execute health policy effectively.

Appendix 4: Guide for Developing ASELPH Case

Guide for Developing an ASELPH Case

Albertina Sisulu Executive Leadership Programme in Health
Excellence, Innovation, Transformation

I. Introduction

Using case studies that illustrate issues arising in the South Africa health care system are an important teaching methodology in ASELPH. This document provides a framework for writing a case and the review process for finalizing the case with the ASELPH brand.

II. ASELPH case format

In this section, you will find the preferred format for ASELPH cases. Before submitting your case for review, make sure you include these elements in your case. In general, try to keep the entire document under 10 pages. See the appendix for a formatted case outline.

Choose a topic and type of case

Select a current and prevalent health system event or problem, perhaps based on your experience. The problem should be an opportunity to teach about improving the quality of service delivery within the Department of Health. The case may focus on any one or more of a range of issues that influence service delivery, for example: leadership, governance, management, human resources, finance, sociocultural values, or ethics. These examples are illustrative only. The possibilities are endless and this list is not exhaustive! Do not forget that you can speak to the ASELPH programme manager at your institution to assist you with identifying a topic.

Remember to choose a type of case that will bring out the value of your case as a teaching tool. You can choose from the following list of case types:

- **Action forcing**: author presents the situation and students discuss the possible actions they could take
- **Retrospective:** author presents a real-life scenario, students are asked to reflect on what was done well and on the areas that need improvement
- **Best practice**: reports on activities intended as a model
- **Role playing:** students act out key players in a given scenario
- **Hypothetical**: a case that is imagined and made-up
- **Realistic**: a case that reflects an actual event that occurred in the past.

  Example 1: A case that presents the Esidemeni crisis and asks students to reflect on how the changes in mental health care were implemented correctly and what changes were not well implemented is an example of a **realistic, retrospective case.**

  Example 2: A case that outlines the key features of universal health care (UHC) expansion in Turkey to explain a successful approach at implementing UHC policy is an example of a **realistic, best practice case.**

Construct the narrative, begin writing

Your case should include the following sections:

Introduction. Begin the case with a paragraph that introduces the reader to the main thrust of the narrative and identifies the key themes.

Body. Delve deeper into the scenario, explaining the problem encountered, underlying conditions and differing perspectives of key role players (if relevant) and also what additional issues remains to be understood. The content of the body depends on the type of case. For example, a role-playing case will use verbatim quotes from key players to describe a particular scenario. A retrospective case will offer more contextual details to help explain the conditions under which a particular scenario occurred. Finally, always think about your pedagogic objective (below). What are you trying to teach? The narrative should allow the reader to engage with (and think more deeply about) the identified learning opportunity and to begin thinking about how certain key theories (taught in class as part of a course) can help to understand the issue(s) presented in the case.

Conclusion. The conclusion includes a summary of key issues. The conclusion will also depend on case type. For example, an action-forcing case will end by asking fellows to explain why or why not they would take certain actions.

Appendix

This is where you may include supporting information to help the reader engage with the case material. Examples include tables that show important statistics (human resources at the district level) or national health account information.

Teaching note

The teaching note provides guidance to the teacher on how to teach using the case. It should be concise, yet comprehensive enough to allow other faculty to teach the case. The teaching note helps to ensure that the faculty structures discussion of the themes in a systematic way. It provides guidance for facilitating constructive class discussion and help fellows engage with the pedagogic objectives. In short, the teaching note is the helpful guide designed to assist you to teach the case.

The teaching note should include the following sections:

<u>Case synopsis</u>

- Brief outline of case: key teaching points and theoretical concepts
- Keep it concise, approximately a half of a page. Include the salient features of the case.

<u>Pedagogic objectives</u>

- What are you trying to teach? A goal is an overarching principle that guides decision-making. What are your teaching objectives? Objectives are specific, measurable steps that can be taken to meet the goal. Keep these simple and straightforward. You may use bullet points with sub-objectives to describe each objective. The follow may help to guide you as you develop the objectives:
    - Objectives are narrow

- Objectives are precise
- Objectives are tangible
- Objectives are concrete.
- Objectives are measurable.

Learning theory

- Which theories are essential to understanding about the key themes of the case? Provide a list of required reading.
- How do the theories help to understand the key themes? In what ways do they not apply?
- What additional reading may help Fellows think more critically about the issues?

Class organization

- How will you deliver your pre-case lecture and organize the case present to the class?
- What are the major points of discussion and when will you raise these points? How will you organize class discussions to facilitate engagement with the pedagogic objectives?
- What are the different arguments that may emerge and how will you respond to these viewpoints to facilitate learning of the objectives? Think about how you can sequence class discussion to reach the identified pedagogic objectives. What are possible sources of entanglement or disputes that may arise during discussion and possible ways to use these as "teaching moments"?
- How will you use teaching aides such as whiteboard, blackboard, or PowerPoint in the class?

Questions

- What are questions that help Fellows think about some of the key issues raised in the case in order to understand the pedagogic objectives?
- Provide a comprehensive answer to each question, drawing on multiple sources and perspectives.

References

- Provide a full reference list at the end. Be consistent in which format you use. The APA "author, date" referencing style (*Author, A. (Year of Publication). Title of work. Publisher City, State: Publisher.*) is easy to use and recommended. [1]

Editing

Make sure you check all spelling and grammar and maintain the same standard font style and size throughout. Times New Roman or Arial in size 12 is acceptable.

Acknowledgements

List the authors at the beginning of the document. ASELPH branding will be applied at the end of the process.

[1] APA Style https://www.apastyle.org/learn/quick-guide-on-references

III. Case reviews

After finishing the first draft of your case, you are ready to submit your case for review by members of the ASELPH team. There are two steps for review. The first step reviews the case to make sure it meets the minimum criteria. Please review the criteria in Table 1 the next section to make sure your case meets the criteria. If you have questions contact your ASELPH programme manager or another designated faculty for advice.

Minimum case standard framework

Table 1. Minimum criteria to proceed to case review

Criteria	Reviewer Assessment	
	Satisfactory	Requires development
Case Topic • Applicability to ASELPH programme and specific course objectives • Suitable topic for pedagogic objectives • Contemporary relevance to the South African health sector and its reform policy objectives		
Case Type • Appropriateness of case type, given case topic and pedagogic objectives		
Pedagogic objectives (contained in the teaching note) • Clearly articulated objectives • Relevant and specific to course/module objectives		
Content and material • Length of the case must be appropriate, given the scope and focus of the case and depth required to engage with pedagogic objectives • Content sufficiently comprehensive and focused on relevant information to achieve pedagogic objectives. • Narrative well-structured and ordered in terms of the chosen case type. If relevant, characters are well developed. • Writing style effective and efficient in creating an engaging narrative and story arc (“hook” and multiple avenues) • Minor grammar and spelling issues		
Sources • Information supported with relevant references • Diverse set of resources (primary sources, secondary, academic, online, media, interviews) • Acceptable quality of sources • Sources properly referenced using a standard method		
Study questions (in teaching note) • Questions clearly stated and formulated • Relevant to pedagogic objectives • Students enabled to answer questions given case construction and background theory • Questions encourage multiple analyses or approaches and stimulate debate and discussion • Comprehensive answers provided		
Teaching note complete and includes the following		

Criteria	Reviewer Assessment Satisfactory	Requires development
• Case synopsis - brief outline of case: key teaching points and theoretical concepts • Pedagogic objectives • Learning theory, required background reading • Class organization - Strategies to sequence of discussion: "order of things" and prediction of different arguments/sources of entanglement/disputes which may arise during discussion and possible ways to use these as "teaching moments"; effective use of board/technology • Questions		
Presentation and layout • Standard ASELPH layout and structure followed as described in the ASELPH guide to case writing		

Harvard framework for case evaluation

After the authors respond to and address any issues raised during the first review of minimum criteria, the authors submit the case for review by Harvard Chan School of Public Health faculty for final review. The ASELPH partners would like to have 10 cases approved by Harvard to demonstrate comfort with developing cases that conform to the Harvard case-teaching methodology. After authors respond to the initial review, they can review the criteria in Table 2 to make sure they are ready for the first Harvard review.

Table 2. Harvard case evaluation criteria

Evaluation criteria	Comment
Case not just a story (has protagonist, an immediate problem)	
Relevant, important issue(s)	
Voyage of discovery (complex problem, solution not obvious)	
Controversial (presents issues to debate, opportunity to test assumptions)	
Provides contrasts or comparisons (could be accomplished using multiple cases in one course)	
Provides currently useful generalizations (forces students to ask the right questions, versus giving the right answers)	
Includes the data required to tackle the problem (context, data, people)	
Personal touch (quotes from key players in the case; videos)	
Well structured, easy to read (requires multiple drafts/revisions)	
Short (8 - 10 pages of text, 5 - 10 pages of exhibits)	
Suggestions for improvement	

Criteria for a completed ASELPH case

Using cases in the classroom is an important part of case development. After using the case in the classroom, authors use feedback about cases to refine the case. Case authors should document the revisions and provide the final case for the ASELPH case file. A final case is one that has been through all four stages (below). It is now ready to be labelled an ASELPH case and sent for publication. Congratulations!

Table 3. ASELPH final case criteria

Stage of case review required for finalization	Passed (check when achieved)
1. Preliminary review	
2. Harvard review	
3. Case piloted	
4. Post-pilot revisions	

Case Elements Outline

Title of Case

Authors and affiliations

Author 1

Author 2

I. Introduction

II. Case content (body)

III. Conclusion

IV. Appendix

V. Teaching note
   a. Case synopsis
   b. Pedagogic objectives
   c. Learning theory
   d. Class organization
   e. Questions
   f. References

Appendix 5: ASELPH Cases

Albertina Sisulu
Executive Leadership
Programme in Health
Excellence, Innovation, Transformation

ASELPH Case: Re-engineering Primary Health Care - Operational challenges in health service delivery through a WBOT lens.

Case author

Professor N Jinabhai prepared this case study.

Case study

Sister (Sr.) Lydia Mampondo, a team leader for the Ward Based Outreach Team (WBOT) involved in primary health care at Cofimvaba Hospital, looked a bit under stress as she left Mrs Themba's homestead. As part of WBOT's programme she had visited the household to check on one of Mrs Themba's children who had been recently hospitalised.

After she had concluded her observing the child, Sr. Lydia was asked by Mrs Themba, at 30 years old a relatively young unemployed mother, to assist her in getting birth certificates for her three children and to assist in educating them. She concluded her pleas by asking Sr. Lydia to also assist with finding her husband a job. The young mother had seen the health benefits brought by Sr. Lydia and her team of community health workers to the community and thought perhaps she could assist her on her other personal issues. All her children had been born at home and no attempt had been made to register their births with the relevant authorities. The rapid tumbling of these requests suggested that she had been patiently waiting for the opportunity to talk to Sr. Lydia and did not want to leave anything out. It was also clear that she did not believe that these were beyond Sr. Lydia's role as a primary health care provider.

The source of Sr. Lydia's stress was the conflict arising out of her recognition of the obvious needs raised by Mrs Themba and her ability to assist while ensuring that she furthered her mandate of effectively providing public health services in the rural Eastern Cape villages. It was these conflicts which caused her a bit of stress as she left Mrs Themba's homestead.

She understood all too well that even if she wanted to, she alone did not have the skills or capacity to assist in getting identity documents, educating someone else's children and finding a job for someone who might not even be interested in getting one. It was also obvious that what she had just been asked was beyond the Department of Health's role. She vaguely recollected from her training that these activities fell within the scope of the Department of Social Development[1] and the Department of Home Affairs.[2]

[1] See Department of Social Development primary core functions at http://www.dsd.gov.za/index.php?option=com_content&task=view&id=31&Itemid=54
[2] See Department of Home Services Civic Services at http://www.dha.gov.za/index.php/civic-services

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Sr. Lydia was, however, equally aware of the implications of the social determinants of health as outlined by the World Health Organisation.[3] These determinants guided the conduct of health workers within the context of the conditions under which they provided health care. The cognition of her constraints and abilities did not absolve her from ensuring that she carried out her mandate as effectively as possible despite the presence of constraints. It was with this in mind that she left Mrs. Themba's house to meet with her District Manager. It did not cross her mind at the time that although she did not personally have direct contacts within the Departments of Social Development and Home Affairs, her superiors should have those contacts. Such cooperation had the potential of reducing the adverse impacts of the social determinants of health.

Sustainable Development Goals (SDG's) to promote health

In September 2015 the United Nations had replaced the Millennium Development Goals (MDG's) with the Sustainable Development Goals (SDG's) to promote global social development. These SDG's included several objectives related to health, as well as integrating all aspects of development policies and services for citizens.

Sr. Lydia had attended some of the seminars on SDGs and was aware that the SA Government had committed to fulfil them and had to report regularly to the UN on their attainment. She believed that she understood her own responsibilities and duties at the local level to ensure that these Goals were met at the national level. In particular she was sensitive to the conditions under which the families in her care lived, the extent of deprivation and poverty and the importance of promoting good health and early health seeking behaviours to detect and treat diseases. She was, however, unaware that, beyond performing her own functions effectively, she could also act as an agent to other government departments to assist the South African Government in fulfiling its Sustainable Development Goals.

Re-engineering Primary Health Care

In 2010, the South African National Department of Health (NDOH) passed a policy document entitled Re-engineering Primary Health Care. The purpose of the initiative was to improve the early diagnosis and referral of people so that they could be provided with routine care, and those with chronic illnesses, to maintain their wellbeing by receiving regular care at a local level before their conditions deteriorated. The initiative also provided for immunisation of children so that they could live healthier lives.[4] To overcome the issue of skills shortages while improving access to health care, the initiative utilised what had come to be known as the Ward Based Outreach Teams (WBOT).

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[3] The social determinants of health (SDH) are the conditions including economic policies and systems, development agendas, social norms, social policies and political systems in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. Sourced from http://www.who.int/social_determinants/en/ on 12 September 2016

[4] https://www.google.co.za/? gfe_rd=cr&ei=zLfXV5zsNeeo8wfZ35DgBg#q=re-engineering+primary+health+care+in+south+africa

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The WBOT were founded on a principle of dense community-based 'economy of care' that emerged in South Africa partly around the response to HIV. Sr. Lydia had been recruited to the Eastern Cape from Durban where she was a Professional Nurse to assist in the roll-out of the Re-engineering Primary Health Care programme. She had been trained in Psychiatric health, community health, midwifery and general nursing and had been doing community health for 5 years, at a Durban Clinic. Her training in nursing had equipped her to do clinical tasks such as doing observations and carrying out medical orders prescribed by a doctor. Past experience in a medical ward at a district hospital entailed carrying out nursing plans and orders already prescribed. Her experience in community health and working in the clinic had included diagnosing minor cases and prescribing medication for minor illnesses, as opposed to just carrying out orders prescribed by physicians. All these entailed co-operation and team-work. This was to serve her well as team leader for the Ward Based Outreach Team (WBOT) although she had no formal management training.

A year ago, Sr. Lydia was told that she would no longer work in the clinic, but would be responsible for leading one of the Ward Based Outreach Teams (WBOT) at Cofimvaba in the Eastern Cape. At the time she did not understand what this project entailed and how it would be implemented as well as what she was expected to do in leading her team. She was only told that she would have a team of six (6) community health workers (CHWs) and that she would be responsible for 'managing' them. Her exasperation was increased by the fact that she was only used to providing clinical care in a clinic and hospital setting, i.e. providing curative care. Now she was expected to provide community based health care, which involved mostly health promotion and prevention activities.

The primary task of the CHW's was to undertake house visits to document the "Household Profiles" recording all the social, economic and health needs of the family members; undertake some basic first aid and nursing care tasks and to work with the Outreach Team Leader (OTL) like Sr. Lydia to provide Home Based Care and some limited treatment. This WBOT consisting of the OTL and the CHW's would then report to the monthly Ward Committee meetings, where the relevant Government departments present would address the problems identified at the household levels. The locally elected Ward Councillor for the area was expected to lead and manage these Ward Committees to ensure adequate service delivery.[5]

Governance: Functioning of the Ward Committee & Councillors

When the Minister of Health had released this Re-Engineering PHC policy document, it was proposed that all major Government Departments dealing with different aspects of social development and care would come together in monthly meetings of the Ward Committee ("War Rooms") to discuss issues emanating from Outreach Team Leaders' report and address them.

[5] Albertina Sisulu Executive Leadership Health Programme (ASELPH). Rapid Assessment of Ward Based Outreach Teams. Prof CC Jinabhai, Prof T Marcus, Dr. A Chaponda, Universities Of Fort Hare & Pretoria

A key member of this committee was the locally elected Ward Councillor, who was a critical facilitator for promoting the welfare of these households and families, mobilising resources from other government and NGO sectors and reporting to the relevant governance structures.

Ward Based Outreach Teams

The thought of having to 'manage' a team, at the age of 29, frightened her as she had no managerial experience or training. However, Sr Lydia was keen to make a difference to the best of her abilities and, in the past, had not been afraid to ask for help and support from her colleagues.

The members of the WBOT under her leadership were recruited from Community Based Organizations (CBOs) already working in the village where they provided home based care activities. These included doing bed baths, assisting with the cleaning of dwellings as well as cooking and providing palliative and rehabilitative care. These community health workers were older than her with an age range of between 30-50 years. They had been working for approximately 10 years in the village, providing these services. They had also had training over the ten years on basic home care and activities mentioned above. However, they had not been specifically trained on how to identify and manage medical problems such as hypertension, diabetes and facilitating the adherence to chronic medication including antiretroviral therapy (ART). A short and brief training lasting ten (10) days, was provided for for them as well as communication on her responsibilities as a team leader. The training for members of the WBOT covered basic Primary Health Care (PHC), first aid, and basic nursing care.

These community based workers, worked initially as volunteers, but later received a stipend of approximately R1200 per month. They worked for five days going from hut to hut in the village, but their hours were not fixed. They also provided assistance to the community over the weekends as they lived in the same village.

Managing CHW's & Task Shifting: Skills, Competencies & Qualities

Delegation of health promotion and preventive activities to lower level health workers such as CHW's is part of a world-wide trend of task shifting; and Sr. Lydia was expected to both manage these CHW's as well as to ensure that the quality of their health related work was according to the standards laid down by the National Department of Health. She thus had to balance her time and skills to provide clinical care to her clients at households, as well as to monitor, supervise and train the CHW's. Thus she needed to develop her clinical nursing skills and complement them with management and supervisory competencies, as well as education and training roles. She however did not seem to be aware of this need and it was not outlined to her.

An additional competency that she needed to acquire was to interpret the household registration data that the CHW's were collecting, analyse it to assess and make a community diagnosis so as to design the appropriate health interventions and report problems identified at the household levels to the Ward committees to be addressed by the relevant government departments. As an OTL, she was also required to submit weekly and monthly reports to the clinic and District Managers.

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Because of her experience in community health and working in the clinic she and her team had numerous successes with her project. Her experience in working as part of a team and the team dynamics skills she acquired enabled her to engender co-operation from her team. These included reaching the clinic's target of immunizing all children under 5 in the village. Since her arrival, all babies were born at the clinic and not at home as had been the case in the past, and all pregnant mothers in the village had been tested for HIV. Those found to be HIV positive had been put on antiretroviral therapy (ART). Of importance was that all those put on ART had maintained treatment. While her passion for her work had assisted, Sr. Lydia's training came in handy, particularly on matters related to the social issues impacting health provision.

On deeper reflection Sr. Lydia also noted that her professional and educational training has prepared for the clinical, technical and some managerial tasks. However dealing with relationships, expectations of her clients and managing & mobilizing service sectors outside the health domain required her to acquire additional skills, competencies and knowledge. These included the capacity for Self-management recognising her own limitations of her own decision space; ability to motivate, communicate and network with other sectors and service professionals and ultimatley to act as a change agent. Some of these related to developing her emotional and social competenceis to develop her leadership qualities and increase her spectrum of management skills.

Confronting the Social Determinants of Health

It was during one of her out-reach activities in the course of implementing the WBOT project that Sr. Lydia came across Mrs Themba. The 30 year-old, Mrs Themba was 36 weeks pregnant and HIV positive. She was diagnosed with HIV during her second pregnancy, three years ago and had been on ART since then. She had three children ages 5, 3 and 2 years. The 5-year-old was a girl who was, at that age, expected to start doing gender-specific duties. When she left the Themba homestead, Sr. Lydia, heard Mrs Themba ask her oldest child to go fetch water for cooking. For clean water, communities walked to the nearest shop located 2 kms away where they had limited access to water from a bore hole. Water for washing was drawn from the river a few kms away. Sr. Lydia couldn't help herself but to compare her own daughter, Joyce, two years older than Mrs Themba's young girl and wonder what the future held for this little girl. Sr. Lydia's daughter had a stable family, providing for all her needs and able to educate her so that she could go to University, get a professional qualification and a good job to secure her future.

Mrs Themba's commune, where she lived with her husband and children, included two huts, one for cooking and eating and the other for sleeping. The primary hut used for meal preparation had a diameter of three meters with only two windows and one door. The small windows did not let in enough light and it was usually dark inside even during day-time. The hut smelled of cow dung as this was used for plastering to make the inner walls smooth. The huts themselves were constructed of clay bricks. The clay had been fortified with cow dung. There were three buckets inside the hut used for sitting on, otherwise two large straw mats on the floor added to the seating arrangement. Other than a few boxes used for storage, there was not much else inside the hut except a fire pit in the centre of the hut for heating and preparation of meals.

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Unemployment was very high in the area. Added to this was high levels of alcohol abuse. Her unemployed husband was abusive and often came home drunk and often beat her up. He also beat up the children for minor transgressions.

The three children had been ill on and off. The 2-year-old girl, who had diarrhoea for three days, experienced the lastest illness. The mother tried using herbal remedies to stop it as soon as it started, unfortunately, the diarrhoea only stopped three days later. By that time, the girl had lost a significant amount of weight and had sunken eyes. The girl survived with the assistance of the local shop owner who drove the mother and the girl to the local hospital, situated 50 kms away, where she was put onto intravenous rehydration therapy to replace lost electrolytes. The local hospital only had one ambulance while the district hospital was located about 200 kms away in East London. The other two children also had their fair share of medical problems, particularly childhood diseases such as ear nose and throat conditions, intestinal worms, skin lesions and respiratory conditions.

Before going to the District Manager's office, Sr. Lydia consulted one of her close colleagues and Supervisor, Sr. Gumede who was also a WBOT Team Leader in another ward. Sr. Gumede fully sympathised with the challenges facing Sr. Lydia and suggested that in her case she had spent several years working with a Community Based NGO where she was able to acquire the skills, knowledge and competency to handle the inter-related health, psycho-social and economic problems.

Complexity of Service Delivery & Status of WBOT

Sr. Lydia was aware that not all government Departments regularly attended Ward Committee meetings and that the Ward Councillor was often busy with other commitments. Many government departments did not have a Provincial component and were unable to have a presence at the Ward level; while communities were increasingly demanding more and more services. As a result, several NGO groups were demanding additional resources. These constraints made her and the CHW not to be able to address some of the expressed needs of the households under their care and thus affected their status in the community. This reduced their ability to motivate community participation in health events. The complexity of delivering health and social services to address the SDH of her clients, gave her valuable insights about the relationship between her leadership and management skills, her roles as a change agent capable of self-management and motivating others.

The Way Forward

As she reached the District Manager's office, Sr. Lydia realised that the source of her stress was not just the request made by Mrs Themba, but how to meet the objectives of the Re-engineering Primary Health Care within the constraints of the social dynamics which determined the accessibility of health for communities entrapped by both poverty and socio-economic circumstances. Mrs Themba was 36 weeks pregnant; she could deliver anytime as she had three other children before. There was a need to arrange a safe plan for delivery as soon as she can, to avoid maternal and neonatal complications , and reduce mother to child transmission of HIV- an event, which could have detrimental effects to her children.

She was also aware that providing some assistance to Mrs Themba would go a long way in increasing their stature in the community and therefore better positioned to motivate community participation in health events, something that was critical in meeting the objectives of the Re-engineering Primary Health Care programme. As she entered the District Manager's office, she mulled over several questions: How was she going to assist Mrs Themba? How could she persuade the District Manager to support her initiative? And what was she missing?

She also realised that to maintain her successes in the health care setting, she needed to balance her technical /clinical and her mangement training, knowledge and competencies with soft skills dealing with emotional competency of managing expectations and needs of her clients. Critical to understanding the multi-diemnesional nature of "health problems" influenced by the SDH and its complexity; required a multi-disciplinary team (including social / development workers) using a inter-sectoral approach, mediated through Ward committees where multiple government departments – including the Municiplaties – were present. She intuitvely recognised the need for a multi-professional approach, involving a inter- and trans-disciplianry developmental approach. She acknowledged that while single health interventions were necessary to alleviate immedaite needs; they were not sufficient to address the full complexity of the challenges confronting her at the household level.

Exhibit 1: Operational Organogram : Participants, Structures, Activities & Reporting lines

WBOT OPERATIONAL FLOW CHART

WBOT TEAM
PROJECT MANAGEMENT SKILLS
LEADERSHIP @ HOUSEHOLD, WARD, MUNICIPAL & PROVINCIAL LEVELS

HOUSEHOLD REGISTRATION
AUDIT OF SDH NEEDS

PRESENTATIONS TO WARD COMMITTEES (WAR ROOMS)

MOBILISING RESPONSES & RESOURCES
INTER-DISCIPLINARY, INTER-SECTORAL & TRANS-PROFESSIONAL CO-ORDINATION SKILLS

MONITORING & EVALUATION SKILLS & KNOWLEDGE

INTEGRATED SERVICE DELIVERY RESPONSE / OUTCOME

CYCLICAL FEEDBACK & COMMUNICATION TO STAKEHOLDERS

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Exhibit 2: Core Learning Outcomes, Management Skills & Networking to address SDH

Participants and structures	Required skills and competencies	Learning outcomes: Impact on interventions
Management of WBOT and PHC services	Clinical Technical and Mx skills, knowledge & practises to fulfil Health needs	Health Interventions: Health promotion- prevention Clinical / Nursing care Rehabilitation
Management of social services: Municipal, Provincial & National Govt departments	Manage and engage relevant actors to render MULTI-DISCIPLINARY health & social services	Ward committees / Municipalities to address Socio-Economic needs & Provide Social Services Monitoring & Evaluation
WBOT Team Leader	Emotional Competencies to balance management and leadership skills Networking Communications	Address the SDH needs comprehensively

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Teaching Note

Pedagogic Objectives

The aim of this case is to teach students about the difference between followers and leaders and to demonstrate the need for adopting and implementing supportive strategies and policy changes that will improve the transitioning of individuals into new roles. Followers perform their duties as set out by their managers whereas managers, in addition to managing their subordinates, they have to constantly make decisions on how to carry out their mandate with the resources at their disposal. In her position as a nurse, Sr. Lydia excelled in sticking to the requirements of her job as set out within the context of her job description. In that role, she had also demonstrated interpersonal skills which were demonstated in her abilities to excell as a team-member and engender co-operation from others she had to work with in carrying out nursing plans and in working in the clinic.

The case also demonstrates the need for contextual leadership skills arising out of the migration from curative to preventative medication as well as an understanding of the agentic role that leaders are often required to play. In this case, Sr. Lydia was also acting as an agent of the Ward Committee where she was required to report back on issues outside her responsibilities relevant to other government departments. Students would learn from the case the need to adapt to changing, or changed, operational environments and the dynamics of change in which Sr. Lydia not only had to lead her team but also to act as an agent of the Ward Committee.

As the Outreach Team Leader, she was not only expected to ensure that the rolling out of the Re-engineering Primary Health Care programme went according to plan but also to ensure that the objectives of the World Health Organisation's social determinants of health were adhered to. This required a transition out of her hitherto career path to broadening her scope of work to include the implementation of national policy decisons and real-time deciion making. In turn, these required not only her profesional competencies as a health professional but also the cognition of her new role as a manager with its powers and the resources which would enable her to delegate rather than just to co-ordinate activities.

To attain the pedagogic objectives of this case, students would need to understand the contextual leadership theory as well as the agentic role that leaders in complex organisations are often called to play. Sr. Lydia's appointment as a team leader for the Ward Based Outreach Team required some form of contextual leadership skills as the context of her leadership was changing within a bigger transition from curative health care to preventative health care as part of the National Health Insurance piloting. As part of the NHI piloting, and the consequential establishment of WBOT, she was also expected to act as an agent of the Ward Committee.

In summary there are three main pedaogogical domains: 1) decentralization theory – she does not appear to have the necessary decision space to do anything about the social determinatns of health. The ward councillor needs to improve service delivery in the areas she has defined, otherwise her job is responding to the failures of local governement (perhaps in this case the degree of decentralization was over ambitious: too much decision space given to local structures without the necessary capacity/authority and accountability at the local level in eastern cape); 2) management

science – cultivating the necessary knowledges and skills to lead community health teams; 3) principle agent theory – appreciating competing interests in the district health system, how this impacts on policy implementation (in this case WBOT) and management strategies/appoaches to respond to these dilemmas. Or a combination of all of the above.

Case Synopsis

Sr. Lydia Mampondo, a team leader for the Ward Based Outreach Team (WBOT) involved in primary health care at Cofimvaba Hospital had been asked by a community member, Mrs Themba, in the village to assist with some issues which were beyond her ability. At the time of the request, Sr. Lydia, had had a number of successes with her project which seemed to be a good breakthrough in her job, these successes included reaching the target of immunizing all children under 5 in the village, all babies being born at the clinic and not at home, all pregnant mothers tested for HIV and those found to be HIV infected put on antiretroviral therapy (ART).

The continued success of these activities depended on continuing community participation in health events where they were educated on preventative health care matters. However, the continued support of the community depended on the level of esteem they had fof Sr. Lydia and her team. This in turn depended on their perception of her and her team's ability to address their needs. Therefore, her ability to assist Mrs Themba was critical to her success.

Sr. Lydia was a well trained and experienced Professional Nurse before being transferred to Cofimvaba. While her duties had been outlined to her, this was the first time that she had acted as a manager and tehrefore was in experienced in leading people and managing relations outside her own area of competency. In addition, the context in which she worked in the villages was not standard as each area had different challenges. She therefore needed to manage and conduct her duties in a manner specific to the context. It was, partially because of this that she was stressed after talking to Mrs Themba. If that was not all, her own performance was also measured in terms of whether she met all objectives including adhering to the objectives of the World Health Organisation's social determinants of health. These objectives demanded that health workers took into account the socio-economic conditions under which their patients lived. Mrs Themba's situation was an example of this although a bit extreme.

When she entered the District Manager's office, Sr. Lydia was acutely aware that her continued success in fulfiling her mandate depended on the community's perception on the degree of her being able to assist them.

Level

This case is aimed at last year undergraduate students and post graduate management students. While the case is situated within the health sciences sector, it is also appropriate for management students and could be used in management and leadership, organisational cahnge and transformation as well as Human Resurces courses.

Suggested Class Discussion Plan

As part of the management course, this case could be used to embed the concepts of institutional transformation, such as those occurring as part of the National Health Insurance's transformation from curative to preventative care, and the consequential need for individual tranformation and the acquistion of skills (such as contextual leadership and own career management) to better function within a changing operational environment where experience has not resulted in the formation of policies and functional guidelines.

To better prepare and benefit from the lessons of the case, the facilitator should ask students to familiarise themselves with the concepts of contextual leadership as well as different roles, such as agency role, that leaders are often required to perform. Therefore, before the class in which the case would be discussed, the facilitator would ask the students to read material related to these (some suggestions have been made below).

<u>On the day of a three hour class:</u>

In groups or syndicates of 6 to 8 students, each group would prepare a presentation on what they would discuss with the District Manager. Each presentation would focus on the next steps to be taken by the district manager to ensure that Sr. Lydia continues to be successful in her role by reducing the effects of cultural dissonance. Such a presentation should include how she fits in within the context of the environment in which she operates, her current position and what resources, if any, she could utilise in her position. The article by Schriner (2007) could provide some guidelines. (45 minutes)

When the class commences, each group would give a 10-minute presentation to the rest of the class and answer any questions between 5 and 10 minutes.

The facilitator would close with a discussion using the guidelines provided by Schriner (2007). An alternative would be for the syndicate groups to prepare and submit presentations before the commencement of the class in which the case would be presented. On the day of the class, students would do step 2 and 3 above following which the facilitator would ask the class whether Sr. Lydia had taken any steps to transition hereself into her role.

The case does not suggest what she did. The Facilitator could then discuss Inkson & King's (2011) suggestion that "the interests of employing organizations and of individual workers often make careers 'contested terrain' in which organizations pursue strategic advantages and individuals personal advantages to highlight the importance of not only relying on organisations to develop individual careers but also that individuals have a duty to develop their own careers. This is further highlighted by Drucker (1999).

Assessment

In assessing students, students should be given some time to read the case. It is only after this that a question sheet will then be availed to the students for them to answer the questions. Students in the health sciences will be expected to contrast this with what they know about clinical governance.

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Case Study Questions

Sr. Lydia seemed unsure about her scope of practice. In your opinion, what do you think Sr. Lydia should consider the scope of her practice to be and why? Please give reasons for your answer.

What support did Sr. Lydia need in doing her job, and how would this assist this young mother? In many instances, health workers feel frustrated with lack of support and sufficient information on their programs, thus negatively impacting on implementation. How could Sr Lydia be a change agent in this context. Namazi (2013, p. 40) defines agency theory as relating "to situations in which one individual (called the agent) is engaged by another individual (called the principal) to act on his/her behalf…" Do you think that Sr. Lydia was an agent? Please explain. If so, was she cognizant of this and how did she perform as an agent?

Analysis

Sr. Lydia seemed unsure about her scope of practice. In your opinion, what do you think Sr. Lydia should consider the scope of her practice to be and why? Please give reasons for your answer.

Sr Lydia only received a short and brief training on WBOT without any managerial training. Accordingly, she seems to believe her scope of work to be limited to what she had been trained and applying it to the context of her current role. This is evidenced by her experiencing a level of stress when she is asked to assist in something outside of what she believes her job should be. As a leader tasked not only with the provision of primary health care but also with assisting in the roll-out of the Re-engineering Primary Health Care programme and ensuring that the objectives of the World Health Organisation's social determinants of health were adhered to. Cognition and acceptance of the scope of her practice as well as the acceptance of her role within that scope would have enabled her to realise that, in her position, she had access to resources that would assist Mrs Themba as well as agentic power within the Ward Committee to ensure that relevant assistance was given to Mrs Themba. This could have reduced her stress levels and her anxiety about losing the support of community members in her health programmes.

What support did Sr. Lydia need in doing her job, and how would this assist this young mother? While Sr. Lydia had made great progress in her Ward, she was entering a phase where her technical abilities were no longer enough in her job and she needed managerial and leadership experience. However, operating in a totally new environment, she had no role-models to emulate in leading her team. Accordingly, her immediate supervisor needs to ensure that she was adequately trained as a manager and provided the required resources including coaching. Such training and guidance would also enable her to be more aware of the roles of different officials and of entities, both government & NGO, in her area as well as the duties of the Ward Committee members so that they could contribute more to these wider issues beyond being just recipients of reports. If she was aware of Home Affairs services in the area, Sr Lydia could ensure that the young mother accesses those services for her ID documents. Liaising with School Health services and the Dept of Education would also assist Sr Lydia in giving the right information to the mother regarding education for her kids. Sr Lydia also needs to be aware of where information regarding various employment opportunities is available; she could then provide this to the young mother.

In many instances, health workers feel frustrated with lack of support and sufficient information on their programs, thus negatively impacting on implementation. How could Sr Lydia be a change agent in this context?

Sr. Lydia is already on the management team as the leader of her team. She also has first hand knowledge of matters happening in the field and can therefore provide fact-based information on what is needed to change the situation and therefore access more support and sufficient information.

Namazi (2013, p. 40) defines agency theory as relating "to situations in which one individual (called the agent) is engaged by another individual (called the principal) to act on his/her behalf…" Do you think that Sr. Lydia was an agent? Please explain. If so, was she cognizant of this and how did she perform as an agent?

In addition to her duties, or as part of her duties as the team leader of the Ward Based Outreach Team, Sr. Lydia was an agent (as defined by Namazi (2013, p. 40)) acting on belf of the Ward Committee. It does, however not seem as if she was cognizant of this fact given her stress following Mrs Themba's requests. Had she been cognizant of this, she would have noted Mrs Themba's requests and presented them to the principals at the Ward Committee.

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Summary of key discussion points:

- Effectiveness in making a health impact, to address the Social Determinants of Health
- Integrity and professionalism, linked a wider scope of practise to enable her in dealing with clients
- Motivating other sectors and cadres of workers that impact on health status
- Navigating the clinical, psycho-social and political / policy domains
- Ensuring that health promotion and disease prevention is effective
- Building confidence among clients to change their behaviours.

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ASELPH Case: Managing relationships with traditional communities: The case of OR Tambo District, South Africa

Case authors

This case study was prepared by Professor Eunice Seekoe of the Fort Hare University and Mr Jabu Maphalala a Doctoral Student at the University of Pretoria's Gordon Institute of Business Science.
The case study is not intended to demonstrate effective or ineffective handling of an administrative or management situation. It is intended for classroom discussion only.

Case study

Friday afternoon in late July 2016 was a particularly quiet day in the offices of the Eastern Cape Department of Health's OR Tambo District. The District Manager, Ms Susan Malabalaba was happy to have the office to herself so that she could concentrate on developing a strategy to convince local authorities to partner with the Department of Health in piloting the National Health Insurance (NHI) in the district. When she was appointed at the beginning of 2016, she was given a mandate of ensuring a successful rollout of the NHI pilot programme in the OR Tambo District. Almost six months into the financial year, Malabalaba found that she had missed her targets by a fairly large margin. She had managed to spend only 15 percent of her allocated budget of R7,2 million.[1] Up until now, she had not measured how far she had gone in fulfilling her mandate as she had been caught up in managing crisis which emanated from the misalignment of the community leaders' expectations and the objectives of the OR Tambo District's Department of Health. These seemed to occur on a daily basis.

While the need and justification to spend her budget allocation had been there all along, she had encountered difficulties in getting the cooperation of the community in the rollout of the pilot project. Without the cooperation of the community, it was not possible to do her job.
Malabalaba had found out the level of her dismal performance when she started to prepare a report on progress in the rollout of the NHI in the district for the Minister of health who was scheduled to arrive at the District office in three days.

She knew that presenting problems alone would not be enough for the Minister, she needed a solution to make him happy. Instead of continuing with the report, Malabalaba decided to start with the development of a strategy to convince local authorities to partner with the Department of Health to pilot the National Health Insurance (NHI) in the district. The question was how she would convince community leaders that their support for the pilot project was in their best interests. The fact that her predecessor had not done any better was not going to be of any consolation as it was her primary role as District Manager to oversee the rollout of the piloting of the NHI in the district.

[1] At an exchange rate ZAR14 to US$1, R7,2 million is equivalent to about US$514,285.00

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Malabalaba found herself making a very slow progress in developing her strategy. This was not due to not knowing what needed to be done, the main issue was how to interest community leaders in adopting the pilot project as their own so that they could support in with great enthusiasm.

The National Health Insurance

In 2011, the South African Department of Health published the Green Paper on the National Health Insurance (NHI). The Green Paper outlined plans on the benefits of implementing a national insurance plan and healthcare financing system. The purpose of the NHI was to "ensure that everyone has access to appropriate, efficient and quality health services".[2] The rationale behind the NHI was that the majority of South Africans had inadequate access to quality health care. Some reports had suggested that about 50 percent of general practitioners and specialists and 30% or nurses worked in the private sector where they served less than 20 percent of the population.[3] The sector of the population they served had access to medical aid schemes. Over 80 percent of the population of about 56 million people[4] therefore depended on public health services. The NHI was intended to provide "coverage to the whole population and minimise the burden carried by individuals of paying directly out of pocket for healthcare services".[5]

The public sector was under-resourced relative to the size of the population that it served and the burden of disease, the NHI was intended to change the prevailing situation where about 85% of the financial and human resources for health benefits a minority of the population with access to medical schemes utilising the private health sector.

While the NHI was intended to be "phased-in over a period of 14 years",[10] it was to be piloted in 10 districts across the country. In piloting the NHI, the Minister of Health wanted a model, utilizing the lessons learned to be used in developing a plan for the national roll-out. The 14-year phase-in period was intended to ensure that the NHI was implemented without many hassles. The OR Tambo District was one of the 10 selected. The criteria for selection was based on the "health profiles, demographics, health delivery performance, management of health institutions, income levels and social determinants of health and compliance with quality standards"[10] of each district. Malabalaba was aware of the importance of making progress in the piloting of the NHI given the unique contribution information from each selected district was to make.

OR Municipal District

As a country, South Africa is demarcated according to nine provinces which have been further subdivided into metropolitan and district municipalities. The criteria for a metropolitan municipality is that it should, inter alia, have high population densities with "intense" movement of people;

[2] Department of Health, Republic of South Africa (2011) National Health Insurance in South Africa Policy Paper. Sourced from www.gov.za/sites/www.gov.files/nationalhealthinsurance.pdf
[3] Ashmore, J & Gilson, L. (2015) Conceptualizing the impacts of dual practice on the retention of public sector specialists-evidence from South Africa, Human Resources for Health 13(1)
[4] Statistics South Africa's 2016 mid-year population was 56 million.
[5] National Health Insurance Policy paper 2011

extensive development with industrial areas and centres of economic activities with a complex and diverse economy.[6] A district municipality on the other hand has a relatively low population density, is relatively underdeveloped with lower economic activity.
District municipalities have been further subdivided into local municipalities. The Eastern Cape has eight districts including OR Tambo which has five local municipalities including King Sabata Dalindyebo municipality, in which Qunu is located. Qunu is the place where former President of South Africa, Mr Nelson Mandela, grew up.

Out of the eight districts in the Eastern Cape Province, the OR Tambo had one of the lowest socio economic profiles. With an estimated 2015 population of 1 432 523 the OR Tambo District Municipality had the highest percentage of households living below the poverty line, the highest percentage of individuals with no schooling and the second lowest percentage of people under medical aid coverage.[7] With only 4.6 percent of the population in the OR Tambo District having access to Medical Aid facilities, the district exemplified the profile sought by the Department of Health to pilot the programme.

Like most of the Eastern Cape which was part of the apartheid era homelands of the Transkei and Ciskei, the OR Tambo District is located far from the country's big cities. While the offices of the Eastern Cape Department of Health's OR Tambo District were located in Bhisho, the former capital of the Ciskei homeland it was still a small town. The rest of the district was made up of poor communities many of them still rural in nature.[8]

A sizeable portion of the area's income came from remittances of migrant workers as many young men from the region worked in South Africa's mines as unskilled labourers.[9] While employment at the mines provided much needed income, the costs included the importation of diseases such as silicosis,[10] and noise induced hearing loss. This added a further burden on the already stretched and under-staffed health facilities.

Given the profile of the district, it fit the criteria for the roll-out of the National Health Insurance pilot project. Lessons learned in piloting the NHI in the municipality were critical in identifying constraints and opportunities in providing health care services in rural underserved areas dependent on public health.

As part of the criteria for identifying the OR Tambo District as one of the piloting sites for South Africa's National Health Insurance, the Department of Health had taken into consideration the impressive state-of-the-art facilities available at the Nelson Mandela Central Hospital. The hospital

[6] http://warwickchapman.com/wp-content/uploads/2010/05/Municipal-Demarcation-Board-Website-About.pdf
[7] See exhibit 2
[8] See exhibit 1
[9] The district had one of the lowest male to female ratio's in the province. See exhibit 2
[10] http://www.sanews.gov.za/south-africa/ex-mineworkers-receive-r59m-compensation. See also http://www.labour.gov.za/DOL/downloads/documents/useful-documents/occupational-health-and-safety/Useful%20Document%20-%20OHS%20-%20National%20Programme%20for%20the%20Elimination%20of%20Silicosis.pdf see also

was built as an "Academic Hospital"[11] following an injection of R100-million by the Former President of South Africa, Mr Nelson Mandela. As the first post-apartheid academic hospital,[12] the facility held pride of place for both the locals and its officials.

In addition to acting as a training centre for specialist medical professionals, the Central Hospital was established to provide inexpensive access to quality health services for residents of the OR Tambo District and those from the surrounding areas[13]. However, the acute shortage of local talent limited the extent to which locals could be employed in the hospital. In addition, those who had come to the area for training left after completing their studies.

Despite the hospital having been in existence for over 10 years, very few of the its graduates served in the district. As many had come to Bhisho, the town where the hospital is located, for their medical studies at the hospital left after completion of their studies, even the few who came from the district also left the relatively rural district to work in more urban centres of the country after completing their studies. Malabalaba was one of those who had left.

Given the shortage of skills in the area, the Eastern Cape Department of Health depended on talent from outside the district. Some of its staff members came from as far as Johannesburg which is about 900 kilometres away.[14]
As the day of the local elections was taking place the following Wednesday, most members of staff had left early that day and taken Monday and Tuesday off to go back to their homes and enjoy some time with their families before going to the polls on Wednesday. This gave Malabalaba the peace and quiet she needed to draft her documents for the Minister.
Engaging Stakeholders

Malabalaba had been excited when she was asked to take over from her predecessor who had decided to go into the private sector. Her excitement emanated from what she saw as an opportunity to return home to make a meaningful contribution to the communities where she was born. Like most graduates, she had been enticed by opportunities outside of the District and now felt that she had acquired enough experience to make a difference here.

After reading the report from her predecessor when she first took over, Malabalaba had made it her business to go to the communities to talk to the chiefs and community members about what she intended to do and also to assess for herself the problems encountered by her predecessor. She had been mildly amused by the report that the chiefs and villagers were xenophobic and preferred to speak their own language. She was amused because she believed that her predecessor was unaware that the language issue was not an act or preference but lack of choice. 98.4 percent of people spoke

[11] http://www.dispatchlive.co.za/news/2014/12/11/nelson-mandela-hospital-hits-milestone/
[12] http://www.unisa.ac.za/contents/colleges/docs/2004/tm2004/tm120804.pdf
[13] http://www.dispatchlive.co.za/news/nelson-mandela-hospital-hits-milestone/
[14] About 560 miles

IsiXhosa, the local language and only 0.6 percent English which is the second most spoken language in the district.[15]

She, however conceded that language could have been an impediment, particularly as most members of staff, including those involved in the Ward Based Outreach Teams (WBOT) came from outside of the district. WBOT are community-based teams comprised of a professional nurse, an environmental health officer, health promoters and a number of community health workers tasked with taking health services to communities.[16] It was because of the importance of these programmes that she had decided to personally engage with the local authorities in order to get their support and co-operation for the desperately needed preventative health care programmes.
She was particularly encouraged by the ease with which she and her team had completed the first phase of the piloting project. This entailed capturing the names of people onto the database, including those who lived in the villages where there were no street addresses. Her predecessor had not succeeded in getting that far citing lack of co-operation from the chiefs and community members. Her success had seen an increase in the regular reporting of births and deaths into the clinic's modest information management systems.

When she first met with the chiefs, some had suggested that she involve members of the community in her projects and as such contribute to job-creation in the region. She viewed this as an opportunity to improve capacity, as well as to ensure co-operation. From her budget, she bought three computers for each clinic to provide free computer training for those interested. The way she conceptualized and got buy-in from both clinic staff and the community was that all members of staff, at all levels, should first learn and then teach volunteers from the community who showed interest. From then on, graduates of the computer centres would provide training to other members of the community. This approach circumvented linguistic as well as other impediments and was a huge success. As part of the training, some former trainees assisted with data capturing leading to its success. They were paid for this function as it formed part of the core activities of the pilot project. It was on the filling of vacancies that she had encountered serious hurdles which had made it difficult to spend her budget for what it was intended.

As a consequence, she had not been able to strengthen the outreach services such as Family Health Teams and School Health Teams to ensure full district health care coverage by taking services to the people. Malabalaba had had difficulties recruiting clinical managers to the five local Municipal clinics. Two had left after the community made it difficult for them to stay as they were outsiders.

In addition to their governance structures of local chiefs, people residing at the OR Tambo Municipal District, like many in the Eastern Cape practiced local traditions and rites of passage for

[15] Eastern Cape Oliver Tambo District Profile. Sourced from www.health-e.org.za/wp-content/uploads/2013/06/Oliver-Tambo-District-Profile.pdf
[16] University of the Western Cape. Re-engineering Primary Health Care: Learning by doing to support equity and access. www.uwc.ac.za/Faculties/CHS/soph/Documents/Re-engineering Primary... · PDF

both young men and women entering adulthood. These rites of passage, conducted through what has been referred to as initiation schools, included the isolation of young men and women from their communities to be taught about traditions and their roles in society as adults. For the young men entering initiation, this included being circumcised which was perceived as a rite of passage into manhood. As such, an uncircumcised man was not considered "manly" in the area to the extent that such a man was accorded inferior status which further compounded the ability of uncircumcised men, even those professionally qualified, to engage effectively with men and community leaders in the area. One of the clinic managers had left following the refusal of his staff to be led by a man who had not gone through the initiation school even though he was from the area.

They demanded that the clinics hire local people and not outsiders. She smiled wryly at the absurdity of one of the demands. After a traineer ambulance driver from the area chose not to return home after being enticed by the lure of the big city, a local person arrived and presented the clinic officials with a newly acquired light motor vehicle driver's license for the job. As the individual did not have other medical qualifications, as demanded by law to drive an ambulance, he was not hired. Co-operation was lost from the community, accusing the clinic manager of denying opportunities for locals. They did not believe the argument that to be an ambulance driver, the applicant had to have further training which was dependent on the possession of a high school certificate.

While in general, the community perceived health professionals coming into the District as taking away jobs that they felt should go to their own people, there was no local talent to fill those jobs. Her predecessor had told her that only two of the ten nurses who completed their training last year stayed. From her discussion with those who stayed, Malabalaba learned that some joined government hospitals in the big cities of Cape Town, East London and Port Elizabeth and others joined private hospitals.

Since she took over, part of the 15% of the budget had been spent on training ambulance drivers and other paramedics to serve the clinics. The successful applicants were sent to Cape Town, Johannesburg and other centres for training but only a portion of them returned while others chose not to return to the rural villages after experiencing life in the country's urban centres. This compromised the ability to form Ward-based Outreach Teams. This was a serious constraint as high poverty levels and the dispersion of villages made it difficult for many patients to come to the medical centres for treatment.

The shared historical experiences, cultural traditions, remoteness from metropolitan centres as well as limited interactions with people from outside created insular communities fiercely protective of their traditions, culture and communities. The fact that most were monolingual with limited education further re-enforced their exclusivity.

Although the provision of quality health care to the most vulnerable was one of the main objectives of the Department of Health, Malabalaba was also concerned that her constraints prevented her

from getting needed resources and supplies to counteract the effects of botched circumcisions which was prevalent in this part of the country.[17]

Conflicting interests

However, the people of the OR Tambo District Municipality, and most likely the rest of the Eastern Cape, were very proud people steeped in traditional practices which defined them as a people. Accordingly, this made community members in these areas very insular with fierce protection of their interests and traditions from outsiders.

Many members of the close-knit communities in the District did not attend meetings called by Malabalaba's staff who were mostly health professionals from outside the Eastern Cape province. In cases where the health professionals visited homes, they encountered language problems as many of them did not speak IsiXhosa which was the local language. Most community members insisted on speaking IsiXhosa[18] which most of Malabalaba's staff members were not conversant in. While the language issue was a real communication impediment, the refusal to attend public meetings where an interpreter could bridge the language issue suggested disinterest.

One of the reasons for the community's attitude towards outsiders was their perception that some of the health professionals occupied jobs that could have been done by members of the community. Without the cooperation of the communities she serves, she would not be able to spend her budget. Part of the requirement of the NHI was to maintain and manage a centralized information management system, including the tracking of patients' progress,[19] through their national identification numbers to ensure that all medical records were accessible to all even in the case of someone moving elsewhere.

She shook her head slightly to get out of her reverie when she recalled that the Minister would not be interested in her problem but in the solution to the problem. She smiled nervously at the fact that without any good news to give to the Minister to deliver, her best alternative was to use the Minister to rally support from community members to support the rollout of the NHI. The problem here was how to interest the community into partnering with her.

NHI Piloting the Social Determinants of Health at OR Tambo District

The Minister was ostensibly coming to the District to officiate in the commemoration of the first patient admitted to the Nelson Mandela Central Hospital's Antenatal wing in 2003. This was a few months after the hospital's official opening by the then Minister of Health[20]. Instead of celebrating

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[17] Associated Press. July 4, 2014. Botched circumcisions becoming a health crisis in South Africa. Sourced from http://nypost.com/2014/06/04/botched-circumcisions-becoming-health-crisis-in-south-africa/

[18] IsiXhosa is a language spoken mostly in the Eastern Cape by Xhosa people

[19] Department of Health, Republic of South Africa (2011) National Health Insurance in South Africa Policy Paper. Sourced from www.gov.za/sites/www.gov.files/nationalhealthinsurance.pdf

[20] http://www.unisa.ac.za/contents/colleges/docs/2004/tm2004/tm120804.pdf

the official opening of the hospital, the current Minister had elected to celebrate the anniversary of the first patient to be admitted to the antenatal wing of the hospital.

As the Minister had made it clear that he wanted good news to share with the staff of the hospital and the community members who would attend the festivities, Malabalaba thought to herself that the Minister's real reason for coming to the District was to campaign for his party for the coming local elections.

The Nelson Mandela Central Hospital was partnering with the Department of Health in piloting the National Health Insurance (NHI) in the District. Malabalaba thought to herself that it must be co-incidental that the municipal elections would take place only two days after the Minister's visit. When she looked at her computer screen, Malabalaba was surprised to find that she had only managed to write three paragraphs in the forty minutes that she had been sitting there.

Malabalaba smiled nervously as she sub-headed the next section of her report, "the social determinants of health". The World Health Organization had termed "the conditions in which people are born, grow, work, live, and age" as the social determinants of health[21] as these shaped the conditions of daily life and the level of access to health.

Rolling out the NHI Pilot Programme

The District Manager shook her head sadly as she reflected on her challenges. She now understood those very well as she grew up in the area. She had, perhaps, naively thought that the place had evolved during her absence. She was fully aware that progress had to be made to get ambulance drivers and clinic managers for clinics whose managers had left. The clinics were central to the effectiveness of the WBOT. Their status had been primary impediments contributing to her lackluster performance as District Manager. Trying to get the cooperation of the community, though not directly contributing to the provision of quality health care for all, took most of her management time. Malabalaba mused wryly as she thought how she had to engage in politics just to be able to do her job. However, before she could solve her problems, she had to give the Minister what he wanted: good news to give to his audience or something that the Minister could say to facilitate community cooperation. Malabalaba knew that as the Minister also came from the area, he wielded considerable influence amongst the local chiefs and members of the community.

[21] www.who.int/social_determinants/en

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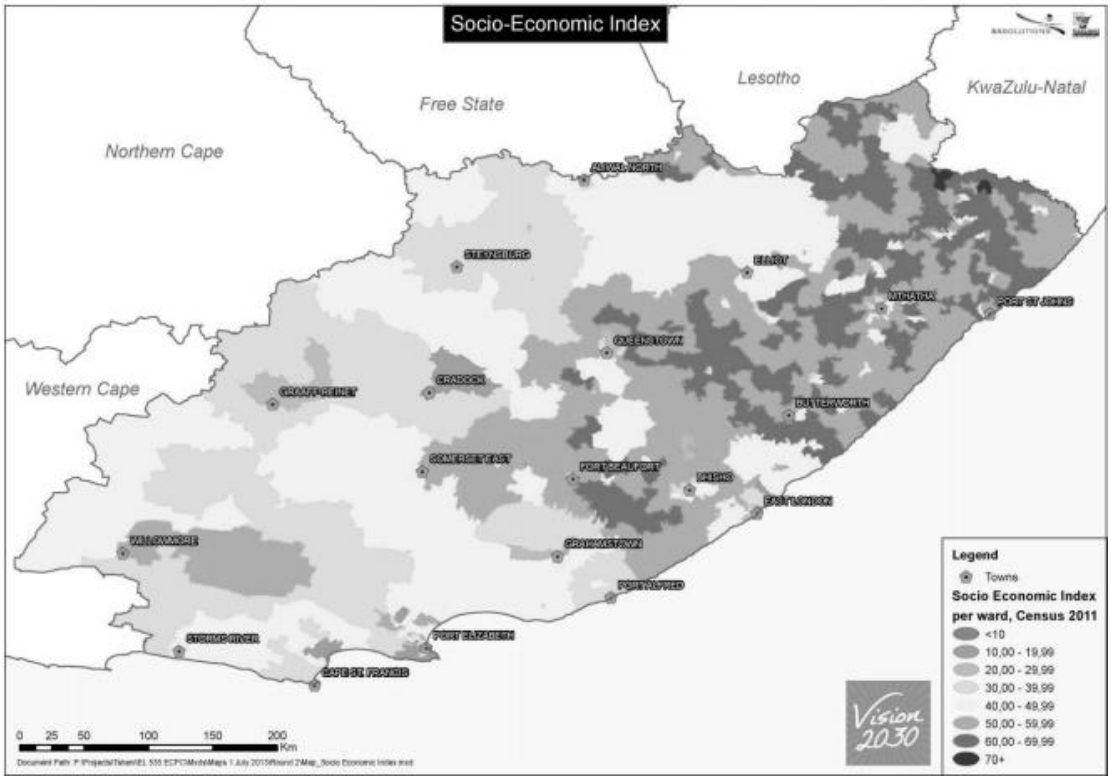
Exhibit 1: Socio Economic Index Map



This socio economic index map is based on the 2011 census data for education, income and unemployment and presents weighted scores on a scale of 0-100. A high score indicates higher levels of deprivation.[22]

[22] Province of the Eastern Cape Health Annual Performance Plan 2016/17 – 2018/19 sourced from http://www.echealth.gov.za/index.php/document-library/annual-performance-plans/send/7-annual-performance-plans/145-ecdoh-annual-performance-plan-2016-2017-to-2018-2019

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Exhibit 2: Socio economic profile of the Eastern Cape by district

District	Total	Percent Men	Households Below PR	Unemployment Rate	No Schooling	Med Aid Coverage
Alfred Nzo	846573	46%	34.8	31.1	14.8	3.5
Amathole	907312	47%	30.4	34	14.2	8.7
Buffalo City	789824	48%	27.9	21.1	5.3	14.7
Chris Hani	827658	48%	29.2	42.8	15	5.9
JoeGqabi	367368	47%	31.1	27.1	15.7	5
Nelson Mandela	1229504	48%	25.5	26.9	3.5	29.4
Or Tambo	1432523	47%	34.9	26.5	17.9	4.6
Sarah Baartman	480205	49%	21.7	21	8.2	14.6

Teaching Note

Pedagogic Objective

The primary goal of the case is to develop leadership skills in strategic stakeholder relationship in complex contexts.

Case Synopsis

The case illustrates the constraints faced by leaders in introducing transformative changes to societies and environments where institutional voids constrain the efficient introduction of such changes. The case explores the real life dilemmas in the piloting of the National Health Insurance (NHI) in the Eastern Cape District of South Africa by the Eastern Cape Department of Health's OR Tambo District. The OR Tambo District is one of the poorest areas of the Eastern Cape Province with important historical significance, as the birthplace of former President of the African National Congress, South Africa's ruling party after which the District is named, as well as the former President of South Africa, Mr Nelson Mandela. The district is also home to the first Academic hospital built after South Africa's historical inclusive national election of 1994 and is named after Nelson Mandela.

The case is set against the backdrop of both piloting the NHI and tackling the constraints of providing quality health care to communities whose circumstances make it difficult to access such care as identified by the World Health Organization's Social Determinants for Health.

Course Usage

The objective of the course is to develop relationship management as well as introducing real life issues of contextual intelligence in leadership for students. The case can be used in both undergraduate courses in the administration of health services and on management and leadership MBA courses as well as change management, relationship management, transformation, human resource management and sustainability courses.

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Case Objectives
The objectives of this case are to

1. Introduce students to real life relationship management issues
2. Elicit management decision-making processes where there are no clear right or wrong answers
3. Tease out issues of cultural boundary spanning in multi-cultural environments
4. Tease out issues of operating in environments characterized by institutional voids

Theoretical Basis of the Case
The theoretical basis of this case is Relationship Theory.

Assignment Questions
Faculty can use the following questions in class discussion or for exam questions.

1. Malabala's problem was her inability to spend an adequate amount of her budget given the constraint she faced from the communities' expectations. Using Relationship Theory, how could she overcome her problems?
2. By recruiting people from the community to train on computers, Malabalaba could have inadvertently created expectations that her return would result in the employment of local people. This was exemplified by a demand to employ an individual with only a motor car driver's license to drive an ambulance. Was this expectation unjustified and what should be Malabalaba's course of action?
3. The training of some community members on computers and the subsequent cooperation of community members to provide personal details for capturing on the database could be construed as some form of exchange between the community and the officials of the Eastern Cape Department of Health's OR Tambo District. If this exchange relationship was to continue, where would this lead to, according to Fournier?
4. Given the shortage of skills in the area and the reluctance of locals to return and work in the District, how could Malabalaba involve the community in resolving the situation and therefore ensure that the objectives of the NHI pilot project are met?
5. Since traditions play an important part in the lives of people in this area, can Malabalaba partner with traditional leaders to ensure that her objectives are better met? If so, how?
6. Although she had been relatively more effective than her predecessor, Malabalaba also seems to have approached the provision of health care in the area from the perspective of her profession.
    a. To what extent is this an asset and to what extent is it a liability?
    b. Given her understanding of the community as well as the health provision environment, how can she better utilize her insights in both worlds to solve her problems?
7. The Minister's visit can be seen as an opportunity for Malabalaba. Based on the case, prepare a speech/presentation for the Minister which, in addition to "Constraints" as a sub-title, should include, "Achievements", "Opportunities" and role for the community. While the speech should serve the political objectives of the Minister, it should also assist Malabalaba break through some of her constraints.

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8. In presenting the theory of relationship management, Ledingham (2003) says it is "effectively managing organizational-public relationships around common interests and shared goals, over time, results in mutual understanding and benefit for interacting organizations and publics" (p. 190). Using this as a basis, did Malabalaba's approach seek out "common interests and shared goals" in her interactions with the communities she was serving? Please discuss.

Analysis

1. Malabalaba's problem was her inability to spend an adequate amount of her budget given the constraint she faced from the communities' expectations. Using Relationship Theory, how could she overcome her problems?

   Part of the student reading for this question is Fournier's (1998) article, Consumers and Their Brands: Developing Relationship Theory in Consumer Research.[23] The article is based on Relationship Theory. Malabalaba's problem is essentially how to manage the relationship with the communities, some under the administration of local traditional chiefs.

   Given the insular nature of the communities, members of the communities "look after their own" and want jobs to go to members of the community rather than outsiders. This attitude had resulted in some staff members of the Eastern Cape Department of Health's OR Tambo District leaving the district due to the difficulties in executing their duties.

   Being originally from the area and fluent in the language, community members may have expected her to subscribe to their way of doing things. Her training of members of the community in computer skills, and securing the services of some of them as field workers, may have created expectations that the Eastern Cape Department of Health's OR Tambo District could accede to the demands. Given the power symmetries between the two parties, it is unlikely that without establishing a co-operative relationship with the local communities, progress would be made.

   In defining relationships, Fournier suggests that they are multiplex purposive process phenomena taking many forms that range across several dimensions to provide a range of possible benefits for their participants. Importantly, Fournier notes that they involve reciprocal exchange between active and interdependent partners involving at their core the provision of meanings to their partners. In addition Fournier suggests that relationships evolve and change over a series of interactions in response to fluctuations in the contextual environment.

   Therefore Malabalaba could overcome her problems by establishing a reciprocal relationship with the communities in the OR Tambo District. In essence, they should also contribute in the relationship which could evolve into change in order to enable her and her team to execute her responsibilities. I suggest giving some options as to **how** she can establish reciprocal relationships - what kinds of exchanges that she has not yet tried should she try?

[23] Fournier S. Consumers and Their Brands: Developing Relationship Theory in Consumer Research. Journal of Consumer Research.1998; 24:343-373. http://bear.warrington.ufl.edu/weitz/mar7786/Articles/fournier%20(1998).pdf

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2. By recruiting people from the community to train on computers, Malabalaba could have inadvertently created expectations that her return would result in the employment of local people. This was exemplified by a demand to employ an individual with only a motor car driver's license to drive an ambulance. Would this expectation be unjustified and what would be Malabalaba's course of action?

   The expectation that the Eastern Cape Department of Health's OR Tambo District should employ local people to fill-up vacancies is not unjustified. The fact that the piloting of the NHI was taking place in their region, given the high unemployment rates and other poverty indicators, locals were likely to expect that job opportunities would be created for this. The sentiment also seems to have been shared by the Eastern Cape Department of Health's OR Tambo District which actually recruited an individual to be trained as an ambulance driver. Unfortunately the individual did not return.

   As part of its mandate, the Eastern Cape Department of Health's OR Tambo District, was duty bound not only to contribute to the reduction of the social determinants of health which impacts on the communities' ability to access quality health care. Part of this was the high unemployment within a community with a large youth population.

   By providing computer training to local individuals and employing then as data capturers, Malabalaba had already, albeit inadvertently, circumvented the problem of non-returning skilled personnel. Instead of sending individuals outside for training, she could use her own staff members, who themselves have demonstrated a lack of long-term commitment to the area, to train locals who would then takeover from them. For other skills that her staff did not have, she could bring in outside trainers for short term periods.

   In addition to addressing the specific problem of job expectations, taking such a course of action could also be used in the transactional relationship building process with members of the community to ensure co-operation of the community in advancing her goals.

3. The training of some community members on computers and the subsequent cooperation of community members to provide personal details for capturing on the database could be construed as some form of exchange between the community and the officials of the Eastern Cape Department of Health's OR Tambo District. If this exchange relationship was to continue, where would this lead to, according to Fournier?

   The exchange between the Eastern Cape Department of Health's OR Tambo District in which some community members were trained on the use of computers and provided with employment and the reciprocity response of community members by co-operating with the provision of their personal details for capturing on the Health Department's OR Tambo District is some form of transactional exchange. Fournier suggests that relationships develop from a series of repeated exchanges between parties.

According to Fournier, these relationships evolve and fluctuate in the contextual environment. It is therefore plausible that if the exchange relationship between the Eastern Cape Department of Health's OR Tambo District and the local communities was to continue, there is a possibility that the relationship could evolve into a trusting symbiotic partnership.

4. Given the shortage of skills in the area and the reluctance of locals to return and work in the District, how could Malabalaba involve the community in resolving the situation and therefore ensure that the objectives of the NHI pilot project are met?

   Malabalaba herself came back to the District. Her return was, however, after she had progressed in her career outside before her return. While there is no one correct answer to this question, she could inquire from those who returned whether the failure of locals to return is due to lack of opportunities or something else. She could also provide incentives for locals to return. Another strategy could be to invite outsiders to come and train locals in their own environment rather than taking them away for training where they could easily be enticed by city life.

5. Given the fact that traditions play an important part in the lives of people in this area, can Malabalaba partner with traditional leaders to ensure that her objectives are better met? If so, how?

   The question is whether Malabalaba has established culturally sensitive areas which community members are reluctant to get outside involvement. One such area is with the initiation schools. In cases such as those, she could partner with relevant traditionalist who could partner with the District Health Department to reach areas where outsiders are not allowed. One partnership initiative would be to train such traditionalists in modern health practices or as facilitators. It is very difficult to train traditionalists in ways that gain their trust so this is a major activity.

6. Although she had been relatively more effective than her predecessor, Malabalaba also seems to have approached the provision of health care in the area from the perspective of her profession.
   a. To what extent is this an asset and to what extent is it a liability?
   b. Given her understanding of the community as well as the health provision environment, how can she better utilize her insights in both worlds to solve her problems?

   6a. Malabalaba's asset in this situation is her familiarity with the culture and the traditions of the place as well as her ability to speak the language. She however, seems to be dealing with the community as if she was an outsider. This may have influenced the response of the community to her. Had she, from the outset sought the community's input into how she could serve them may have produced a different outcome.

   6b. She could partner with community members and schools to get solutions from community members so that they could be part of the solution rather than passive recipients of health care services.

7. The Minister's visit can be seen as an opportunity for Malabalaba. Based on the case, prepare a speech/presentation for the Minister which, in addition to "Constraints" as a sub-title, should

include, “Achievements”, “Opportunities” and role for the community. While the speech should serve the political objectives of the Minister, it should also assist Malabalaba break through some of her constraints.

Malabalaba’s constraints includes her inability to fulfil vacancies.
Her achievements include managing to compile a database of community members
Her opportunities is to develop a different model for providing health which would include partnering with affected communities so that they could be active partners in the provision of health services.

8. In presenting the theory of relationship management, Ledingham (2003) says it is “effectively managing organizational–public relationships around common interests and shared goals, over time, results in mutual understanding and benefit for interacting organizations and publics” (p. 190). Using this as a basis, did Malabalaba’s approach seek out “common interests and shared goals” in her interactions with the communities she was serving? Please discuss.

   To some extent she did by getting community involvement in building databases. It however seems like she had focused more on her own objectives rather than on common interests and shared goals.

South African health decentralisation: requiring contextually intelligent leaders

Ellenore Meyer, Leena Thomas, Selma Smith and Caren Scheepers

Introduction

The day had started well enough, another glorious day in sunny Pretoria, South Africa. But for Ayanda Nkele, a newly appointed programme manager in the Egoli Health district, it had not been easy[1]. It had been a frustrating few months and he realised that he had to find a way to address his dilemma sooner rather than later.

Nkele had been appointed in the Egoli district to establish and monitor ward-based Public Health Care Outreach teams (WBOTs). He was a trained professional nurse with 5 years' experience working in primary health care (PHC). It had not been easy being a male nurse in a female dominated occupation, but he was young, passionate and ambitious. He hoped to move further up the management ladder with his new position. The Egoli health district was part of the provincial health department, with the district health manager reporting to the provincial health office. Nkele had been very excited to get his appointment letter a few months back. He had assumed that once in his post, he could start making a difference. He knew that first he had to recruit the human resources for his WBOTs, train them, provide equipment and then assign them to vulnerable communities in the district. However, at every turn, Nkele appeared to hit a road block.

When he attempted to advertise the posts of Community Health Workers (CHWs) in his district, he was told he had to wait for the provincial head office to do so. The province decided on the number of funded CHWs per district, and they had not yet finalised their planning in this regard. Nkele, being a proactive person, sent the province the numbers he felt were required in his district. He tried to understand the district ward populations and using this he was able to determine the number of WBOTs required and hence the number of CHWs. He felt the poorest wards had to be prioritised and was hoping to introduce WBOTs there first, before expanding further, but no one at the provincial office looked at his estimates.

Then, when he attempted to identify unemployed youth in the communities interested in being CHWs, the local ward councillors resisted. The ward councillors wanted to do the selection themselves. Intially Nkele had been excited about this, but the clinic manager burst his bubble. "Mr Nkele, the ward councillor just wants to employ his own relatives and friends! Don't let him bully you!" Oh, no. Nkele felt like giving up. He had heard about corruption and nepotism by local politicians, but he never thought to confront it himself. It was a sobering moment for him.

He also had an idea to use as many nurses already employed in the clinics as he could. These nurses would take health care to the communities, thus reducing the number of sick patients coming to clinics, in the medium to long term. Eventually, he felt there would be less need for as many clinic-based nurses. Nkele felt that clinic heads could not see these

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longer term benefits; instead, they were more concerned with how to deal with the increasing influx of clinic patients. Most of the clinics in the Egoli district were run by the local municipality; they did not report to Nkele's district health manager, so they refused to give him nurses for the WBOT programme. Nkele realised that he could not re-organise health service delivery in Egoli; he needed to consider who could. Meanwhile, Nkele had to think of a Plan B. He realised he also had to recruit new nurses. When he tried to recruit nurse team leaders, he was told, by the district human resource official, that posts had to be established first, and this could only be done once approved by the head of provincial health and provincial treasury. Nkele tried to be proactive and submitted some cost estimates of the number of nurses required and how these posts could be funded. However, he was told that because of financial mismanagement at the provincial health level; the provincial treasury had frozen the creation of new posts.

Nkele experienced similar challenges when he sought to purchase equipment for the teams and received feedback that there was no dedicated budget for his programme.

Njele felt despondent; he was a hard worker, capable, dedicated and honest. He was a reasonable planner too. He could not understand why what he planned for could not be executed. Situated in the district, he knew how many teams were needed, where the CHWs could be recruited from and how to optimise existing staff to support his programme. He could not imagine giving up. He knew that his career depended on him making the right choices and decisions and on managing these challenges. He had ideas on collaborating with non-governmental organisations, private health providers, local businesses and local nursing colleges to provide the required funding and resources. But could he get buy-in and support from his district manager for his new ideas? Without this support, he feared that he could not implement his WBOT programme.

Nkele realised that despite all his ideas and plans, and despite his appointment in the district, he did not have the authority to make necessary decisions required to implement his programme. He felt he could neither generate revenue nor allocate funds to his programme; he could not create posts for CHWs or nurses; he could not recruit new staff, nor could he decide on how health services could to be re-organised.

Nkele had heard the term "Decentralisation" before, and knew that it was about improving local accountability and governance, but he had not really given it much thought. Now he realised that he was in a situation where he needed to understand, very quickly, what it all meant, and if he could still effect change at a district level. He had to investigate whether "decentralisation" would be an enabler or a hindrance. He realised that he would need to understand his context better especially with regards to his decision-making ability and what he could control. He knew he had to find a way to get things done. Could a decision space mapping exercise assist him?

Background on health services in the South African context

South Africa is known as the rainbow nation of the globe. It is a multinational country with its heritage as colourful as its flag. The nation has 11 official languages and 13 constitutionally recognised people groups with many other nations that have joined this multicultural society (Rainbow Nation, 2016).

Health services in South Africa are currently offered by two co-existing sectors: the public health sector and the private health sector. Over the last decade, the National Government and Ministry of Health has expressed its intention to unify the services under a national health system with a health insurance model that would cover the majority of the population. This is the National Health Insurance (NHI) model currently being tested in South Africa (Matsoso and Fryatt, 2013).

Current status quo

Nkele decided to conduct a detailed decision space analysis. He wanted to determine the areas he had direct control over and those that he did not, but could potentially still influence. Nkele felt that if he did this before approaching his district manager, it would grant him adequate insight to create a business case for why the district manager's support was so crucial. He also felt he needed to understand how health services were being delivered in South Africa.

Organisation of services

Traditionally, South Africa has three levels of government, namely, a national government, provincial government and local government. South Africa is divided into nine provinces, with 52 districts. Each of these districts may have one or more municipalities as part of local government, and each district is further divided into a number of municipal wards (The Local Government Handbook, 2016). (See map of South Africa's 9 provinces in Exhibit 1).

The National Department of Health, through the office of the Minister of Health and the Minister, has overall responsibility for health care in the country, with a specific responsibility for the public sector. The public health sector reflects the same three-tier system as the rest of government: consisting of a national, provincial and district level. At the national level, the National Department of Health formulates national policy and legislation, strategically manages resources and assures that standards and norms set nationally are adhered to throughout the health sector. The National Department of Health also establishes national priority health programmes such as the HIV/AIDS, TB and maternal and child health programme (Health, 2016).

Provincial Health Departments implement national health policy and deliver health care in their province through central, tertiary, regional and district hospitals, emergency services and comprehensive PHC programmes. As such, provincial health departments provide and manage comprehensive health services, via a hospital- and district-based, public health care model (Health Care in South Africa, 2016).

Hospitals in the current system are either private or public. Private hospitals function independently and determine what services they would like to offer. This is a very costly service industry and the Minister of Health has scrutinised escalating private health costs and has introduced certain regulatory legislation to control hospital costs (SALGA, 2016).

Public hospitals (Tertiary and regional hospitals controlled by the provincial health departments and district hospitals controlled by the district health authority) can charge a nominal fee that is also pre-determined for services offered. The provincial government has delegated authority to hospitals over some operational issues, such as how the budget allocated by the provincial government is spent as well as appointment of human resources. (Creation of posts are controlled by provincial authority) (SALGA, 2016).

District health management structures are responsible for delivering health care, health promotion and disease prevention services for communicable and non-communicable diseases and maintenance of a healthy living environment (White Paper, 2016; McCoy and Engelbrecht, 2016). Each district is also supposed to manage their own budget and provide PHC services within the district. These services are mainly offered through district hospitals and primary care clinics, through district management structures. Public sector primary health care services are mandated by the National Government to be free to all citizens.

In spite of the available free services at least 17 per cent of the population has opted to take out private health insurance and up to 30 per cent of the population access private care provided by private health practitioners in independent practices (Health, 2016).

Municipalities, which form the third tier of government, are responsible for health-related services such as Environmental health services, Disaster management and Emergency Fire services in respective districts (Balfour, 2016). They are funded via various avenues such as property rates and service charges and have the authority to allocate spending as they see fit. Although health service delivery is the mandate of Provincial Health departments, prior to 2003, certain big municipalities were also responsible for primary health care services and emergency medical services in their area. (Municipalities received funding from provincial health departments to provide these services.) This is still the status quo although these services are slowly being provincialised into provincial health departments as per the National Health Act of 2003 (National Health Act, 2003).

Human resources

A national public service administration governs over one million civil servants in South Africa. These include officials at national and provincial health departments, who are appointed according to similar post structures and salary scales. Posts are created and people are appointed by the National Department of Health for the national structure, and by the provincial health departments and district health departments for hospitals and primary care clinics under their authority. Some authority has also been given to public hospitals enabling them to appoint certain categories of personnel according to standard public service regulations (DPSA, 2016).

Local government (Municipalities) on the other hand, do not fall under the national civil service, but have instead a national bargaining structure for municipal workers. Municipalities are autonomous institutions and as such appoint their own personnel according to municipal contracts and salary scales, with salaries and benefits often different from the other two spheres of government (SALGA, 2016; SALGBC, 2016).

The workings of the three spheres of government can be demonstrated in the re-engineering of PHC strategy (Naledi *et al.*, 2011) introduced in 2010 by the national government. The National Health Department determines policy, and in this context and for priority areas allocates funds to provinces through conditional grant funding.

CHWs are contracted directly by provincial health departments or through non-governmental organisations (NGOs) that volunteer health and social services. Certain municipalities also take responsibility for CHWs that are organised into WBOTs (National Department of Health, 2016). Although appointed by different employers, payment of CHWs ultimately is the responsibility of the provincial government, as all these employers receive funding from the provincial departments for these services. Co-ordination of services and linking of data between provincial, municipal health departments and NGOs still require further attention. Alignment of contracts and conditions of service, salaries and training required is also necessary, as the different requirements and reporting structures have led to labour disputes. In many health districts, there is a serious attempt to amalgamate these teams from various employers to prevent duplication of services.

The WBOT team leader manages up to 6-10 CHWs that are each assigned up to 250 households to visit and offer basic health and social services (Econex, 2013). The CHWs report on this data weekly to a nurse team leader. A monthly report is submitted to the health district. The content of what is reported on is determined by national reporting tools. The data that are reported on currently address certain maternal and child health priorities, but further attention needs to be given to what is being reported on and also how to respond locally to the content of the reports.

The highlight of Nkele's week became the weekly strategic meetings with the WBOT team leaders and CHWs. During these sessions, he was able to assist the teams to manage their individual cases and improve the lives of families on a case-by-case basis. For example, one of the CHWs, Elise Guelu, started assisting a patient with home-based care. This

patient was not able to take care of herself, Elsie and another CHW would visit daily to help the patient bathe; Elsie even went so far as to clean her patient's house weekly and started cooking for her. During these weekly visits they discovered the patient's son was addicted to "nyope" (a local mixture of rat poison and marijuana) and they were able to assist him with his addiction and referred him to an NGO in the neighbourhood that supported him through his rehabilitation.

Financing

The national budget is allocated to provincial level through the provincial and national treasuries. Ministry of Health has an oversight role on the health budget, especially for conditional grant funding. From provincial health departments, funds are allocated to district health authorities and through subsidies to municipalities. Municipalities also receive funds from the national equitable share (Table I) (The South African Treasury Department, 2016).

The local government equitable share (equitable interpreted to more or less mean "according to need") is given to municipalities for local development and basic service provision. Allocation of equitable share from the national budget is calculated on a needs-based formula. The amount a municipality gets depends mainly on the number of low-income people in the area – rural municipalities usually get more. Most municipalities only get a small part of their operating budget from the equitable share. Other sources of revenue include loans, government grants, contributions and private-public partnerships. Local municipalities also generate an income for their operational budget through property and other service rates, taxes and fines. In recent years, certain municipalities have not been able to co-ordinate and manage their finances and services leading to problems with service delivery in certain regions. At a municipal ward level, a ward councillor together with a ward committee is responsible for planning and deciding how a ward budget will be spent in accordance to local needs and plans. Community participation is encouraged by government, although in practice it is arguable how much this takes place.

Access rules

National government prioritised vulnerable populations and areas first through their reconstruction and development programmes. Local governments can however allocate resources towards the most deserving groups based on their locally identified needs. Citizens can attend any public primary health clinic for free (Department of Health, South Africa, 2000). It is preferred that they access the clinic nearest to their home or work. Access to public hospitals and specialists are via referral from clinics although this rule is not strictly or uniformly implemented.

Governance rules

Local accountability and community participation are principles within decentralisation that have been difficult to implement. It varies from community to community, and is dependent on local capacity for leadership and community empowerment. Governance for Health

Table I National treasury budget highlights 2014–health

District Health Services	R52.3 billion	10.9%
Provincial Health Services	R26.7 billion	5.5%
Central Hospital Services	R24.3 billion	3.5%
Other Health Services	R19.4 billion	11.6%
HIV/AIDS and TB	R15.3 billion	16.3%
Health Infrastructure	R7.7 billion	1.1%

Source: The South African Treasury Department, 2014

services, for the planned NHI has been legislated, such as the Office of Health Standards Compliance (SALGBC, 2016).

Hospital boards are appointed in most public sector hospitals, and again have varying degrees of participation in governance. Clinic committees are also central to improving governance in PHC clinics, but these have been extremely difficult to implement.

The South African health sector has made significant progress over the last 20 years in terms of establishing infrastructure and developing and legislating for a national strategy for health that addresses principles of universal access to care, reducing financial hardship in accessing care and offering quality health care that enables health. The implementation of this strategy at provincial and district level will determine the success thereof. To achieve this end local capacity, service coordination and grassroots leadership should be strengthened.

Recent developments

Re-engineering of primary health care

In 2010, the South African minister of health, Dr Aaron Motsoaledi implemented the re-engineering or revitalisation of PHC initiative with the intent to address some of the challenges currently faced by the health sector. This initiative orientates health care services towards proactive household- and community-focused interventions (General Household Survey, South Africa, 2015). The South African National Government had formulated an overall target of providing opportunity for "A long and healthy life for all South Africans". The Minister of Health as part of his performance agreement signed off on four main targets: increasing life expectancy; decreasing maternal and child mortality; reducing HIV infection and tuberculosis transmission and strengthening the effectiveness of the health system. The South African model for re-engineering PHC that was initiated as an outcome of this agreement was strongly influenced by a visit of the Minister to Brazil in 2010 to learn from their successes and failures. As an outcome to this, the National Health Council in November 2010 accepted a narrative document that redirected health services in South Africa towards a district health system approach with CHWs working in close relation with health professionals. The re-engineered PHC model that was adopted had three major streams of focus: ward-based PHC outreach teams, district clinical specialist teams and school health teams. The image in the exhibits (Exhibit 2) depicts the re-engineered PHC model (Barron, 2011).

The re-engineering of PHC and the proposed National Health Insurance are further elaborated on in the White Paper on NHI for South Africa published on 10 December 2015 (SALGBC, 2016).

Impact of the larger context on Nkele's situation

The larger context impacts Nkele's situation a great deal. In the past CHWs have not been paid on time. Currently not all provinces pay a similar salary for a CHW and this has been a major cause of strikes. Certain provinces require that a CHW has completed school to qualify for the position. This is not however consistent nationally. The training of CHWs has also not been standardised nationally. The national government together with external donor partners developed a 15-day training course on introductory health topics for CHWs. Access to the course has however been difficult and continuous professional development is up to the discretion of the district. CHWs are appointed on a year-to-year contract basis by districts. The authority to appoint or dismiss CHWs lies with the district and ultimately – the province.

Looking ahead

Nkele had investigated "Decentralisation" and realised that it offered him the opportunity to effect change at a district level. The important principle behind decentralisation was to promote and improve local decision-making and accountability through community participation and engagements. Increasing local control would of course improve efficacy, equity and quality as well as having an impact on making better financial choices and addressing local priorities. The question therefore was how much authority and responsibility should have remained at central or provincial levels and what could be delegated to the districts at the periphery.

Nkele considered the Harvard Professor Tom Bossert's framework for analysing decentralisation known as the Decision Space Approach. It mapped out functional areas where expanded choices could occur on areas such as finance, service organisation, human resources, access rules and governance rules. For each of these areas the range of choice for local control could be narrow, moderate or wide, depending on the type of decentralisation practiced.

Nkele intended to use this framework in writing his business case to speed up the execution of his establishment of his teams. He looked forward to his meeting with his district manager the next day to present his arguments, based on decentralisation principles.

Appendix on South African health landscape

Presently around 17 per cent of the population has private medical cover, and the remaining majority are dependent on the public health sector (General Household Survey – South Africa, 2015). Quality of care in the private sector is perceived as excellent and comparable to first world countries (Econex, 2013). The quality of care in the public health sector is often perceived to be very poor. However, both sectors have inefficiencies. Private sector health service problems include escalating prices, over-servicing, limited access and often lack of focus on preventative and primary health care services especially on the country's biggest health burdens: HIV and tuberculosis. Public health sector problems include poor quality care, high patient volumes, fragmented and hospi-centric health services, limited human resources, drug supply shortages and uncoordinated patient management between the various levels of care (Coovadia *et al.*, 2014).

Access to quality patient data is a problem in both sectors. This is either because there is no appropriate patient data system or because the data that exists is not shared. Private-public partnerships have been piloted in a few places with varying success. A national strategy on optimal utilisation and synergism of the three-tiered public system and between public and private health care is a priority within an NHI as is the re-engineering of PHC. It is hoped that decentralisation of health services may help achieve some of these objectives (McIntyre and Klugman, 2003; Van Rensburg and Pelser, 2004).

In 2013, the Office of Health Standards Compliance was established at national level. The Office of Health Standards Compliance is specifically tasked to monitor and enforce compliance by health establishments with the norms and standards for all levels of health care prescribed by the Minister in relation to the national health system (Office of Health Standards Compliance, 2016). Payment of private hospitals is through a third-party payment where a private health insurance settles the claim with the hospital or private health provider. If there is a shortfall (which is often the case), the onus lies with the patient to settle the account. Up to 30 per cent of the population will access private services from time to time paying out of pocket (Health, 2016).

With an unemployment rate between 25.5 and 35.5 per cent (depending on definition) and the proportion of 15-64-year-olds not economically active at 42.7 per cent, this translates to public sector health care expenses for approximately 80 per cent of the population (South Africa Data Portal, 2016). In 2014, the government allocated 11.8 per cent of its

budget (3.8 per cent of GDP) towards health (R145.7-148.9 billion). The 3.8 per cent of the GDP that is spent by the state on health care reflects spending on the public health sector. During this period, the private sector expenditure was R310 billion on health care. The White Paper on NHI states that "South Africa spent approximately 8.6 per cent of GDP on health services in 2013/14 (both public and private), with an annual average real increase in spending of 1 per cent a year over the past three years". The WHO recommends that a country spends at least 5 per cent of their GDP on health. The average for a middle income country is 3 per cent (World Health Organisation, 2003).

Only 16 per cent of the South African population can afford private health insurance with up to 30 per cent accessing private health services occasionally. The private health sector is run largely on commercial lines via private funding. Approximately 81 per cent of private health expenditure is funded by private medical insurance and the rest by out of pocket expenditure. Health expenditure in the private sector is comparable to expenditure of the public sector (52.1 per cent of total health expenditure vs. 47.9 per cent) (McIntyre and Klugman, 2003).

Currently South Africa has more than 110 registered medical schemes, with around 3-4 million principal members and 7-8 million beneficiaries. Private health insurance is unaffordable for most, increasing inequity in health status and health care delivery. These medical schemes are used by patients to access mostly private health services. These medical schemes often "run out" of patient benefits before the end of each year and patients end up spending thousands of rands to pay the shortfall out of pocket. Certain public hospitals have opened private-public wards where they offer competitive health services that are paid for in a manner similar to that of the private sector. This is often more affordable to those on certain types of private medical insurance (Shupingi and Kabaneii, 2016).

"Double dipping" also takes place where privately covered patients access the public sector and use the service that are offered free of charge. Under the current system, tracking this is very difficult with the onus being on the patient to disclose.

In recent years, the Government has also voiced its intent to implement an NHI attempting to address many of the issues mentioned above. The green paper for the NHI has been published already in 2011 and the White Paper was published for comments in December 2015 (SALGBC, 2016). Pilot sites have been started during 2010-2015, with one in each province funded through an NHI grant.

People who can afford private medical care, either as out of pocket expense or through medical aid schemes can consult any private primary care practitioner, general practitioner or primary care specialist, for example, paediatricians, of their choice. (Depending on the rules of their medical aid scheme and the coverage option plan they are subscribed for). If necessary they are referred to specialists by the general health practitioners.

White Paper on National Health Insurance for South Africa

The NHI White Paper describes structural problems in the current health sector, some of which are already highlighted above. Cost drivers in the public health sector are identified as: human resources and laboratory services as well as pharmaceuticals, blood and blood products, equipment and surgical consumables. In the private sector, the following cost drivers are listed: the fee for service model, imbalance in tariff negotiations between providers and funders, small fragmented risk pools in schemes with limited cross subsidy between young and old, sick and healthy and prescribed minimum benefits.

Problems with quality of health care services in both the public and private sectors also exist. The hospi-centric focus of the health care system, maldistribution and inadequate human resources of health further worsens the situation. The financing structure of both sectors is characterised by fragmentation and marginalisation of the poor.

The plan is to address the above problems by extending health service coverage to all South Africans and legal permanent residents irrespective of their socio-economic status where they will not be expected to make out of pocket payments. Services will be paid for through the NHI Fund. Pooling of funds for the NHI and health services will be publicly managed according to the White Paper. Taxation (direct, indirect and payroll taxation) and restructuring of medical scheme arrangements in response to the services covered by the NHI Fund will be the main revenue sources. The household and individual contributions will be calculated according to a progressive taxation model as determined by the Government. No mention is currently made on ability at local level to determine sources of revenue.

The introduction of the NHI will further require restructuring of intergovernmental functions and fiscal relations in the health sector. Changes in legislation will have to be made and this will impact on the National Health Act (South African National Government, 2003) and Municipal Act (South African National Government, 2000) amongt others. There is currently no clear answer about how much choice local authorities will have on allocation of resources.

Refugees and asylum seekers may have limited access to health services. South Africa has an estimated one million undocumented immigrants, although some reports speculate it may be up to five million people (Wilkinson, 2015) that may not be able to access health services except for emergency services and notifiable diseases. The South African Constitution continually distinguishes between the rights of citizens and the rights of everyone in the country. According to Chapter Two of the Constitution, the Bill of Rights, all people in South Africa have the right to access health services, including reproductive health services, basic food and shelter and social security. It also states that no one may be refused emergency care.

Access to the system will be through PHC providers and through registration in the NHI. The access will be through providers who serve a specific catchment population. Providers could be working in accredited teams or networks. Individual practitioners will have to be part of referral networks. Access to specialists or hospitals will be governed by a strict referral system.

A comprehensive package of health services will be provided and will have detailed treatment guidelines and an essential drug list which will be updated by the NHI Benefits Advisory Committee. Services available will be informed by changes in burden of disease, demographic profile of the population and the evidence on cost-effectiveness and efficacy of treatments and interventions. For services which are not covered, such as elective cosmetic surgery, costs must be covered in full by the patient either out of pocket or via a complementary medical scheme insurance.

It is reiterated that PHC including health promotion, disease prevention, curative services, rehabilitation and palliative services, will be the corner stone of the system. PHC re-engineering will continue with all the streams implemented: WBOTs (responsible for health promotion and disease prevention in vulnerable households), Integrated School health programme, District Clinical Specialist teams (currently supporting mother and child services) and a fourth stream, contracting non-specialist private health care practitioners through a capitation model instead of a fee for service model. A National Health Commission will advocate health promotion by ensuring multi-sectoral collaboration.

District Health Management Offices will be responsible and manage all district health and PHC services. (personal and non-personal services) It is planned to delegate greater management responsibilities from higher levels to district level. District hospitals may be made responsible for management of the hospital and PHC facilities linked to it, creating a contracting unit. Larger and more specialised hospitals will gradually become more autonomous. The level of autonomy will differ according to their level of service with central hospitals having full delegation and decision-making powers over finances, human resources and infrastructure. The authority of other hospitals will probably include

delegations of the management of human resources, finances and procurement. All facilities, clinics and hospitals will have clinic committees or boards to advice and advocate for the communities served.

The Office of Health Standards Compliance (DPSA, 2016) will enforce compliance with quality norms and standards. It is believed that the Ideal Clinic initiative, where set standards and norms of what an ideal clinic should offer and how it should function that was launched by the Government in 2014, will assist in greatly improving core quality standard compliance in the public sector. An Ombudsman will address patient complaints.

There are initiatives to improve access to medicines and to improve the costing structure of the National Health Laboratory Service.

Emergency Medical Services will provide a uniform level of quality care across both public and private sectors and use one central emergency number.

The NHI Fund will be established as a single payer-single purchaser fund responsible for the pooling of funds and purchasing of personal health services, eventually encompassing all current compensation funders of health care such as the Roads Accident Fund.

The NHI Commission will provide oversight to the NHI Fund and will be accountable to Parliament.

Payment of health care providers will be by a mix of mechanisms from a risk-adjusted capitation system to a capped case-based fee, depending on the level and type of provider. A National Health Information Repository and Data system will be established with linkages between NHI Fund membership database and contracted providers. The proposed Health Patient Registration System (HPRS) and Health Provider Registration System will be key components of the NHI Information System.

NHI funding will be mobilised through mandatory prepayment and individuals will not be permitted to opt out of making a financial contribution towards NHI. Utilisation of the coverage benefits under NHI is optional. The White Paper states that it would not allow insurance against the same health care cost or risk twice (both NHI and private). It proposes that all medical schemes will only offer complementary services that are not included in the health services benefits and medicines approved by the NHI Benefits Advisory Committee.

This transition will require changes to the existing Medical Schemes Act. Expertise existing in the medical scheme industry will be drawn upon where necessary to develop the NHI and build in-house capacity within the NHI. The debate on the moral and legal duty of Government to offer freedom of choice (and also the freedom to buy private health care if one can afford it) is not limited to South Africa (Schafer, 2016). The South African Constitution allows for freedom of association and arguably a choice also to access private care. How much Government can regulate this is will be a debate as the services and NHI plan unfolds. A similar court case on the limitation of optional private care has been filed in 2015 against the Canadian government (Schafer, 2016).

Keywords:
Organisational behaviour,
Human resource management,
Health and safety,
Public adminstration

Note

1. This case is meant to enrich and initiate a conversation on current health practices and future health planning in South Africa and other emerging markets. The end goal being to stimulate thought on how to achieve quality care, increase access and improve the health status of a nation by adjusting the control knobs of health systems in a sustainable fashion. Ayanda Nkele was a disguised character, based on a real programme manager's account of his work dilemmas.

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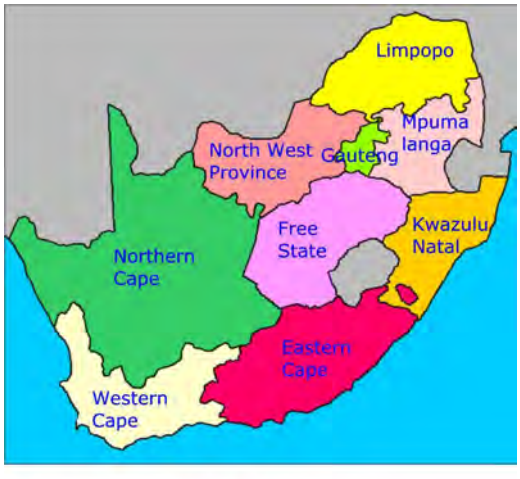
Exhibit 1

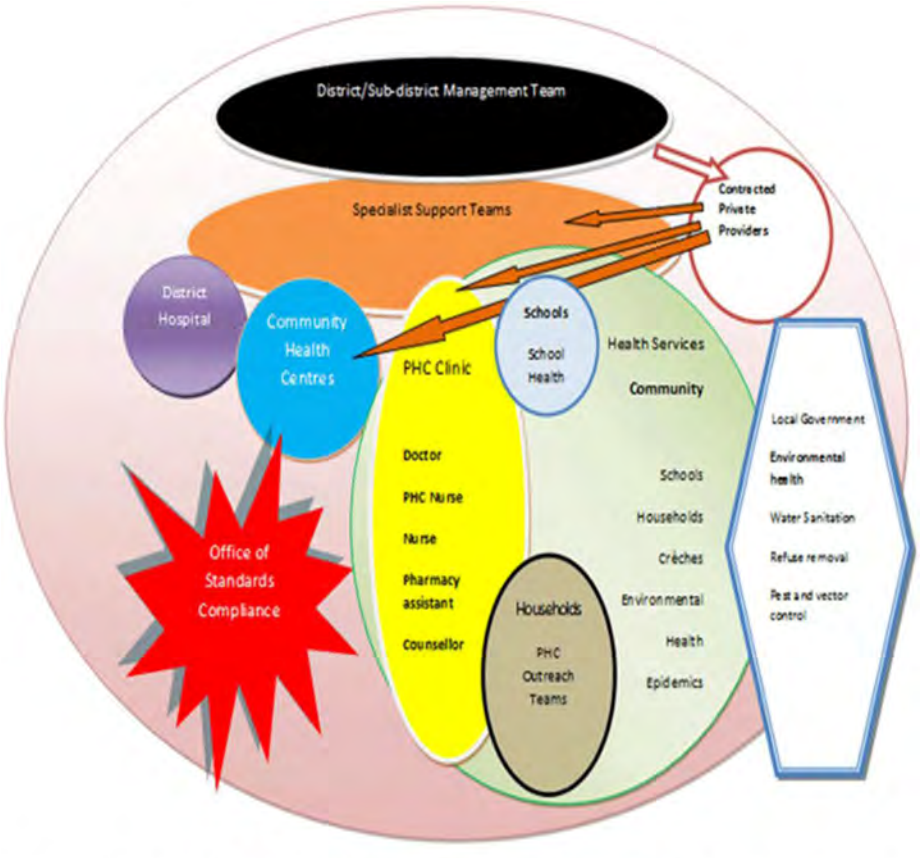
Figure E1 Map of South Africa's 9 provinces



Source: www.municipalities.co.za

Exhibit 2

Figure E2 Proposed public health centre model



Source: Barron P. 2011. Public health association of South Africa (PHASA); (Shupingi and Kabaneii, 2016)

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Teaching notes

Ellenore Meyer, Leena Thomas, Selma Smith and Caren Scheepers

Abstract

The case unpacks decentralisation as a means to promote and improve local decision-making and accountability through community participation and engagements. Ayanda Nkele was a programme manager in a health district in South Africa. He was faced with many challenges when trying to implement his programme, most of which were related to local authority, responsibilities and decision-making abilities at his level.

This case describes briefly the South African health system and how it functions. It describes the proposed changes to the health system and its transformation towards Universal Health Coverage. The decision space analysis as discussed in the case illustrates the types of decentralisation in the country and how this also applies to Nkele's level.

The teaching note will assist facilitators in understanding the South African context better, and also assist them to apply the decision space analysis in their own situation, especially in developing countries and emerging markets. Innovative leadership and management can be applied in situations with narrow decision space.

Even though the case is set in the health sector, the principles of decentralisation and decision space analysis can apply in other government structures in particularly emerging market environments. The learning for students includes the explaining of the concepts of the types of decentralisation and the decision space approach.

Research approach

This case is based on the observations of the authors within the South African health system. Ayanda Nkele is a disguised name, but based on a real character in a health district in South Africa. These are common challenges experienced by managers in developing countries.

These authors used their experiences to create the story of the case and conducted a number of focus groups during the last 5 years while lecturing on the ASELPH course; the Albertina Sisulu Executive Leadership Program for Health, which had been running over the last 5 years at the Universities of Pretoria and Fort Hare in collaboration with the Harvard School of Public Health. The researchers also interviewed a particular District Manager on his current lack of decision space and his difficulties, on which the case story had been created.

Learning outcomes

- Understanding the concepts and principles of decentralisation within the context of strengthening district health services, the re-engineering of PHC and rolling out a National Health Insurance in South Africa.
- Applying the "decision space" approach to analyse the extent of decentralisation.
- Grasping the requirement of leaders to be "contextually intelligent" and identify the important contextual variables to take into account when analysing public health care.

Discipline and level of course

- This case can be used at a postgraduate level for honours or master's programmes in courses on public health, executive leadership and management, organisational development and public administration leadership.

Class discussion and, or exam/assignment questions

Q1. What are the types of decentralisation? What type of decentralisation is evident in Nkele's situation?

Q2. Using the Decision Space Map Template, indicate the range of choice that currently is available to Nkele and then the changes proposed in the NHI White Paper.

Q3. Display competence as a "Contextually intelligent leader" by conducting an analysis of contextual variables to identify the current challenges faced within the SA decentralisation process.

Teaching plan and focus areas for the session

The three learning outcomes are formulated to assist the facilitator to focus on the main areas in the disciplines, namely understanding the purpose of decentralisation, types of decentralisation and how to apply the decision space analysis by being "contextually intelligent".

The first two assignment questions relate to the first two learning outcomes. The last one encourages critical thinking, in analysing contextual variables and reflection in the students. In some cases, lecturers could use the question as a class discussion topic to enable lively debate or as an assignment to consider after class and prior to the next lecture (Table II).

The table above is for quick reference to the reading material and discussions for each of the learning outcomes.

In the next section a Teaching Plan is provided.

Schedule for a 90-min lecture structure

Theory. Or the facilitator could conduct a prior lecture or discussion session on the concepts of decision space and on types of decentralisation.

The lecture could start with theoretical principles:

For each of the learning outcomes, there are specific theoretical principles to discuss. Slides could be used for this purpose to direct the learning points. (Around 30 min).

Practical application discussion

- Facilitators could then divide the class to enable small group discussions. The number of syndicates will depend on the size of the class. Groups of around 8-12 members are ideal for this purpose.

Table II Learning outcomes with questions, reading material and dilemmas for debate:

	Learning Outcome 1	*Learning Outcome 2*	*Learning Outcome 3*
Learning outcomes	Understanding the concepts and principles of decentralisation within the context of strengthening district health services, the re-engineering of primary health care and rolling out a National Health Insurance in South Africa	Applying the "decision space" approach to analyse the extent of decentralisation	Identifying relevant contextual variables within the decentralisation process of health care in South Africa
Topic	Decentralisation and types of decentralisation	Decision space analysis	Contextually intelligence for effective leadership
Assignment or exam question	What are the types of decentralisation? What type of decentralisation is evident in Nkele's situation?	Using the Decision Space Map Template, indicate the range of choice that the NHI White Paper proposes nationally	Display competence as a "Contextually intelligent leader" by conduct an analysis of contextual variables to identify the current challenges faced within the SA decentralisation process
Main prescribed readings	Bossert (2004)	Bossert (2004)	Kutz and Bamford-Wade (2013)
Dilemma to be debated	Nkele is appointed at a district level. He is unable to implement his programme. How do decentralisation and the type of decentralisation explain the dilemma faced by Nkele?	How much decision space is evident at the various levels of the health system, as outlined in the NHI White Paper. Students can interpret this at any level of the health system. The discussions/feedback will be richer that way	There are a number of ways to analyse an environment. In the case the following variables had been identified as relevant: socio-political; financial etc. The students could debate whether other variables could be more relevant, such as power dynamics and impact on environment as social issues

- Depending on the time limit for the class, each group may report back on their findings and they have to refer to examples from the case.
- In other situations, only one group could report per question discussed and then the other groups could just add what had not been mentioned by the group presenting. (Around 45 min)

Integrate with relevant theory: The facilitators could refer to relevant literature in closing of the session. (Around 15 min)

The authors would recommend the following tips to the lecturer or facilitators

- Facilitators have to ensure that the students conducted the pre-reading to contribute to the discussion.
- If e-learning is being used, the report back could be via discussion boards on Blackboard Learning or other e-learning platforms.
- If report back was captured via the e-learning platform, it enhances this session.

Model answers to assignment or exam questions. The next sections offer the actual answers that students might come up with and could be used to ascertain what the best answer would look like. Facilitators could gain the model answers in this section to mark the students' exam question answers or direct their conversations in class.

Q1. What are the types of decentralisation as identified by Bossert (2004) that Nkele had to contend with?

Bossert (2004) identified the following four types of decentralisation:

1. De-concentration: power shift from central to peripheral offices of the same administrative office; often the Ministry of Health.
2. Delegation: authority shift to semi-autonomous agencies such as an independent regulatory commission.
3. Devolution: a responsibility shift from the central office to local authorities, but separate administrative offices including local government of provinces and municipalities.
4. Privatisation: where there is a transfer of responsibility (and in some cases ownership) to private entities.

What type of decentralisation is evident in Nkele's situation?

In Nkele's situation, the type of decentralisation is de-concentration, (Bossert, 2004) as the Egoli district is part of the provincial health structure, where there is a shift of some power from central to periphery (district) level. In Nkele's environment, the devolution of responsibilities also took place, but unfortunately these processes had not posed to be effective and as a result he was struggling to get his work off the ground.

Galbraith (2008, p. 326) contends that lists like the one below are still used today in deciding whether to place decisions in the field or at headquarters, for instance Galbraith (2008) emphasises that the decentralised model would offer an organisation the opportunity to take decisions based on local differences or facts. In the case study, Nkele had intimate knowledge of what type of services and levels of health services had been required in his district. His local insight would have awarded him the change to customise the service to the local needs. In the table below, these advantages are listed, as formulated by Galbraith (2008) (Table III):

Q2. Using the Decision Space Map Template, indicate the range of choice that the NHI White Paper proposes nationally

In the case study, Nkele had limited decision-making power because of his limited range of choice. The students could be given a template with for example, a list of functions as the first column, such as finance, service organisation, human resources etc. The next column is the range of choice, which could range from narrow to wide, with moderate in the middle.

After the lecturer had explained the NHI and students had studied the relevant documents to gain better insight and understanding of the policy, the following exercise could be offered as practical application.

Table III Advantages of centralised and decentralised decisions

No.	*Centralised*	*Decentralised*
1	Based on company best practice and knowledge	Based on local differences or facts
2	Consistent across field units	Fast and immediate
3	Eliminates duplication	Attracts local talent
4	Coordinates interdependence	Allows independence and autonomy
5	Made by the most competent, experienced people	Made quickly on the spot

Source: Galbraith (2008)

The instruction: "Given your insight into the NHI, populate the template on the range of choice of specific functions".

*The range of choice here is one of interpretation. What is more important is not what is chosen, but the learner being able to defend his position (Table IV).

Explanation of the decision space map answers, according to functions

Finance

1. Sources of revenue:

Choices about where the sources come from: For example, are the local authorities allowed to assign their own source of revenue to health?

Answer: Narrow

2. Sources of revenue will be mainly through changes in taxation and pooling of funds for the NHI and health services will be publicly managed according to the White Paper. The household and individual contributions will be calculated according to progressive taxation model as determined by Government. No mention is currently made on local level ability to determine sources of revenue.

Table IV

Functions	*Range of Choice* *Narrow*	*Moderate*	*Wide*
Finance			
Sources of revenue	X		
Allocation of expenditures	X		
Income from fees and contracts	X		
Service organisation			
Required programmes/norms	X		
Hospital autonomy		X	
Insurance plans	X		
Payment mechanisms	X		
Contracts with private providers			
Human resources			
Salaries	X		
Contract staff	X		
Civil service	X		
Access rules			
Target populations	X		
Governance rules			
Local accountability		X	
Facility boards		X	
Health offices		X	
Community participation		X	

3. Allocation of expenditure

Choices about how to allocate funds: For example, are the local authorities allowed to assign funds to different priority programmes. For example, Hospitals versus Primary care?

Answer: Narrow-moderate

The introduction of NHI will further require restructuring of intergovernmental functions and fiscal relations in the health sector. Changes in legislation will have to be made and this will impact on the the National Health Act and Municipal act among others. There is currently no clear answer about how much choice local authorities will have about allocation of resources.

4. Income from fees and contracts

Choices about local charges: For example, are local authorities allowed to set fees at all, and if so are they allowed to determine the levels and change them?

Answer: Narrow

Fees will be done through a capitation model and will be nationally determined according to the White Paper.

Service organisation

1. Required programmes and norms

To what degree does the central authority define what programmes and services the local health facilities have to provide?

Answer: Narrow-moderate

2. Hospital autonomy

Can local authorities grant hospitals autonomy and select the degree of autonomy allowed?

Answer: Moderate

3. Insurance plans

Can local authorities create, manage and regulate local health insurance plans?

Answer: Narrow-moderate

4. Payment mechanisms

Can local authorities select different means of paying private institutional providers? For instance per capita, fee for service, disease related groupings or per admission?

Answer: Narrow

5. Contracts with private providers

Are local authorities allowed to "contract out" services (clinical or other, e.g. cleaning)?

Answer: Moderate

Human resources. Answer: All narrow

1. Salaries

Are local authorities allowed to set different salary levels? Are they allowed to determine bonuses?

2. Contract staff

Are local authorities allowed to contract short-term personnel and set contract terms and compensation levels? Are the contracts fixed by national authorities or can local authorities negotiate their own contracts?

3. Civil service

Are local authorities allowed to hire and fire the permanent staff without higher approvals? Are civil service rules uniform throughout the nation or do state or municipal civil service rules vary? Can staff be promoted, demoted or transferred by local authorities without higher approval?

Access rules

1. Target populations

Do local authorities decide who has access to facilities and who is covered by insurance? Are these rules determined by constitutional or national laws or is variation allowed to the local offices?

The NHI White Paper stipulates clearly that national policy will determine that only NHI registered people will be covered. This will include asylum seekers and those with refugee status. Illegal immigrants and other people will have to obtain private coverage and/or pay out of pocket.

Answer: Narrow

Governance rules. Are local authorities accountable through local elections? Do local authorities have choices about the size and composition of hospital boards or local health offices and of community participation?

Answer: Moderate

Q3. Conduct an analysis of contextual variables to identify the current challenges faced within the SA decentralisation process

The lecturer could offer an explanation of contextual intelligence prior to answering the question in detail by referring to the following summary of relevant conceptual principles:

Contextual intelligence is essential for today's public health leaders. Gaining contextual intelligence involves conducting systematic analysis of important and relevant contextual variables. Understanding context is crucial for effective leadership (Nye, 2011). Kellerman (2013) argues that this is a moment in human history where contextual intelligence in its broadest sense is of paramount importance. Intelligence is seen by traditional researchers, such as Spearman (1904) and later on by Sternberg (1996) as something that grows in an individual as a result of experience and learning, an accumulation and recall of external stimuli or what accumulates from experience and knowledge, internal awareness and coding that is often interpreted differently by each individual involved.

Mayo and Nohria (2005) define contextual leadership intelligence as the ability of the leader to understand an evolving environment and to capitalise on trends, aligning resources with objectives, and moving with the flow of events to implement a strategy. They argue that there exists a connection between organisation's performance and the context understood by the leader. Trends are constantly emerging within the economic, political, ecological and social environment that are giving rise to contextual conditions that will have varying impact on organisation. These revolutionary changes challenge leadership to become more contextually intelligent.

In the case study, it was required of Nkele to be contextually intelligent. He had to diagnose his context accurately. To diagnose context requires of leaders a keen awareness of their surroundings. In the case on decentralisation, context is a web-like pattern of relationships, which refers to Kutz's (2008, 2011) definition as the nature of interactions and interdependencies among and between people, political alliances, organisations and social contexts (Kutz and Bamford-Wade, 2013. Contextual intelligence assists in understanding the impact of culture, power distribution, flow of information and follower's needs and demands, on the organisation (Kutz, 2008).

In the case study .the following contextual variables had been identified that had been important to Nkele as a contextually intelligent leader:

Socio-Political

The rollout of universal coverage should be in-line with international human rights principles and should account for the local resources, needs and current health status of the population. Policy and new health legislation should be in accordance with the South African Constitution; Bill of Rights. The White Paper currently proposes a change in certain legislation, for example, the Medical Schemes Act. Government can and should make new health priorities and plans that honour the values of the Constitution. Practical description and implementation thereof should be done with expert and public opinion.

Financial

South Africa has many areas that still need further development of which one is health care. The Government has to budget responsibly and decide how much of the GDP should be assigned towards health and health services and what should be spent on social, educational and other areas. Establishment of an NHI fund requires that funds be allocated to achieve this. Decisions on how the money should be pooled and from where the resource should come (and how much), for example, taxation requires meticulous planning and calculations. The private industry has a history of expensive cost drivers, whereas the public sector has been accused of wasting of resources. Capacity to manage the finances and other resources is of importance for the NHI to be successful. Limited funds and budgeting for health and social services on municipal and higher levels and deciding on which should receive greater priority influence the care from area to area with some facilities offering better services than others. Lack of quality health data on disease profile, the cost of average patients, number of visits per patient per facility and control of chronic diseases all influence the ability to plan/budget on facility and district level. Strategy and capacity on national and local level on how to set up fund management and the balance between delegation and devolution of funds (local government vs. municipal government) impact on health services. Integration of private and public on all levels and innovative contracting and income generation are areas that need due attention.

Service Organisation

Required programmes/norms under the NHI include a PHC package. According to the White Paper, Emergency Medical Services will provide a uniform level of quality care across both public and private sectors and use one central emergency number. PHC re-engineering will continue with the four streams implemented: WBOTs (responsible for health promotion and disease prevention of specific households), Integrated School health programme, District Clinical Specialist teams (currently supporting mother and child services) and contracting non-specialist private health care practitioners through a capitation model instead a fee for service model private care currently uses. The National Health Commission will support disease prevention by ensuring multi-sectoral collaboration. Integration of a very successful public sector that serves a small portion of the population with a public sector that is overcrowded and under-resourced will be one of the challenges faces with the re-organisation of services.

Hospital autonomy

District Health Management Offices will be responsible and manage all district health and PHC services. (Personal and non-personal services) It is planned to delegate greater management responsibilities from higher levels to district level. District hospitals may be made responsible for management of the hospital and PHC facilities linked to it, creating a contracting unit. Larger and more specialised hospitals will gradually become more autonomic. The level of autonomy will differ according to their level of service with central hospitals having full delegation and decision making powers over finances, human resources and infrastructure. The authority of other hospitals will probably include delegations of the management of human resources, finances and procurement. All facilities, clinics and hospitals will have clinic committees or boards to advise and advocate for the communities the institution serves.

The devolved and deconcentrated plans set out in the White Paper could improve local ability to respond to needs, manage performance and act accordingly. The risks when increasing local authority is that there might be some areas with less capacity and poorer care as an outcome to that and also the risk of local pressures to meet a select group's needs. This should however not stop Government to increase local authority, but a definite plan to develop local capacity should be in place.

Insurance plans

The White Paper allows for private health insurance as a supplementation to the coverage under NHI. It currently proposes that someone may not be insured against the same risk/disease under both the NHI and another health insurance. The question is whether an individual has the right to buy extra private health care (in its broadest entity) despite the public services and health coverage offered to him/her.

Payment mechanisms

The NHI Fund will be established as a single payer-single purchaser fund responsible for the pooling of funds and purchasing of personal health services, eventually encompassing all current compensation funders of healthcare such as the Roads Accident Fund. The NHI Commission will provide oversight to the NHI Fund and will be accountable to Parliament.

Payment of health care providers will be by a mix of mechanisms from a risk adjusted capitation system to a capped case based fee, depending on the level and type of provider. The challenge will be to get private health practitioners that currently work on a fee for service basis to buy into the proposed payment model.

Contracts with private providers

The White Paper proposes that contracts with private non-specialist providers be done on a capitation model, rather than fee for service. Private health professionals from different specialities will be able to form group practices. The payment on capitation base and how this will be negotiated with providers can be a challenge in a health environment that is already under resourced in terms of health professionals available to offer services (both public and private).

Human resources

It appears that salaries will not be determined by local authorities, but centrally under the proposed NHI. A challenge will be to retain competent staff who have worked on a capitation fee in the private sector. The country has over the past two decades seen a major brain drain and further legislation that impacts on a free market system could further contribute to this.

Contracts and civil service on local level, especially with regards to the functioning of hospitals will be allowed. This authority could improve local effectiveness. Capacity and ensuring good quality care and not allowing corruption are challenges that should be addressed.

Access rules

The Constitution does not distinguish between the right of the foreigner, refugee or citizen when it comes to the right to access health care. Section 27 of the Constitution of South Africa states:

Everyone has the right to have access to:

- health care services, including reproductive health care;
- sufficient food and water; and
- social security, including, if they are unable to support themselves and their dependents, appropriate social assistance.

The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.

No one may be refused emergency medical treatment.

Currently the White Paper only wants to fulfil the last part of Section 27, where no citizen may be refused emergency medical treatment.

Governance rules

Local authorities will have a choice on hospital boards and the White Paper also proposed community representation as key. Implementation and realisation of this policy to have the locals empowered and represented could be a challenge.

Extra resources

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Abstract

Title – *South African health decentralisation: requiring contextually intelligent leaders.*

Subject area – *Public Health; Leadership; Organisational Development; Organisational Behaviour; Public Administration Management.*

Study level/applicability – *Postgraduate level for honours or masters programmes in courses on public health; executive leadership and management programmes; MBA level.*

Case overview – *The case unpacks decentralisation as a means to promote and improve local decision-making and accountability through community participation and engagements. Ayanda Nkele was a programme manager in a health district in South Africa. He was faced with many challenges when trying to implement his programme, most of which were related to local authority, responsibilities and decision-making abilities at his level. This case describes briefly the South African health system. and how it functions. It describes the proposed changes to the health system and its transformation towards Universal Health Coverage. The decision space analysis as discussed in the case illustrates the types of decentralisation in the country and how this also applies to Nkele's level.*

Expected learning outcomes – *Understanding the concepts and principles of decentralisation within the context of strengthening district health services, the re-engineering of primary health care (PHC) and rolling out a National Health Insurance in South Africa. Applying the "decision space" approach to analyse the extent of decentralisation. Grasping the requirement of leaders to be "contextually intelligent" and identify the important contextual variables to take into account when analysing public health care.*

Supplementary materials – *Teaching Notes are available for educators only. Please contact your library to gain login details or email support@emeraldinsight.com to request teaching notes.*

Subject code – *CSS 7: Management Science.*

Appendix 6: Ward Based Primary Health Care Outreach Teams Policy Brief

Albertina Sisulu
Executive Leadership
Programme in Health
Excellence, Innovation, Transformation

A health policy brief on the Implementation of Ward based Primary Healthcare Outreach Teams (WBPHCOT) in South Africa based on Policy Round Tables hosted by ASELPH for the NDOH

Introduction

Policy development is an opportunity for collective engagement on key national priorities such as Primary Health Care re-engineering and must reflect the principles of integration, standardization and collaboration across the country. However, translating policy into action or implementation is not an easy process. A policy implementation plan could elaborate on the processes and structures required for effective implementation. Three round table seminars were held to discuss the Ward Based Primary Health Care Outreach Teams (WBPHCOT) policy implementation plan and address implementation barriers. This health policy brief highlights important considerations for the WBPHCOT policy implementation in South Africa arising from the round table discussions. These included factors such as roles and management of teams, support structures, recruitment, training, and monitoring and evaluation amongst others.

The context

One of the legacies of the apartheid health system and the then international trend towards a more bio-medical model of health care is that democratic South Africa inherited a curative-focused health service. In addition, although South Africa commits significant resources to health service delivery, the country's health outcomes remain a major challenge. While much has been done since 1994 to strengthen Primary Health Care (PHC) and integrate health services, it has become increasingly apparent that the current curative focused health system is not sustainable.[1] Since 1994, the ruling African National Congress has widely affirmed that health promotion, disease prevention and appropriate treatment through a Primary Health Care approach would be the cornerstone of the South African health system.[2,3] Health system reforms towards re-engineering the PHC-based system have been gaining momentum in the last few years.

Most health-related conditions in Africa and the developing world have a socio-economic context and association. To tackle these social, economic and environmental determinants of health to achieve better health outcomes, inter-sectoral and inter-governmental collaboration is required.[4] It is within this context that South Africa joins the global community in striving towards the attainment of the Sustainable Development Goals (SDGs).

A partnership of
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Transforming the existing health system in South Africa is imperative to enable the achievement of universal health coverage, using the National Health Insurance (NHI) scheme as a means to achieve this.[5] The 2015 and 2017 versions of the White Paper on National Health Insurance for South Africa outlines and distils key strategies and interventions to transform the health system.[6] The Primary Health Care re-engineering strategy is one such strategy and includes the establishment of Ward based Primary Health Care Outreach Teams (WBPHCOTs).[7] Community based health services, designed around the WBPHCOTs and based on Community Health Workers (CHW) led by Nurse Outreach Team Leaders (OTL), prioritises health promotion and disease prevention in households and communities.

Community health worker programmes and community-based health services have gained recognition as vital components in the provision of health and social services, especially in low- to middle-income countries (LMICs) such as Brazil.[8] International experience and evidence from CHW programmes indicate that this cadre can contribute to improving access to health and social services in low and middle-income countries and thereby positively influence health outcomes.[9] WBPHCOTs were introduced into the South African health system in 2010 before a clear national policy on this was developed. This policy vacuum led to various models of practice and implementation across the country. Although this resulted in a number of challenges, the lessons learnt provided important considerations during the broader national consultation on the development of the WBPHCOT policy framework.

The WBPHCOT policy development process went through three years of wide-ranging stakeholder consultations. The National Health Council (NHC) eventually approved a policy framework and strategy in 2017.[10] The WBPHCOT approach and model of care expects to integrate CHWs into the health system within the prescripts and legislative framework of the National Health Act of 2003 and other related legislation. It is anticipated that the policy framework will enable the formalization of WBPHCOTs within the health system and empower CHWs to bridge the gap between communities and the health services. The policy framework seeks to ensure a standardized implementation and management approach across the country but be flexible enough to accommodate local contextual variances. The WBPHCOT policy framework has four broad policy objectives: the efficient management of teams within the health system, improving human resource recruitment and selection, standardizing scope of work and training; and developing an appropriate monitoring and evaluation framework. This would strengthen appropriate WBPHCOT management, supervision and support structures within districts. The policy framework states that CHWs should prioritize poorest communities; have a scope of practice aligned to national health concerns; and have a minimum skills requirement. The framework further articulates the role of national, provincial and district levels of government.

While the framework provides a structure for the WBPHCOT programme, there is a gap in the details required to implement the policy objectives. Therefore, the National Department of Health

(NDoH), cognisant of the need to ensure effective implementation of the approved policy framework, decided to collaborate with the Albertina Sisulu Executive Leadership Program for Health (ASELPH) and host a series of three round table seminars and discussions on WBPHCOT implementation. The *content* and *modality* of the four policy framework objectives required intense deliberation and consultation. The country needed to draw on international and local experience as well as best practices, which responded to its unique health system, legislative and regulatory contexts.

The round table discussions were held within the following context:

- A WBPHCOT policy framework was developed and approved; therefore, deliberations of the round tables were to focus on implementation issues.
- CHWs to be integrated into the health system as part of a re-engineered system aligned to the country's vision of Universal Health Coverage through the National Health Insurance (NHI) scheme and the National Development Plan (NDP).
- Standardisation and consistency in the implementation of the programme is necessary at national level, with sufficient ability for flexibility to take into consideration local contexts. The design of the programme must be based on provincial and district contextual factors (geographic, socio-cultural, socio-economic, epidemiological and demographic).
- A phased approach to implementation must be undertaken, taking into consideration available resources and the national fiscal framework.
- Partnerships with other stakeholders should form an important part of the implementation plan. Harmonisation with and integration of NGOs, donors and stakeholders from other sectors are important for the programme's functionality and success. These partnerships are important in addressing the differences in implementation that exist across provinces among various partners.

Perspectives on implementation emanating from the round tables

Round table seminars were held in March, August and December of 2017, with each seminar attempting to build on the deliberations of previous seminars. The participants included role-players and stakeholders from government, academia, funders, technical agencies, the NGO sector and community health workers themselves.

All three round tables focused on the development of a national implementation plan for WBPHCOT, deliberating on the implementation implications of the four main policy framework objectives. The first round table seminar discussed possible barriers to WBPHCOT policy framework implementation, the second explored additional gaps, and the third explored CHW training content, training approaches and its standardization nationally. The richness in terms of the content of the deliberations is captured in the full reports of these seminars.[11,12,13] This policy implementation brief seeks to summarise the most pertinent considerations from the three sessions.

Considerations for effective policy implementation

Management, referral systems and placement

The WBPHCOT policy framework refers to standardizing the management of WBPHCOTs across provinces. The round table deliberations focused on where to locate the management of WBPHCOTs within health services. It was agreed that WBPHCOTs were to be managed within the broader context of Primary Health Care, with a dedicated management structure for community-based services, at national, provincial and district level. Political support and buy-in through national and provincial structures was essential.

At a facility level, WBPHCOTs would report directly to the Facility Manager, with the nurse OTL being part of the clinic staff. There also needed to be mechanisms of reporting or feedback to the local ward councillor, in order to encourage greater community involvement. At a sub-district level, teams would report to the PHC manager, who in turn reports to the District manager.

Ideally, every household in South Africa should have access to a CHW; but practically this is not possible within current resource constraints. Identifying and prioritizing poorest areas and vulnerable households with a high disease burden would focus the efforts of CHWs and the WBPHCOT program in the short to medium term. A poverty index and other developmental indicators could be used to identify vulnerable communities and determine numbers and placement of CHWs. The round table discussions agreed that Provinces, together with their districts, would be responsible for determining the numbers of CHWs needed and the effective placement and distribution of CHWs in identified geographical areas.

The WBPHCOTs function within a broader health system; an effective referral system supporting upward referral by CHWs and downward referral to the CHW is thus essential for an effective and integrated health system. There is a need to strengthen the patient referral system upward from community to PHC levels and downward from PHC levels to community services to ensure that the community experience seamless movement through the entire health system. Health services have to ensure CHWs are supported and given feedback on their referrals. The role of community structures such as ‘war rooms’ where community challenges are discussed could be opportune platforms for WBPHCOT engagement and feedback and have to be strengthened. The referral challenges as well as the role of the community and other stakeholders in responding to the socio-economic determinants of health, have to be considered comprehensively during implementation.

Conditions of service, career paths and retention

The round tables agreed that the formalization of CHWs within the health system is an imperative. The national WBPHCOT policy framework acknowledged the challenge with the current status of CHWs in the country, where they are neither workers nor volunteers. Participants in the round tables agreed CHWs should have job security within a regulated and standardized environment. The participants felt that the ideal position was for full time government employment, but this could

only be progressively realized due to fiscal constraints; and so in the interim, credible NGOs and the public health sector had to continue being involved and working collaboratively with WBPHCOTs so as to ensure a uniform approach to recruitment, remuneration, training, and management. This could be outlined through a detailed Memorandum of Understanding between NGOs and government.

Round table participants felt that the current fiscal constraints should not deter from the fact that CHWs are an investment not just for the health service, but also towards improved health of the country's citizens, and therefore advocacy for additional funding should be pursued. This is a position reiterated globally, where the increasing view is that investing in CHWs should be concurrent with and part of integrating CHWs into mainstream Primary Health Care services and the health system.[14] In ensuring adequate funding for WBPHCOTs there would be sustainability and institutionalization of WBPHCOTs within health services. There were also suggestions to transform the current HIV/AIDS conditional grant into a Community Based health services grant, which would be inclusive in its scope of all diseases in communities.

Retention of CHWs within the health services was another topic discussed. Adequate monetary incentives (salaries) are important, but it was also felt that improved working conditions with adequate equipment, space, recognition and appreciation were critical non-monetary incentives that would enable retention.

In addition, there must be prospects for career development and progression of CHWs within the health system. The job of the CHW can be a career in itself, but there are other career development opportunities to be explored to further develop CHWs. CHWs could be promoted to supervisor positions or developed for other health sector positions. CHW training has to prepare CHWs for articulation into further training opportunities. Currently there is neither a structured retention strategy nor a formal career path for CHWs.

<u>Roles and job description, including scope of work</u>

The policy framework indicates the need to standardize the scope of work of CHWs in the country. This includes developing a clear scope of practice for CHWs, with defined roles and a detailed job description. In addition, the role clarification for CHWs will minimise confusion amongst various cadres and address expectations of both community members and the formal health system. Currently different cadres of community health workers; home based carers and lay counsellors work in health services, as well as cadres in other sectors such as social development and local government; and therefore, cadre differentiation is a consideration. The challenge with having various cadres at a household level was that a number of these workers visiting on a regular basis could overwhelm households. There is often duplication of roles and responsibilities. There is a need for greater integration and harmonization of role clarification across the various cadres with consideration for specific needs at the different health service levels, such as clinics, communities

and households. The round table discussions suggested that a clear scope of practice for CHWs would assist in reducing some of these challenges.

Ideally, the scope of practice of CHWs should be comprehensive and integrated and could include counselling and home-based care. It could also include health promotion, disease prevention, social mobilization, and community advocacy. However due to the uncertainty and tensions on how to deal with existing home-based carers and lay counsellors, it was felt that the ideal state of an integrated cadre could only be progressively achieved.

Evidence suggests that with appropriate and adequate training, CHWs can play an important role in the provision of preventive, promotive and limited curative PHC services. While a comprehensive range of services is envisaged for priority health issues, the challenge is in ensuring that CHWs are trained sufficiently to meet these needs.

Recruitment, selection and training.

The WHO states that CHWs should be members of the communities where they work, selected by and answerable to their communities, and supported by the health system. It was agreed in the round tables that CHWs should be selected from and work in the areas they reside in. The role of the community in this regard and the mechanisms and structures that could be in place to support this process, were not detailed. However, it was suggested that local ward councillors, clinic committee members and even traditional healers could play a role in recruitment and selection at community level. What was not discussed were ways to regulate community involvement to ensure transparency and accountability in these processes.

The round table participants felt there needed to be minimum entry requirements for recruitment; and considered a Grade 12 (matric) qualification as being the minimum. Once more, this highlighted the deviation from existing practice, where it is not always possible to recruit matriculants, and where a large number of existing CHWs do not have a matric qualification. It was also agreed that basic numeracy and literacy skills were crucial, though it was not discussed if this should be in English or the local language. The minimum entry requirements appeared to be another area that would have to be progressively realized. Although not emphasized in detail, other requirements for CHW recruitment included ethical behaviour and having the right values and attitudes.

Training for CHWs was discussed in detail during the round tables and explored different training programs, training approaches, methods, content, and duration across provinces in the country.
It was agreed that training needed to be commensurate with the roles and scope of the CHWs and responsive to the needs of the communities served. It had to build on existing CHW knowledge and experiences. Initial CHW training approaches had to be standardized and ensure core knowledge and competencies; with the latter reinforced through on-going continued training.

Current national CHW training was categorized into Phase 1 and 2 modules with over 600 topics on priority health conditions, covered over a few short weeks. There was also discussion on the formal CHW qualification, where CHWs are enrolled in a 12-month program. Given the huge number of CHWs in the country, currently estimated at 50 000 CHWs, training all these numbers would be difficult if just a qualification route was attempted. Experiences from provinces was that these training approaches took far too long to train large numbers, and it would probably take decades before all the thousands of CHWs nationally could be trained. A shorter, more accelerated approach was required in order to scale up CHW training nationally. There was discussion around how the Capability approach to Learning using Work Integrated Learning (WIL) could address this and would put the learner at the centre of their learning. The WIL approach could empower districts to utilize the district Master trainers; learning could be further cascaded to OTLs and from them down to their CHWs. Learning would take place in homes, communities and health facilities where WBPHCOTs worked. Large numbers of CHWs could be trained simultaneously by their OTLs across districts.

Involving the OTLs in CHW training was an important part of the WIL approach that was reiterated in the workshops; to ensure that the team dynamics are not negatively impacted by differential skills and training between the CHWs and the OTLs. Participants agreed that there should be standardization of content of training materials for all CHWs and this needed to be simple and basic, but also enabling CHWs to provide a comprehensive range of services. It was further agreed that there needed to be greater collaboration and integration between government departments responsible for service delivery (PHC branch), human resource development (Regional training centres), provinces and training providers (NGOs, universities, private training providers) and funders, in ensuring standardization of CHW training.

Support and supervision

The identification and characteristics of a CHW supervisor within the WBPHCOTs, and how they could provide support to the teams was elaborated on. Success of CHW programmes relies on regular, skilled and supportive supervision.

In the WBPHCOT programme, the link between the CHWs and the health service is the nurse outreach team leader (OTL). It is important for this OTL to be empowered to support his/her CHWs. The support can be provided through arranging and conducting supervisory visits in the community, daily and weekly meetings with the CHWs that include continued education and ensuring other health service support in the form of equipment and logistical support. Recognition and appreciation are also key motivators for CHWs, though details of this were not deliberated.

There was robust discussion on the ideal CHW supervisor (OTL), whether it could be a senior CHW or a nurse (professional or enrolled). It was agreed that in the current context of inadequate numbers of professional nurses, enrolled nurses would be used as the OTL. Enrolled nurses are

more in supply in the health worker labour market than professional nurses. Professional nurses undergo a four-year qualification, while enrolled nurses have two-year training. The deliberation did not rule out the possibility of using senior CHWs as supervisors in the future. Mentoring of CHWs was also raised as a consideration for further deliberation, although the details of who could be CHW mentors were not discussed.

There was a brief discussion on strengthening the OTL supervisory role, by involving them in CHW training and community feedback and ensuring support from empowered Facility Managers.

Identified professional health workers at the health facilities should also support OTLs, with the PHC re-engineering strategy being introduced into the curriculum of undergraduate health sciences students in medicine, nursing and other health-related disciplines.

In addition to the Facility Manager, who the team reports to, it was suggested that a Deputy Facility Manager post be established in health facilities. This position would provide further support to the OTL, and greater accountability of the envisaged responsibilities; however, within current fiscal constraints it was not discussed how this could be justified or implemented. If it was by identifying a 'champion' amongst existing clinic staff, this would be feasible; but if this required the creation of an additional post, it may not be so.

Contribution of the WBPHCOTs to routine health information system (RHIS) as well as monitoring and evaluation of the CHW programme

The round table discussions suggested that there must be clarity on the sort of routine health and related information CHWs needed to collect and report on but did not elaborate on the kind of data to be collected. Currently multiple systems, tools and reporting lines complicate the collection, collation, of capturing of routine health information into systems such as the District Health Information System (DHIS).

There must be on-going monitoring, revision and adaptation, as well as regular evaluation of the programme based on valid, reliable, and timely data to ensure optimal response to local challenges. The benefits of formal research in evaluating the programme were not deliberated upon. Households generate a large amount of personal and health related data captured by the CHWs. Technology using mobile health devices could support and improve management of CHWs, collection and storage of data and reporting of data. Investing in m-health technology for CHWs could be a critical component of health service planning within health districts.

Conclusion

There is sufficient international evidence (literature reviews, case studies, large reports) to support the implementation of CHW programmes such as the WBPHCOT programme. CHW programmes present enormous potential to improve performance of health systems, address social determinants of health, and ultimately improve health outcomes.

Evidence shows that CHW programmes are complex in terms of both design and implementation. Success requires a delicate balance between national level support and guidance while at the same time providing for flexibility and adaptability to local contexts and realities. It also requires a progressive realization of identified milestones.

The supply of potential recruits is abundant, and training at scale can be achieved with adequate collaboration and support of all role-players. South Africa has an opportunity to optimise the WBPHCOT program to create decent jobs and opportunities for thousands of unemployed women, men and youth. Investing in health worker cadres such as community health workers will not just improve health outcomes, but can, in addition, be a productive investment in the economy of the country.[15]

There must be adequate and appropriate incentives and compensation that includes both monetary and non-monetary benefits. CHWs must be part of the health system; either through NGOs or direct employment by the government, notwithstanding national policy.

While the implementation framework should provide further clarity and policy options on the points that were not adequately addressed during the round table discussion. The discussions and ideas raised at the three round policy round tables seminar, together with the national WPHCOT draft policy, provide a solid foundation on which the national implementation framework can be further developed. A better understanding of barriers and gaps to policy implementation concerning the areas of recruitment, training, certification, remuneration, monitoring and evaluation, and governance can enable policy implementers, and therefore the round tables discussions are of value.

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Appendix 7: Course Evaluation Report

Albertina Sisulu Executive Leadership Programme in Health

A programme of South Africa Partners

COURSE EVALUATION

Therese Boulle

October 2017

Executive Summary

South Africa Partners has requested a review of the course evaluations submitted by Fellows of the *Albertina Sisulu Executive Leadership Programme in Health*. Reviewers were provided with the evaluations of eight courses, split between University of Fort Hare and University of Pretoria. These were conducted between 2012 and 2017. The review was required to identify trends, indicate key messages from the evaluations and answer the question: "are we getting better."

Course evaluations had been collated and were provided to the reviewers. Where possible, the reviewers collated the evaluations into excel spreadsheets for comparison between the years; and otherwise the content of the evaluations was summarized. Excel spreadsheets are provided as appendices with the comparative evaluations for five of the eight courses.

The key message from the evaluations is that there isn't any improvement, but importantly, that there was no need for improvement. The courses have been consistently evaluated as within the range of good and excellent from the self-reporting evaluation forms. There are some interesting, noteworthy trends which emerge from the data, but these serve to underscore the consistency in outcomes throughout the years. The most notable of these trends is the students' response to group discussions. Group discussions score consistently amongst the most well-received aspects of all the courses. Students report that the opportunity to discuss the topics with the lecturers and their fellow students is an invaluable and irreplaceable facet of the learning process.

Similarly, the responses to the quality of teaching remains consistently good throughout the years. There is predictably a large upward shift in comparisons in the level of knowledge prior to and after the courses.

Comparative evaluations were more possible with UFH as courses and questions on the evaluation forms remained more consistent and similar. With UP, comparative data was more limited, as the form of evaluation and course content changed. The reviewers relied on comments to draw some conclusions about these courses.

There were some specific instances where minor complaints were raised such as a venue being too small, seating uncomfortable or the air conditioning not working. These however were raised only once, implying that the matters had subsequently been resolved. The two Skype presentations were not effective as the internet connection appeared to be unstable. These are relatively minor challenges, which with attention, can easily be remedied.

Overwhelmingly, students were positive. They appreciated the course, commended the lecturers for their knowledge and understanding of topics and exhort the continuation of the ASELPH course.

Therese Boulle (October 2017)

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Introduction

The academic offerings of the *Albertina Sisulu Executive Leadership Programme in Health* (ASELPH) are implemented by the Universities of Fort Hare and Pretoria. Courses have been conducted from December 2012 at UP and from 2014 at UFH. Each day at each course, the students have been asked to evaluate the programme, providing for their perceptions of the presentations and discussions, information about their levels of knowledge prior and after the presentations; and requesting for their comments. The universities have collated all the course evaluation materials into their respective courses and years. This report provides for an overview of these evaluations.

The request from SA Partners:

- When relevant, comparisons between the three cohorts;
- Where there is no comparison to be made, indicate this
- Identification of trends
- A summative review which answers the questions: what are the evaluations telling us, and are we getting better?

Results have been tabled comprehensively in excel spreadsheet which are attached to this document. They are well worth perusing because from them, it is possible to gain further insights into the perspectives that have been summarized within this report.

Methods

Eight Course Evaluations have been completed: four from the University of Fort Hare and the same number from the University of Pretoria.

Course Evaluations had been collated over the two or three-year cohorts for University of Fort Hare (UFH) and University of Pretoria (UP). For UFH, these included 2014, 2015/16 and 2017. For UP, questions had been asked related to the specific topics within the course. The topics related to presentations and group discussions. The Likert Scale was most commonly used for the evaluations. These presented a range of possible answers from which to choose, given a sentence/ statement about the course. An example of the statements: “The quality of the input on the course: Introduction to Public Administration and Learning in Public Health was:”. The following range of options was provided: excellent; good; acceptable; poor; very poor. At UP, statements were provided to which the participant agreed/disagree/ strongly agreed/ strongly disagreed/ or neither agreed nor disagreed. (An example: The materials will be applicable in my place of work.) Students were also asked about their level of knowledge prior to and after the course.

The universities had collated the responses from the students per course per cohort. Answers were provided in percentages, which were graphically represented. Each day usually presented between nine and sixteen questions which the students were required to complete. There was one course that had only 6 questions: UP Learning in Public Health, 11-15 Nov, 2013). Most questions were accompanied by comments. These were also provided to the reviewers. Comments were collated for each topic (after the question or

statement per topic), as well as more general comments about the course at the end of each day.

For this report, the Course Evaluation results gathered from the universities were collated and tabled per course per year or cohort, into excel spreadsheets. Because some courses, notably at UFH followed a similar outline, each year of the course allowed for comparisons to be made. Where the questions were the same, tables have been generated in excel to provide the comparison. Not every year's course had the same topics or questions. Some years were different and hence no comparison could be made. Where this has occurred, most notably at UP, the authors have provided a written summary of the evaluation data.

Whilst the comparative tables have condensed the information from the various years, the data is still lengthy. This report attempts to condense still further the outcomes of the evaluations.

The term modules have been utilized (particularly in the excel spreadsheets) to encapsulate a range of topics within courses. These however more often relate to specific days but are not uniformly so.

A request was made to identify the course convenors and lecturers. The evaluations were inconsistent in including their names. Sometimes these were included in the format of the reporting and other times their names were picked out from the student comments. There is no doubt however that this list is incomplete. There were many instances where students commended their lecturers but their names were nowhere to be found.

The Narrative report on findings

A format has been followed for each of the eight modules which condenses the information from the excel spread sheet and provides for the names of convenors and lecturers, numbers of students and dates of the course; with a summary of the evaluation findings per course. The spreadsheets however contain the summative collation of results and are well worth perusing.

1. University of Fort Hare: Introduction to Public Administration and Learning in Public Health

Course Convenors: Prof Thakhati, Mr W Mupindo
Contributors: 2015/16: Dr Wiseman

Cohort / Year	Dates / relate to modules (on spread sheets)	Number of Students per day (refers to maximum respondent numbers per day)
Cohort 2014	13 May, 7 July, 5 August 7 August 8 August	44 40 49 35 40
Cohort 2015 / 2016	21 July 15 24 August 15 19 January 16 20 January 16	29 19 18 17
Cohort 2017	29 May 30 May 31 May 01 June	21 18 16 17

Summary of Evaluation Data

An accurate comparison of the three cohorts is possible over the first three teaching days, however, after the third day the course content changes significantly and accurate comparisons are no longer possible. However, a few trends emerge in the responses that are of significance.

Before evaluating these trends, it is worth noting that there are a few general observations that will be applicable for all data sets compared in this report. First, a cursory examination of all the responses to the survey questions reveals that the vast majority of responses fall within the positive range, that is between 'Excellent' and 'Acceptable', and 'Strongly agree' and 'Neutral.' Where the responses deviate from this trend, careful attention is paid to the comments on the question to ascertain what resulted in the negative response.[1]It is important that this be kept in mind in the report, for where there is an improvement or regression, it is usually of small degrees within a particular 'sentiment bracket'[2] rather than a massive shift in sentiment.

[1] The author feels it is important to point out that these instances are incredibly rare, and are quite often not accompanied by an explanatory comment.
[2] This term might need some clarification – by 'sentiment bracket' what is meant is the general response to the question. Students express positive sentiment where most of the responses fall between 'Excellent' and 'Good', for instance.

Second, when asked to assess their knowledge of the topic prior to and after the day's presentations, students almost always note an increase in their knowledge – this poses some interesting questions about the nature and timing of these questions. This will be examined later in the report, but for now it is enough to note that this is a persistent trend amongst all the cohorts examined.

Comparing the cohorts for the Introduction to Public Administration and Learning in Public Health yields some interesting results. While, there are no major shifts between the years in responses to the course-specific questions, the end-of-day summary questions (about the quality of teaching, knowledge gained by students, and the quality of discussion) provide some insight into students' reception of the course. In particular, there is a slight, but noticeable decline in positive responses to the quality of teaching. This, however, coincides with a fairly large positive shift in responses to the question about the quality of discussions. Additionally, students' comments reveal that the discussions are an integral part of the learning process. Many students wanted more time to be dedicated to discussion.

For every cohort, students reported that they had gained new knowledge as a result of the course. Notably, the 2017 cohort saw the largest increase in this area – perhaps indicating some slight improvement in the course organisation, or the value added by group discussions.

The 2017 cohort noted a few concerns with the dissemination of course information, with numerous respondents complaining that the course information was – in places – incorrect, and was not handed out far enough in advance of the course's commencement.

2. University of Fort Hare: Public Health Policy Transformation and Legislation

Convenors
Contributors Prof S Hendricks
Dr Bossert
Dr Thomas
Dr Jinabhai

	Dates	Number of students
Cohort 2014	22-Sep	41
	23-Sep	38
	24-Sep	39
	25-Sep	36
	26-Sep	39
Cohort 2017	24-Jul	24
	25-Jul	23
	26-Jul	25
	27-Jul	20
	28-Jul	16

Summary of Evaluation

Although there were a number of significant changes between the 2014 iteration of the course and the 2017 iteration, a comparison of the two cohorts remains possible because there remained enough overlap in the course content to yield comparative data. While much of the course content remained the same in 2014 and 2017, there were changes to the structure of the course – with modules being introduced and examined at different times on different days. The impact of this change is hard to quantify or examine in any truly meaningful way, but a reasonable inference would be that this change would emerge in responses about the overall impact of the course on students.

Responses to the course content see little change between 2014 and 2017, with one exception in the student responses to the Overview of the Flagship Framework section. In this, the responses from 2017 show a marked decline from those in 2014. This, it appears, was due to this section being conducted via Skype – over what appears to have been a poor connection. If anything is to be learned from this, it is surely that Skype is not an ideal medium through which to conduct a presentation.[3]

[3] Or, at the very least, every effort must be made to ensure a strong and stable connection prior to conducting a presentation via Skype.

Another trend which emerges from the data is that students respond very positively to the discussion segments of the course. Students consistently refer to the value of the discussions in their comments and even call for more time to be allocated to discussion.

Between 2014 and 2017 there is a slight dispersion of responses to the question of quality of teaching methods. While, in 2014, students were equally likely to respond that the teaching quality was 'Excellent' or 'Good', in 2017 there were fewer 'Excellent' responses and more 'Neutral' responses.

Furthermore, this trend appears to repeat in the students' responses to the question of whether or not the course objectives were achieved. While almost all students from both cohorts agreed that the course objectives had been achieved, the 2014 cohort was much more effusive in their praise of the course.

Worryingly, there was a sharp decline in the view that the course was well organised and well managed between 2014 and 2017, with one student feeling that the course was very poorly run.[4]

A consistent request from students of both cohorts is that the lecture slides be provided to students prior to the presentation on that topic. This is a common response across all cohorts, courses, and questionnaires.

[4] Again, the author feels it is necessary to point out that this is not a decline into 'negative' territory but rather a decline within the positive 'sentiment bracket.'

3. University of Fort Hare: Human Resource Management

Convenors

Contributors: Prof Mahlati

	Dates	Number of students
Cohort 2014	09-Jul	40
	10-Jul	33
	13-Nov	34
	01-Dec	40
	02-Dec	30

Contributors: D Meecham & D Seekoe

Cohort 2015/16	26-Aug	14
	27-Aug	17
	28-Aug	15
	19-Nov	16
	30-Nov	16
	01-Dec	19
	21-Jan	17

Summary of Evaluations

Comparing the responses from the two cohorts provides some interesting insight into the progress of the course over the years. While the courses start out mostly the same, there are some significant changes to course content and structure between the years. Overall, however, these changes to the course structure seem to have been beneficial, as there is a slight improvement in responses.

Of the courses examined in this report, this course fares best in terms of the improvement that has been made from cohort to cohort. For most of the course-specific questions, responses either remain comparable or indicate a slight improvement in the 2015/2016 cohort.

The most dramatic improvements are apparent in the overall course review, with students in the 2015/2016 cohort indicating that the course had done an excellent job in achieving the course objectives and providing the students with the relevant competencies. Additionally, there was a marked improvement in the perceived organisation and management of the 2015/2016 course.

Some of the trends identified in the above courses are also evident in this course. Group discussions are consistently considered to be one of the most valuable aspects of the

course, with a large portion of the students indicating that they gained a great deal of knowledge from class interactions.

Students from both cohorts indicate that they gained new knowledge over the duration of the course, and many of them responded that this new knowledge would be of use to them in their work environments.

4. University of Fort Hare: Re-engineering Primary Health Care and Decentralisation

Year 2015: contributors: Dr H Zokufa, Dr A Pillay, Dr Zungu, Dr Sibeko, Dr K Chetty & Dr Funani.

April Year 2016: Contributors: Prof E Seekoe, Dr S Tshabalala, Dr Mbengashe, S Monakali, Prof Hendricks, Dr E Meyer, Dr Zungu, Dr Mubaiwa, Ms J Hunter

May Year 2016: Contributors: Prof Hendricks, Dr J Ledwaba, M Zungu, Dr Mtshali, Dr Zokufa

Year	Dates	Number of students
Cohort 2015	24-Aug	27
	25-Aug	23
	27-Aug	22
	28-Aug	17
Cohort May 2016	09-May	7
	11-May	8
	12-May	8
	13-May	6
Cohort April 2016	12-Apr	9
	13-Apr	10
	14-Apr	10
	15-Apr	8
	16-Apr	7

Summary of Evaluations

There were significant changes to the course structure between 2015 and May 2016, but much of the same ground was covered - albeit in a different order. This means that comparisons of the content-specific questions are possible, but may not be as accurate a reflection on the course as they could be. For instance, if a topic is covered early in the day, it may be received differently by students than if it were the last topic of discussion on a particularly long day.

Comparisons of teaching quality and knowledge gained are also possible, but – given the restructuring of the course – could also be misleading. In addition to this, the 2016 cohort spent the second day of the course visiting the NHI Pilot District. The 2015 cohort did not do this, and so no comparison of the experience is possible.

A further constraint to the comparison of the two cohorts is that the 2016 cohort consisted of just 8 people – much smaller than the class of 27 from the previous year. This could conceivably skew the data that emerged from the 2016 cohort.

Overall, the responses to the course in 2016 were more positive than those in 2015. Students in 2016 responded much more positively to the questions about core competencies and course objectives. In addition to this, there was a slight, but consistent, improvement in the overall quality of teaching from 2015 to 2016.

Students in both cohorts responded very positively to the group discussions, but the 2016 cohort was much more effusive in their praise of the group discussions in their comments on the course. It is, however, quite likely that the noticeable upturn in group discussion quality could be put down to the fact that there was a small group of people in the class – a better environment for discussion.

The cohort April 2016 evaluated the course on Decentralisation which bore no resemblance to the previous two courses. Again, students were impressed with the course, their answers reflecting in the excellent and good range. What was noticeable was that this small group of eight students, had a power-house of course educators such as in Dr Mbengashe, Superintendent General, Eastern Cape Department of Health and Ms J Hunter, Deputy Director General Primary Health Care, National Department of Health.

5. University of Pretoria: Decentralisation

Convenors and contributors: Not specified

Year	Dates	Number of students
Cohort 2014	15-Sep	49
	16-Sep	45
	17-Sep	33
	18-Sep	36
	19-Sep	47
Cohort 2016	10-Oct	47
	11-Oct	46
	12-Oct	43
	13-Oct	46
	14-Oct	40

Summary of Evaluations

Unfortunately, a data-driven comparison of these two cohorts is not possible because the course evaluations changed dramatically between 2014 and 2016. This is, in fact, true of all course evaluations emanating from the University of Pretoria which are examined in this report.

Course evaluations in 2014 followed a similar pattern to those conducted by the University of Fort Hare, but the 2016 evaluations take on an entirely different format. Thankfully, however, some insight can be gained from comparison, as the final questions in the course evaluation in each year are somewhat similar. Although not identical, it is possible to take into account the student comments and overall sentiment of each cohort to examine course outcomes and improvement between the years.

The 2014 cohort was fairly pleased with the course overall, indicating that they gained a lot of knowledge from the group discussions and presentations. There were, however, quite significant complaints about the venue for the class – a faulty air conditioning unit seems to have resulted in a less than ideal learning environment.

Furthermore, while the class was quite happy with the quality of teaching, they were displeased with the organisation of the course. A number of students complained that important course information was disseminated too late and that some of the proposed modules were not completed because of a lack of time.

2016 fared slightly better in terms of the overall response to the course. Students indicated that they were happy with the course structure and the clear presentation of the content. Group discussions were, once again, singled out as being a vital aspect of the learning

process. The change in course structure was also well-received, with students being consistent in their praise of a case study-oriented, practical approach to learning about Decentralisation.

It would seem therefore that the course convenors had learnt from some of the criticism about organization of the course.

6. University of Pretoria: Human Resource Management

Convenors and Contributors:
2013: Dr Guilin, Prof Hendricks, Dr Mahlathi
2017: Dr L Thomas, Dr T Makola, Dr S van der Breg Cloete, D Conco

Year/ Cohort	Date	Number of students
Cohort 2013	02-Dec	49
	03-Dec	47
	04-Dec	50
	05-Dec	41
	06-Dec	30

Cohort 2017: Dates: 5 – 9 June 2017 (numbers unspecified)

From the title page indicates 36 – 48 respondents

Summary of Evaluations

As with all of the evaluations coming from the University of Pretoria, there is very little overlap of evaluation questions between the 2013 and 2017 cohorts. What can be gleaned from the course evaluations, however, is that the learning outcomes remained fairly consistent despite significant changes in course structure.

The 2013 cohort ran into some significant problems, however, with part of the course being conducted via Skype. Students noted that the connection was inconsistent and that, although the content of the presentation was interesting and the discussion engaging, significant audio issues forced the presenter to repeat himself a number of times, wasting valuable time.

Despite the issues with Skype, the 2013 cohort reported that the course was otherwise well organised and informative. Feedback on the quality of teaching was all positive, and the group discussions once again featured prominently amongst the students' praise.

The trend of students finding the group discussions to be of particular value continued in 2017, with a vast majority of students reporting that the group discussions helped them immensely with their knowledge of the subject. Additionally, a trend that emerges within the 2017 data is that the students found the presentations to be clearly structured and well presented. Students were very happy to have lecturers who were knowledgeable and engaging.

If anything, there is a slight improvement in the responses between the 2013 and 2017 cohorts. At the very least, outcomes have remained consistently good.

7. University of Pretoria: Learning in Public Health

Nov 2013: Contributors not specified

April 2015: Contributors: Thomas, Hendricks, Chaponda, Grobler, Botha, Medien, Seekoe, Buch, Thakathi, Whittaker

August 2015: Contributors: Hendricks, Buch, Thomas, Senkugube, Naran, Venter

Year	Dates	Number of Students
Cohort 2013	11 -15 Nov	40
Cohort 2015	20-Apr	21
	21-Apr	34
	22-Apr	33
	23-Apr	23
	24-Apr	34
Cohort 2016	15-Aug	37
	16-Aug	39
	17-Aug	36
	18-Aug	36
	19-Aug	39

Summary of Evaluations

Significant changes to the course structure and course evaluation between the years makes the comparison of outcomes almost impossible. Additionally, the 2013 course evaluation focused almost entirely on information relating to university services and therefore offers no insight into the course content itself.

There are, however, a few comparisons which are possible – these serve to reinforce the trends which have emerged in the other courses examined in this report. Students responses to group discussions are, as always, very positive. Additionally, the reported quality of teaching methods remains consistent throughout the years.[5] Students consistently report knowledge gains over each day of the course, and these gains remain consistent from cohort to cohort.

[5] The value of this in relation to the 2013 course is questionable due to the focus on university services in the evaluation – how much this reflects the quality of teaching of course content still remains unclear.

Students' additional comments offer perhaps the best insight into how well the course is received and how well it is achieving its aims. From these comments, it is possible to infer that the course has had consistent outcomes in the positive range over the three years that are compared.

8. University of Pretoria: Policy Transformation

Cohort 2012: Contributors Unspecified

Cohort 2014: Prof Tom, Marc and Dr Alban Pillay

Year	Dates	Number of Students
Cohort 2012	22-Oct	12
	23-Oct	13
	24-Oct	8
Cohort 2014	24-Feb	48
	25-Feb	49
	26-Feb	50
	27-Feb	50
	28-Feb	50

Summary of Evaluations

A comparison of the two cohorts is made difficult by the quite significant change in course content between the two years. The courses start out very similarly, but diverge a great deal after the second teaching day, making data-driven analysis of the course evaluations almost impossible. Drawing on the available data, however, provides some insight into the impact of the course.

There is a noticeable and quite significant improvement in the quality of input and presentations of the course content. There is a large shift from the 'Good' range to the 'Excellent' range that happens from 2012 to 2014. It is unclear what caused this shift since the quality of teaching methods and group discussion quality are lacking comparisons in the course evaluation. Furthermore, the magnitude of the gain in knowledge as reported by students is significantly higher in 2014 than in 2012. It is quite unfortunate that the most relevant comparative data is unavailable as this would provide a great deal of insight into why the 2014 course fared so much better than that of 2012.[6]

Students in both years indicate that the presentations were clear, and that group discussions were both enjoyable and enlightening. When asked about the core competencies and the course objectives, students from both cohorts answered that they gained a great deal from the course. Additionally, respondents said that the course was well managed and well organised in both years.

[6] The author feels it is necessary to point out that the 2012 course did not fare poorly in the course evaluations, but rather the 2014 course fared remarkably well.

Conclusion

It would be quite easy to infer from the above critical analysis that the differences between the compared cohorts are quite significant; that where there is improvement it is quite minor and where there is regression it marks a significant problem. In truth, however, what emerges from the comparisons detailed above is that the courses have remained consistently good between 2012 and 2017. Where there have been regressions in outcomes, they have been a slight shift from the upper reaches of the positive 'sentiment bracket' to the upper-middle region. Similarly, where there have been improvements, they have been largely contained to improvements within the positive 'sentiment bracket.'

The picture that emerges from the comparison of the various courses and cohorts is one of consistency in self-reported learning outcomes. On the whole, there hasn't been a great deal of improvement or regression, but there hasn't needed to be. Students consistently report being happy with the courses and the presentation of content. Overwhelmingly, there is positive feedback on course organisation and management.

There are some interesting, noteworthy trends which do emerge from the data, but these only serve to underscore the consistency in outcomes throughout the years. The most notable of these trends is the students' response to group discussions. Group discussions score consistently amongst the most well-received aspects of all the courses. Students report that the opportunity to discuss the topics with the lecturers and their fellow students is an invaluable and irreplaceable facet of the learning process. Where students have complaints about the group discussions, it is almost invariably that the discussion was cut short, and they felt that more could have been gained by exploring the discussion further. The importance of this form of engagement with the course material cannot be understated.

Another trend which emerges from the data is that students consistently report gaining knowledge after every day of each course. Indeed, this should not be surprising, it is the entire purpose of education. However, there are some important questions about the way in which this is evaluated that need to be raised. It is unclear from the evaluations just when the students are asked to evaluate their knowledge of the topic prior to and after the day of learning. The very nature of the question is about time and understanding, and the timing of the question could have a significant impact on the responses received. For instance, if students are asked to rate their prior knowledge of a topic before that topic is even broached their response will (conceivably) be quite different to the response they would give if asked to rate their prior knowledge of that topic after it is discussed. The problem is this: students who have learned more about a topic have the tools necessary to assess their prior knowledge of the topic, but will also be less likely to accurately assess that knowledge.[7]

[7] It is, in fact, a quite well-known psychological phenomenon known as the Dunning-Kruger effect. This is where people with low ability routinely overestimate their ability, and people with high ability routinely underestimate their ability.

One final observation that can be made from the above report is a response to the question: Are we getting better? The answer from the evaluations is probably and accurately, 'No.' However, this is, in a sense, a good thing. While improvements are always desirable in this realm, there isn't a need for improvement in this instance. The course outcomes are consistently good, and responses are consistently positive. While there is no clear improvement across the board, there is also no indication of regression. Additionally, this report can assist in identifying areas for possible improvement. One such area is the use of Skype for presentations – it is not clear that using Skype for presentations adds value to the classes. Or rather, it would add value if the Skype connection were consistently stable. Another area of possible improvement would be to acquiesce to students' requests for the slides to be sent out ahead of the presentation. Having access to these slides would perhaps aid the students' note-taking and preparedness.

These are just two examples of possible areas of improvement, but it must be stressed that the overall diagnosis of the compared courses is very positive. The courses are clearly effective in achieving their goals, and students are reportedly very happy with the outcomes, and exhort that the course continues into the future.

List of Appendices

Appendix One: UFH HR Management (1)

Appendix Two: UFH Policy Transformation (1)

Appendix Three: UFH Public Administration (1)

Appendix Four: UFH Re-engineering PHC (1)

Appendix Five: UP Policy Transformation (1)

Report compiled by Therese Boulle
October 2017

Appendix 8: ASELPH Cohorts

ALBERTINA SISULU EXECUTIVE LEADERSHIP PROGRAMME

UFH COHORT 1: Starting date: May 2014

Active (A) = 20
Graduated (G) = 26

	Surname	First Name	Province	District	Current Position	Status (G - A)
1	Bokleni	Nomteto	EC	O. R. Tambo	Deputy Director	A
2	Bomela	Noxolo	EC	O. R. Tambo	Deputy Director HR	A
3	Gede	Sindiswa	EC	Amathole	District Manager	A
4	Jack	Nomfanelo	EC	O. R. Tambo	Health Practitioner	A
5	Kalala	Johnston	EC	O. R. Tambo	Chief Executive Officer	A
6	Madlebe	Masizakhe	EC	Amathole	Assistant Manager	A
7	Magingxa	Nomakhosi	EC	Cacadu	Deputy Director Hospitals	A
8	Mandondo	Sibongile	EC	Amathole	Obstetrics & Gynaecologist	A
9	Mayekiso	Nomahlubi	EC	O. R. Tambo	Sub-District Manager	G
10	Meyile	Sindile	EC	Nelson Mandela Metro	Nursing Services Manager	A
11	Mnyaka	Victress	EC	O. R. Tambo	HR Development Manager	A
12	Mnyamana	Tozama	EC	O. R. Tambo	Deputy Manager Nursing	G
13	Ndlovu	Garfield	EC	Head Office	Senior Manager	G
14	Ndwandwe	Miriam	EC	Amathole	Manager Pharmaceuticals	G
15	Ntshanga	Nomvume	EC	O. R. Tambo	Sud-District Manager	G
16	Sandi	Beatrice	EC	Provincial Office	Acting Senior Manager	A
17	Siyangaphi	Thembinkosi	EC	O. R. Tambo	Hospital Manager Deputy Director	G
18	Sodlula	Mary	EC	Provincial Office	Director/Senior Manager Mother	A
19	Tofu	Xolani	EC	Amathole	Deputy Director	G
20	Trollope	Leigh	EC	Amathole	Dietician	A
21	Tshamase	Nozibele	EC	Cacadu	Hospital Manager Deputy Director	G
22	Wagner	Ronele	EC	Amathole	Chief Executive Officer	G
23	Zamxaka	Nontlantla	EC	Provincial Office	Manager District Health Services	G
24	Bennett	Fabion	EC	Private		G
25	Goon	Daniel	EC	Private	Researcher	A
26	Mrwebi	Khungelwa	EC	Private	Medical Practitioner	G
27	Mlisa	Lily-Rose	EC	Private	Director	G
28	Mandeya	Andrew	EC	Private	Statistical Consultant	G
29	Dlamini	Khulekani	KZN	Umkhanyakude	Deputy Manager	G
30	Dlomo	Bukeliwe	KZN	Umsinga	Chief Executive Officer	A
31	Dlwati	Pakama	KZN	Uthungulu	District Pharmacy Manager	A
32	Madlala	Bright	KZN	uThukela	Medical Manager	A
33	Mkhize	Ntokozo	KZN	Ugu	Chief Exective Officer	G
34	Mkhwanazi	Nqobile	KZN	Uthungulu	Chief Executive Manager	G
35	Mkhwanazi	Siduduzo	KZN	Uthungulu	Human Resource Deputy Manager	A
36	Ndhlovu	Nomalanga	KZN	uThukela	Clinical Specialist	G
37	Nxumalo	Maureen	KZN	Ugu	Chief Exective Officer	G
38	Tshabalala	Sandile	KZN	eThekwini	Medical Manager	A
39	Xokwe	Madoda	MP	Joe Gqabi	Health Promotion Manager	G
40	Modupe	Olurotimi	MP	Private	Medical Manager	G
41	Rakumakoe	Jacob	NC	Private	Chief Executive Officer	G
42	Mbobo	Angela	GP	Private	Health service manager	G
43	Molokomme	Victoria	GP	Private	Registered Nurse	G
44	Palmer	Eurica	GP	Private	Director	G
45	Selepe	Dikeledi	GP	Private	Lecturer	G
46	Ngecebetsha	Avela	WC	Private	Optometist Managing Director	A

ALBERTINA SISULU EXECUTIVE LEADERSHIP PROGRAMME

UFH COHORT 2: Starting date: June 2015

Active (A) = 21
Graduated (G) = 0

	Surname	First Name	Province	District	Current Position	Status (G - A)
1	Lunika	Tembela C.	EC	Amatole	District Clinical Specialist	A
2	Makinana	Noxolo B.	EC	Provincial Office	Primary Health Care Manager	A
3	Msengana	Nqatyiswa F	EC	Amatole	District Clinical Specialist	A
4	Ndukwana	Tobeka C.	EC	Alfred Nzo	Sub-district manager	A
5	Sixam	Nkosazana A	EC	Chris Hani	Quality Assurance Manager	A
6	Sobuza	Ntombizethu	EC	Chris Hani	Clinical Specialist Nurse	A
7	Mtheleli	Philasande	EC	OR Tambo	Senior Manager (Finance & Supply Chain OR Tambo)	A
8	Mini	Phamphilia	EC	Nelsom Mandela Metro		A
9	Lunyawo	Liziwe F	EC	Provincial Office	Deputy Director HIV/AIDS	A
10	Mngweba	Nombuyiselo E	EC	Alfred Nzo	Chief Executive Officer	A
11	Mbuthuma	Sydney S.	EC	Alfred Nzo	Senior Manager (Finance & Supply chain Alfred Nzo)	A
12	Soka	Ayanda	EC	Amatole	Pharmacist	A
13	Makeleni	Ntombekhaya	EC	Amatole	Deputy Director (HAST)	A
14	Dndzwayiba	Tabisa P	EC	Amatole	Pharmacist	A
15	Taukeni	Simon G	EC	UFH	Post Doc.	A
16	Mntambo	Themba C.	KZN	Pietermaritzburg	Senior legal administration officer	A
17	Msane	Sihlesambo L.	KZN	Uthungulu	District Finance Manager	A
18	Khanyile	Margaret Z.	KZN	Ulundi	Chief Executive Officer (CEO)	A
19	Mthembu	Elizabeth	KZN	Gwala	CEO/Medical Manager	A
20	Mabaso	Sindi	KZN	Uthungulu	District Manager	A
21	Vilakazi	Vusumusi	KZN	Itshelejuba	CEO	A

ALBERTINA SISULU EXECUTIVE LEADERSHIP PROGRAMME

UFH COHORT 3: Starting date: May 2017

Active (A) = 20
Graduated (G) = 0

	Surname	First Name	Province	District	Current Position	Status (G - A)
1	De Vos	Patricia D.	Eastern Cape	Cacadu	District Manager	A
2	Muavha	Mukondeleli	Eastern Cape	Sarah Baartman	DCST Paediatrics	A
3	Hobo	Bukeka S	Eastern Cape	Amathole	Dep Director in Quality Assurance Program	A
4	Nyangintsimbi	Nozibele P	Eastern Cape	Joe Gqabi	Deputy Director:Strategic Planning	A
5	Madikizela	Zukisa P	Eastern Cape	Sarah Baartman	Principal (GRD 3) Dentist	A
6	Mpofu Mtshwane	Doris Noluntu	Eastern Cape	Province	Acting Director Senior PHC Programs	A
7	Mjekula	Vatiswa M	Eastern Cape	Amathole	General Health Program Manager	A
8	Sohuma	Ntombifikile	Eastern Cape	Mhlontlo Health	Assistant Director	A
9	Mabentsela	Bonga	Eastern Cape	Province	Project	A
10	Dunywa	Zanele W	Eastern Cape	Nelson Mandela	Assistant Director	A
11	Mashiya	Mbulelo C.	Eastern Cape	Hewu Hospital	Senior M.O.	A
12	Mciteka	Nomzamo	Eastern Cape	Province	Project Manager	A
13	Sejosengoe	Ntombombuso V	Eastern Cape			A
14	Xongwana	Biziwe P	Eastern Cape	Province	Research and Office Manager	A
15	Msutu	Siphokazi O.	Eastern Cape	Nelson Mandela Metro District	LSA Manager	A
16	Ngonyama	Fikiswa	Eastern Cape	Frontier Hospital	Obstetrician & Gynaecologist	A
17	Selanto Chairman	Nonkosi P	Eastern Cape			A
18	Msutu	Nomaphelo	Eastern Cape	Province	Deputy Director	A
19	Mbewu	Mvuyisi K.	Eastern Cape	Nompumelelo Hospital		A
20	Ntombela	Zandile K.G.	Eastern Cape Private	Mthatha	Optometrist	A
21	Lebodi	Arthur T.	Gauteng		Head of Dental Clinic	A
22	Ngema	Simphiwe P. E.	Kwazulu Natal	Ngwelezane Hospital	Clinical Manager & HOD	A
23	Pitso	Setshone L. K.	North West		CEO	A

ALBERTINA SISULU EXECUTIVE LEADERSHIP PROGRAMME

UFH COHORT 4: Starting date: March 2018

Active (A) = 18
Graduated (G) = 0

	Surname	First Name	Province	District	Current Position	Status (G - A)
1	Mzwandile	Banda	Eastern Cape	Amathole	Oral and Dentral Manager	A
2	Zodwa	Gqirana	Eastern Cape	Amathole	Operational Manager	A
3	Busisiwe	Jele	Eastern Cape	Province	Assistant Director	A
4	Zingisa	Lamle	Eastern Cape	Amathole	Quality Assurance Manager	A
5	Zolani	Maswazi	Eastern Cape	Province	Medical Officer	A
6	Nomfusi	Magugu	Eastern Cape	Province	Health Technology Manager	A
7	Asanda	Maholwana	Eastern Cape	Amathole	Clincial Coordinator	A
8	Monwabisi	Maseti	Eastern Cape	Amathole	Assistant Manager Pharmaceutical Services	A
9	Mbangatha	Mzuyanda	Eastern Cape	Nelson Mandela	Health Technology Manager	A
10	Mpumelelo	Melamane	Eastern Cape	Amathole	Medical Officer	A
11	Mnyanda	Yandisa	Eastern Cape	Amathole	Medical Officer	A
12	Siyotula	Sithula	Eastern Cape	OR Tambo	Medical Officer	A
13	Nomawetu	Stamper	Eastern Cape	Province	Assistant Director	A
14	Tom	Pumlani	Eastern Cape	Amathole	Health technology Manager	A
15	Kgasane	Jonnase	Free State	Pelonomi Hospital	Deputy Pharmaceutical Service Manager	A
16	Jumba	Nwabisa	Free State	Province	Deputy Director	A
17	Lubabalo	Hoho	KwaZulu Natal		Trainer and Training Facilitator	A
18	Motlatla	M	Northern Cape	Province	Enviromental Health Officer	A

UP COHORT 1: Starting date: October 2013

Active (A) = 1
Graduated (G) = 53

	Surname	First Name	Province	District	Current Position	Status (A - G)
1	Jaxa	Nozipho	EC	Provincial Head Office	Director - Clinical Trainings - Provincial Office	G
2	Maqubela	Lizeka	EC	OR Tambo	Deputy Director: Information	G
3	Mlenzana	Sidney	EC	OR Tambo	NHI M&E Coordination	A
4	Ndzwayiba	Pearl	EC	Amathole (Buffalo City)	Assistant ManagerPHC	G
5	Soka	Ayanda	EC	Provincial Head Office	Manager	G
6	Tolom	Andile	EC	Nelson Mandela Distric Municipality	Director	G
7	Vapi	Vatiswa	EC	OR Tambo	Sub-District Manager	G
8	Yose-Xasa	Bongiwe	EC	Amathole (Buffalo City)	Medical Officer	G
9	Malinga	Nthabiseng	FS	Fezile Debi	CEO Fezile Dobi Hospital	G
10	Moatlhodi	Letlhomile	FS	Xhariep	Chief Executive Officer - Diamant Hospital	G
11	Molokomme	Phuti	FS	Mangaung	CEO: Peloguim	G
12	Mtimkulu	Dorcas	FS	Thabo Mofutsanyane	CEO: Mofumahadi Mmanapo Hospt	G
13	Ramodula	Baesi	FS	Mangaung	CEO: NDH	G
14	Botsane	Montwedi	GP	Provincial Head Office	Budget Manager	G
15	Cloete	Sophy	GP	UP	UP Emerging Faculty	G
16	Jiyane	Priscilla	GP	UP	Emerging Faculty	G
17	Langa	Boitumelo	GP	West Rand	Gauteng Department of Health	G
18	Lebodi	Tebogo	GP	Provincial Head Office	HR Planning and Support	G
19	Lubisi	Khensane	GP	Tshwane	Specialist Paediatrician	G
20	Malebo	Lorraine	GP	Tshwane Distict Health Services	Director Corporate Services	G
21	Mashigo	Elizabeth	GP	Ekurhuleni	Deputy Director: PHC	G
22	Masilela	Nonceba	GP	Tshwane	AD: HAST	G
23	Mathole	Peter	GP	Ekurhuleni	Deputy Director	G
24	Mojapelo	Cecilia	GP	Tshwane	Medical Advisor HAST	G
25	Mokwene	Lebogang	GP	Tshwane	Medical Manager - Kalafong Hospital	G
26	Sokudela-Eccles	Funeka	GP	Provincial Head Office	Specialist	G
27	Hlaba	Doris	GP	Provincial Head Office	Hospital Services Manager	G
28	Kommal	Terrence	GP	National Department of Health	CEO - Medical Expert Consulting Group	G
29	Dube	Jabulile	KZN	Gert Sibande	HSS Manager	G
30	Gyapersad	Evani	KZN	Ethekwini	Physiotherapist	G
31	Jikijela	Sgananda	KZN	Provincial Head Office	Deputy Manager	G
32	Khanyile	Thandeka	KZN	Uthungulu	CEO Hospital	G
33	Khumalo	Eugenia	KZN	Lithukela	Leadership Mentor	G
34	Langa	Londa	KZN	Provincial Head Office	Acting Director KZN DoH	G
35	Mndaweni	Simpiwe	KZN	Provincial Head Office	General Manager: Strategic Health	G
36	Mubaiwa	Victoria	KZN	Provincial Head Office	Manager	G
37	Shabane	Joshua	KZN	Ilembe	CEO	G
38	Krüger	Philippus	LP	Capricon	Senior Manager: Malaria	G
39	Latif	Shamila	LP	Provincial Head Office	Manager M/E	G
40	Lavhelani	Ndivhaleni	LP	Vhembe	Nurse Manager	G
41	Ntsewa	Aldina	LP	Waterberg	Acting District Executive Manager	G
42	Rampamba	Enos	LP	Vhembe	Pharmacists	G
43	Luthuli	Thembekile	MP	Gert Sibande	Deputy Director: NHI - M&E	G
44	Thabethe	Christinah	MP	Provincial Head Office	Deputy Director	G
45	Lamola	Deborah	National	National Department of Health	NDOH	G
46	Mbewu	Muvyisi	National	National Department of Health	Manager	G
47	Moonasar	Devanand	National	National Department of Health	Director: Malaria	G
48	Phiri	Rapule	National	National Department of Health	Deputy Director: Inspectorate	G

	Surname	First Name	Province	District	Current Position	Status (A - G)
49	Tsaagane	Lydia	National	National Department of Health	Compliance Inspector	G
50	Dintwa	Dineo	NW	Provincial Head Office	Assistant Manager PHC	G
51	Letong	Olaotse	NW	Dr RSM District	Clinical Manager Dental	G
52	Masudubele	Senei	NW	National Department of Health	Dentist	G
53	Seleke	John	NW	Ngaka Modiri Molema	PHC Manager	G
54	Setlhare	Itumeleng	NW	Provincial Head Office	Registrar	G

ALBERTINA SISULU EXECUTIVE LEADERSHIP PROGRAMME

UP COHORT 2: Starting date: April 2015

Active (A) = 0
Graduated (G) = 35

	Surname	First Name	Province	District	Current Position	Status (G - A)
1	Maepa	Mahlabane Linah	Limpopo	Sekukune	District Executive manager	G
2	Manganye	Bumani	Limpopo	Vhembe	Operational Manager	G
3	Mahoomola	Thabane	Limpopo	Waterberg	Assistant Director: Speech Therapy and Audiology	G
4	Leburu	Ncanyana	North West	Kenneth Kauanda	Clinical Manager	G
5	Serapane-Setlhare	Kesenogile	North West	Procv HOD	Deputy Director	G
6	Seshaeng	Amogelang	North West	Ruth Mopamati	Assistant Manager: Pharmaceutical Services	G
7	Shakung	Michael	North West	Kenneth Kauanda	Medical Manager	G
8	Tuge	Tshwanelo	North West	Procv HOD - Nutr	Deputy Director	G
9	Khawula, Gabriel Benedict	Bigboy	Kwa-Zulu Natal	Ugu	CEO	G
10	Sakyi	Thabi	Kwa-Zulu Natal	Amajuba	CEO	G
11	Shabangu	Gugu	Kwa-Zulu Natal	Health District	Distict Director	G
12	Sosibo	Thandi	Kwa-Zulu Natal	Ungunumgugundluvo	Senoir Manager: Nursing	G
13	Khuzwayo	Khulani	Kwa-Zulu Natal	Illebe	Private Medical Practitioner	G
14	Maya	Sabata	Free State	Thabo Mutsanyane	District Manager	G
15	Mngomezulu	Jabu	Free State	Lejweleputswa	CEO	G
16	Molefe	Madge	Free State	Motheo	Deputy Director Nursing	G
17	Mbatha, Nothando Andile	Thando	Gauteng	Tshwane	Nutritionist	G
18	Motswaledi	Lerato	Gauteng	Tshwane	Chief Supervisor Occupational Therapist	G
19	Ogunrombi	Modupe	Gauteng / Private	Ga-Rankuwa	Senoir Lecturer	G
20	Sello	Thato	Gauteng / Private	JHB Central	Director	G
21	Ramodipa	Khomotso	Gauteng / Private	No district (Private)	Optometrist	G
22	Matsepe	Beauty	Gauteng / Private	No district (Private)		G
23	Jagdeep, Chantal	Chantal	Gauteng	Ekuruleni	Speech Therapy & Audiology District Co-ordinator	G
24	Africa	Khanyi	Gauteng	Ekuruleni	Acting CEO	G
25	Malimabe	Joyce	Gauteng	Sedideng	Assistant Director	G
26	Meyer, Ellenore	Ellenore	Gauteng	Tshwane	Emerging Faculty	G
27	Burisch	Tanja	Gauteng	Ekurhuleni	Phamaceutical Services Ekurhuleni	G
28	Matome	Jimmy	Gauteng	West Rand	CEO	G
29	Sibanyoni	Thembi	Gauteng	Ekurhuleni	Assisstant Director	G
30	Matsaba	Tshidi	Gauteng	West Rand	District Deputy Director	G
31	Kunene	Khosi	Gauteng	No district (Private)	Occupational health programme Manager	G
32	Selepe	Conny	Gauteng	Ekuruleni	Chief Supervisor Occupational Therapist	G
33	Sikakane	Prudence	Gauteng	Head Office	Deputy Director HRM and Organisational Behaviour	G
34	Hokwana, Sheila	Sheila	Eastern Cape	Buffalo City	Programme manger: Comprehensive Care Management and Treatment	G
35	Harris, Rodney	Rodney	Eastern Cape	NM Metro	Acting Depot Manager PE Pharmaceutical	G

ALBERTINA SISULU EXECUTIVE LEADERSHIP PROGRAMME

UP COHORT 3: Starting date: September 2016

Active (A) = 3
Graduated (G) = 46

	Surname	First Name	Province	District	Current Position	Status (G - A)
1	Lekola	Mohubedu	Free State	Free State Head Office	Director, Internal Audit - Department of Health	G
2	London	Grace	Free State	Mangaung Metro	Chief Director DHS & Health Programme - Dept of Health Free State	G
3	Makune	Tsietsi Ebenezer	Free State	Thabo Mofutsanyana	Chief Executive Officer - Department of Health FS	G
4	Mfanta	Xolani	Free State	Xhariel	Acting CEO - Health Department	G
5	Mokoena	Monaheng	Free State	Manguang	Financial Manager - Dept of Health , FS	G
6	Msibi	Sibusiso	Free State	Lejweleputswa - Free State	Professional Nurse - Dept of Health, FS	G
7	Ramokotjo	Masebina Cecilia	Free State	Thabo Mofutsanyano	Deputy Director - PHC - Thabo Mofutsanyana Health District	G
8	Thejane	Mosebi Alexis	Free State	Fezile Dabi District	Clinical Manager - Fezil Dasi District - Dept of Health	G
9	Khumalo	Nonhlanhla	Gauteng	Ekurhulweni	Family Physician - Gauteng Dept Health - Ekhurhuleni	G
10	Mabusela	Philly Phillip	Gauteng	City of Tshwane	Senior Medical Manager - Dr Geirge Mukhari Academic Hospital	G
11	Mahlangu	Sylvia	Gauteng	Tshwane District	Nurse Manager - Mamelodi Hospital	G
12	Moola	Feroza	Gauteng	Ekurhulweni	Clinical Manager - Gauteng Health	G
13	Mosoane	Mpho	Gauteng	Tshwane District	Chief Executive Officer - Gauteng Department of Health	G
14	Motloung	Sibongile Alice	Gauteng	Ekurhuleni	Deputy Director - HAST - Dept of Health	G
15	Mukheli	Tshifhiwa	Gauteng	City of Johannesburg	Deputy - Director - Physiotherapy - Charlottes Maxeke Johannesburg Academic Hospital	G
16	Nkoana	Elliot	Gauteng	Jhb Metro	Deputy Director Administration - Sizwe Tropical Disease Hospital	G
17	Ntamane	Patience	Gauteng	Jhb Metro	Director - Quality Assurance - Gauteng Provincial Office	G
18	Nyathi	Anna	Gauteng	Tshwane Metro	Assistant Manager - Weskoppies Hospital	G
19	Prince	Ntombifuthi Roseline	Gauteng	Ekurhuleni	Assistant Manager - Tambo Memorial Hospital	G
20	Runnalls	Nadia	Gauteng	Ekurhuleni	Pharmacist - Department of Health	G
21	Binase	Nomawethu	KZN	Harry Gwala	Chief Executive Officer - EG & Usher Memorial Hospital	G
22	Dlamini	Pamela	KZN	Uthekela	Medical Manager - Dundee Hospital	A
23	Govender	Jegenthiren (Jack)	KZN	KZN Head Office	Chief Director - KZN Dept of Health	G
24	Ngcobo	Thamela	KZN	Ilembe	Chief Executive Officer - Stanger Hospital	G
25	Shezi	Brian Mzwakhe	KZN	Province	Director / Actin Chief Director - Dept of Health, KZN	G
26	Zuma	Gremma Lindeni Lindiwe	KZN	Harry Gwala	District Manager, Dept of Health, KZN	G
27	Kaka	Johanna Tlou	Limpopo	Waterberg District	Chief Executive Officer - Ellisras Hospital	G
28	Modiba	Ali (Dr)	Limpopo	Capricon	Chief Executive Officer - Pietersburg Hospital	A
29	Mufamadi	Mpho Elvis	Limpopo	Vhembe	Chief Executive Officer - Department of Health, Tshilidzini Hospital	G
30	Peniel	Lotte	Limpopo	Mopani	Chief Executive Hospital - Van Velden Hospital	G
31	Prinsloo	Luka Cornelius (Dr)	Limpopo	Mopani	Clinical Manager: Dentist - Van Velden Hospital	G
32	Aphane	Janky Sefelenyane	Mpumalanga	Gert Sabande	Chief Executive Officer	G
33	Konaite	Irish	Mpumalanga	Nkangala	Chief Executive Officer - Mmametuyake Hospital	G
34	Makhubele	Pauleck	Mpumalanga	Neslpruit Provincial	Manager: office of HOD - Department of Health	G
35	Matsinhe	Thembisile B	Mpumalanga	Provincial Office - Mbombela (Nelspruit) Mpumalanga Province Ehlanzeni District	Deputy Director - Mpg Provincial Govt	G
36	Mogane	Pharais	Mpumalanga	Ehlazeni Health District	Director Hospital Services - Dept of Health, Mpg	A
37	Phiri	Hawor Willejah	Mpumalanga	Mpumalanga Provincial Office	Deputy Director - HRMIS - Dept of Health	G
38	Shabangu	Steven	Mpumalanga	Mpumalanga Provincial Office	Director: Manager Accounting - Dept of Health, Mpg	G
39	Grootboom	Daniel	N Cape	Namakwa	Chief Executive Officer - Springbok Hospital	G
40	Huna	Thobeka	N Cape	Z F Mgcawa District	District Clinical Specialist - PHC Deapartment of Health	G
41	Lesenjane	Obakeng	N Cape	Provincial - NC Office	Director, Auxiliary Services - Department of Health	G
42	Links	Albert	N Cape	Francis Baard (Kimberley)	Chief Executive Officer - Department of Health NC	G

	Surname	First Name	Province	District	Current Position	Status (G - A)
43	Manyetsa	Elizabeth Dibueng	N Cape	Provincial - Francis Baard Dist	Deputy Director - Department of Health, NC	G
44	Moncho	Thapelo	N Cape	Frances Bhard Health District	Chief Executive Officer - West End Specialist Hospital	G
45	Titus	Charl Angus	N Cape	Provincial office	Senior Manager - Dept of Health	G
46	Tsholo	Vincent Gobusamang	N Cape	Provinvial Office	Acting Director Human Resources - Dept of Health, NC	G
47	Segwai	Karabelo	North West	Bojanala	Acting PHC Manager - Moretele Health subdistrict (NWDOH)	G
48	Sesinyi	Ockie	North West	Dr Kenneth Kaunda District	Assistant Manager Nursing PHC - Maquassi Hills Subdistrict	G
49	Setlhodi	Tumediso	North West	Dr RS Mompati District	Chief Executive Officer - Taung District Hospital	G

Appendix 9: ASELPH Graduates

ASELPH GRADUATES

as of 30 September 2018

University	Cohort	Surname	First Name	Province	District	Current Position
UP	C1	Ndzwayiba	Pearl	Eastern Cape	Amathole	Assistant ManagerPHC
UP	C1	Yose-Xasa	Bongiwe	Eastern Cape	Amathole	Medical Officer
UP	C2	Hokwana	Sheila	Eastern Cape	Buffalo City	Programme manger: Comprehensive Care Management and Treatment
UP	C2	Harris	Rodney	Eastern Cape	Nelson Mandela Bay Metro	Acting Depot Manager PE Pharmaceutical
UP	C1	Tolom	Andile	Eastern Cape	Nelson Mandela Bay Metro	Director
UP	C1	Maqubela	Lizeka	Eastern Cape	OR Tambo	Deputy Director: Information
UP	C1	Vapi	Vatiswa	Eastern Cape	OR Tambo	Sub-District Manager
UP	C1	Jaxa	Nozipho	Eastern Cape	Provincial Head Office	Director - Clinical Trainings - Provincial Office
UP	C1	Soka	Ayanda	Eastern Cape	Provincial Head Office	Manager
UFH	C1	Mayekiso	Nomahlubi	Eastern Cape		District Office: Sub-district manager
UFH	C1	Mnyamana	Tozama	Eastern Cape		District Office: DD Health Programs
UFH	C1	Ndlovu	Garfield	Eastern Cape	Provincial Office	Director: Hospital Services Finance
UFH	C1	Ndwandwe	Miriam	Eastern Cape		District Clinical Specialist - PHC
UFH	C1	Ntshanga	Nomvume	Eastern Cape		District Manager : OR Tambo (P)
UFH	C1	Siyangaphi	Thembinkosi	Eastern Cape		District Office: Deputy Director - Employee Relations (P)
UFH	C1	Tofu	Xolani	Eastern Cape		
UFH	C1	Tshamase	Nozibele	Eastern Cape		Hospital Manager
UFH	C1	Wagner	Ronele	Eastern Cape		
UFH	C1	Zamxaka	Nontlantla	Eastern Cape		Director: Provincial Office (P)
UFH	C1	Bennett	Fabion	Eastern Cape		Hospital General Manager: Private Sector
UFH	C1	Mrwebi	Khungelwa	Eastern Cape		Regional Clinical Manager (P)
UFH	C1	Mlisa	Lily-Rose	Eastern Cape		Manager: Community Projects
UFH	C1	Mandeya	Andrew	Eastern Cape		
UP	C3	Thejane	Mosebi Alexis	Free State	Fezile Dabi District	Clinical Manager - Fezil Dasi District - Dept of Health
UP	C1	Malinga	Nthabiseng	Free State	Fezile Dabi District	CEO Fezile Dobi Hospital
UP	C3	Lekola	Mohubedu	Free State	Free State Head Office	Director, Internal Audit - Department of Health
UP	C2	Mngomezulu	Jabu	Free State	Lejweleputswa	CEO
UP	C3	Msibi	Sibusiso	Free State	Lejweleputswa	Professional Nurse - Dept of Health, FS
UP	C1	Molokomme	Phuti	Free State	Mangaung Metro	CEO: Peloguim
UP	C1	Ramodula	Baesi	Free State	Mangaung Metro	CEO: NDH
UP	C2	Molefe	Martha Caroline	Free State	Mangaung Metro	Deputy Director Nursing
UP	C3	London	Grace	Free State	Mangaung Metro	Chief Director DHS & Health Programme - Dept of Health Free State
UP	C3	Mokoena	Monaheng	Free State	Manguang Metro	Financial Manager - Dept of Health , FS
UP	C3	Makune	Tsietsi Ebenezer	Free State	Thabo Mofutsanyana	Chief Executive Officer - Department of Health FS
UP	C2	Maya	Sabata	Free State	Thabo Mofutsanyane	District Manager
UP	C1	Mtimkulu	Dorcas	Free State	Thabo Mofutsanyane	CEO: Mofumahadi Mmanapo Hospt
UP	C3	Ramokotjo	Masebina Cecilia	Free State	Thabo Mofutsanyano	Deputy Director - PHC - Thabo Mofutsanyana Health District
UP	C3	Mfanta	Xolani	Free State	Xhariep	Acting CEO - Health Department
UP	C1	Moatlhodi	Letlhomile	Free State	Xhariep	Chief Executive Officer - Diamant Hospital
UP	C2	Sello	Thato	Gau / Private	JHB Central/Private	Director
UP	C2	Ramodipa	Khomotso Anastacia	Gau / Private	No district (Private)	Optometrist
UP	C2	Matsepe	Beauty Ntabanyane	Gau / Private	No district (Private)	
UP	C2	Kunene	Makhosazana	Gau/ Private	No district (Private)	Occupational health programme Manager
UP	C3	Mukheli	Tshifhiwa	Gauteng	City of Johannesburg	Deputy - Director - Physiotherapy - Charlottes Maxeke Johannesburg Academic Hospital
UP	C3	Nkoana	Elliot	Gauteng	City of Johannesburg	Deputy Director Administration - Sizwe Tropical Disease Hospital
UP	C3	Ntamane	Patience	Gauteng	City of Johannesburg	Director - Quality Assurance - Gauteng Provincial Office
UP	C3	Mabusela	Philly Phillip	Gauteng	City of Tshwane	Senior Medical Manager - Dr Geirge Mukhari Academic Hospital
UP	C3	Mahlangu	Sylvia	Gauteng	City of Tshwane	Nurse Manager - Mamelodi Hospital
UP	C3	Mosoane	Mpho	Gauteng	City of Tshwane	Chief Executive Officer - Gauteng Department of Health
UP	C3	Nyathi	Anna	Gauteng	City of Tshwane	Assistant Manager - Weskoppies Hospital
UP	C1	Lubisi	Khensane	Gauteng	City of Tshwane	Specialist Paediatrician
UP	C1	Malebo	Lorraine	Gauteng	City of Tshwane	Director Corporate Services
UP	C1	Masilela	Nonceba	Gauteng	City of Tshwane	AD: HAST
UP	C1	Mojapelo	Cecilia	Gauteng	City of Tshwane	Medical Advisor HAST
UP	C1	Mokwene	Lebogang	Gauteng	City of Tshwane	Medical Manager - Kalafong Hospital
UP	C2	Meyer	Ellenore	Gauteng	City of Tshwane	Emerging Faculty
UP	C3	Motloung	Sibongile Alice	Gauteng	Ekurhuleni	Deputy Director - HAST - Dept of Health
UP	C3	Prince	C3	Gauteng	Ekurhuleni	Assistant Manager - Tambo Memorial Hospital
UP	C3	Runnalls	Nadia	Gauteng	Ekurhuleni	Pharmacist - Department of Health
UP	C1	Mashigo	Elizabeth	Gauteng	Ekurhuleni	Deputy Director: PHC
UP	C1	Mathole	Peter	Gauteng	Ekurhuleni	Deputy Director
UP	C3	Khumalo	Nonhlanhla	Gauteng	Ekurhulweni	Family Physician - Gauteng Dept Health - Ekhurhuleni

University	Cohort	Surname	First Name	Province	District	Current Position
UP	C3	Moola	Feroza	Gauteng	Ekurhulweni	Clinical Manager - Gauteng Health
UP	C1	Botsane	Montwedi	Gauteng	GP Head Office	Budget Manager
UP	C1	Lebodi	Tebogo	Gauteng	GP Head Office	HR Planning and Support
UP	C1	Sokudela-Eccles	Funeka	Gauteng	GP Head Office	Specialist
UP	C1	Cloete	Sophy	Gauteng	UP	UP Emerging Faculty
UP	C1	Jiyane	Priscilla	Gauteng	UP	Emerging Faculty
UP	C1	Langa	Boitumelo	Gauteng	West Rand	Gauteng Department of Health
UFH	C1	Mbobo	Angela	Gauteng		Health Services Manager: Nursing
UFH	C1	Molokomme	Victoria	Gauteng		HOD: Critical Care Unit (P)
UFH	C1	Palmer	Eurica	Gauteng		Independent Consultant
UFH	C1	Selepe	Dikeledi	Gauteng		
UP	C2	Mbatha	Thando	Gauteng	City of Tshwane	Nutritionist
UP	C2	Motswaledi	Lerato	Gauteng	City of Tshwane	Chief Supervisor Occupational Therapist
UP	C2	Jagdeep	Chantal	Gauteng	Ekurhuleni	Speech Therapy & Audiology District Co-ordinator
UP	C2	Africa	Khanyi	Gauteng	Ekurhuleni	Acting CEO
UP	C2	Burisch	Tanja	Gauteng	Ekurhuleni	Phamaceutical Services Ekurhuleni
UP	C2	Sibanyoni	Thembi	Gauteng	Ekurhuleni	Assisstant Director
UP	C2	Selepe	Conny	Gauteng	Ekurhuleni	Chief Supervisor Occupational Therapist
UP	C2	Sikakane	Prudence Motsehoa	Gauteng	GP Head Office	Deputy Director HRM and Organisational Behaviour
UP	C2	Malimabe	Joyce	Gauteng	Sedideng	Assistant Director
UP	C2	Matome	Jimmy	Gauteng	West Rand	CEO
UP	C2	Matsaba	Tshidi	Gauteng	West Rand	District Deputy Director
UP	C2	Ogunrombi	Modupe Olifunmilayo	Gau / Private	Ga-Rankuwa/private	Senoir Lecturer
UP	C2	Sakyi	Thabisile Bongiwe	Kwa-Zulu Natal	Amajuba	CEO
UP	C1	Gyapersad	Evani	Kwa-Zulu Natal	Ethekwini	Physiotherapist
UP	C1	Dube	Jabulile	Kwa-Zulu Natal	Gert Sibande	HSS Manager
UP	C3	Binase	Nomawethu	Kwa-Zulu Natal	Harry Gwala	Chief Executive Officer - EG & Usher Memorial Hospital
UP	C3	Zuma	Gremma Lindeni Lindiwe	Kwa-Zulu Natal	Harry Gwala	District Manager, Dept of Health, KZN
UP	C2	Khuzwayo	Khulani Theodore	Kwa-Zulu Natal	Ilembe	Private Medical Practitioner
UP	C3	Ngcobo	Thamela	Kwa-Zulu Natal	Ilembe	Chief Executive Officer - Stanger Hospital
UP	C1	Shabane	Joshua	Kwa-Zulu Natal	Ilembe	CEO
UP	C1	Jikijela	Sgananda	Kwa-Zulu Natal	KZN Head Office	Deputy Manager
UP	C1	Langa	Londa	Kwa-Zulu Natal	KZN Head Office	Acting Director KZN DoH
UP	C1	Mndaweni	Simpiwe	Kwa-Zulu Natal	KZN Head Office	General Manager: Strategic Health
UP	C1	Mubaiwa	Victoria	Kwa-Zulu Natal	KZN Head Office	Manager
UP	C3	Govender	Jegenthiren	Kwa-Zulu Natal	KZN Head Office	Chief Director - KZN Dept of Health
UP	C3	Shezi	Brian Mzwakhe	Kwa-Zulu Natal	KZN Head Office	Director / Actin Chief Director - Dept of Health, KZN
UP	C2	Shabangu	Gugu Charlotte	Kwa-Zulu Natal	KZN Health District	Distict Director
UP	C2	Khawula	Bigboy Gabriel Benedict	Kwa-Zulu Natal	Ugu	CEO
UP	C2	Sosibo	Thandi Cynthia Nompumelelo	Kwa-Zulu Natal	uMgungundlovu	Senoir Manager: Nursing
UP	C1	Khanyile	Thandeka	Kwa-Zulu Natal	uThukela	CEO Hospital
UP	C1	Khumalo	Eugenia	Kwa-Zulu Natal	uThukela	Leadership Mentor
UFH	C1	Dlamini	Khulekani	Kwa-Zulu Natal		Hospital CEO (P)
UFH	C1	Mkhize	Ntokozo	Kwa-Zulu Natal		District: Director for District Health Services (P)
UFH	C1	Mkhwanazi	Nqobile	Kwa-Zulu Natal		
UFH	C1	Ndhlovu	Nomalanga	Kwa-Zulu Natal		
UFH	C1	Nxumalo	Maureen	Kwa-Zulu Natal		
UP	C1	Krüger	Philippus	Limpopo	Capricorn	Senior Manager: Malaria
UP	C1	Latif	Shamila	Limpopo	LP Head Office	Manager M/E
UP	C3	Peniel	Lotte	Limpopo	Mopani	Chief Executive Hospital - Van Velden Hospital
UP	C3	Prinsloo	Luka Cornelius	Limpopo	Mopani	Clinical Manager: Dentist - Van Velden Hospital
UP	C2	Maepa	Mahlabane Linah	Limpopo	Sekhukhune	District Executive manager
UP	C2	Manganye	Bumani Solomon	Limpopo	Vhembe	Operational Manager
UP	C1	Lavhelani	Ndivhaleni	Limpopo	Vhembe	Nurse Manager
UP	C1	Rampamba	Enos	Limpopo	Vhembe	Pharmacists
UP	C3	Mufamadi	Mpho Elvis	Limpopo	Vhembe	Chief Executive Officer - Department of Health, Tshilidzini Hospital
UP	C2	Thabane	Mahoomola Warrence	Limpopo	Waterberg	Assistant Director: Speech Therapy and Audiology
UP	C3	Kaka	Johanna Tlou	Limpopo	Waterberg	Chief Executive Officer - Ellisras Hospital
UP	C1	Ntsewa	Aldina	Limpopo	Waterberg	Acting District Executive Manager
UP	C3	Matsinhe	Thembisile B	Mpumalanga	Ehlanzeni	Deputy Director - Mpg Provincial Govt
UP	C1	Luthuli	Thembekile	Mpumalanga	Gert Sibande	Deputy Director: NHI - M&E
UP	C3	Aphane	Janky Sefelenyane	Mpumalanga	Gert Sibande	Chief Executive Officer
UP	C1	Thabethe	Christinah	Mpumalanga	MP Head Office	Deputy Director
UP	C3	Makhubele	Pauleck	Mpumalanga	MP Head Office	Manager: office of HOD - Department of Health
UP	C3	Phiri	Hawor Willejah	Mpumalanga	MP Head Office	Deputy Director - HRMIS - Dept of Health
UP	C3	Shabangu	Steven	Mpumalanga	MP Head Office	Director: Manager Accounting - Dept of Health, Mpg
UP	C3	Konaite	Irish	Mpumalanga	Nkangala	Chief Executive Officer - Mmametuyake Hospital
UFH	C1	Xokwe	Madoda	Mpumalanga		
UFH	C1	Modupe	Olurotimi	Mpumalanga		Clinical Manager: Barberton Hospital (P)
UP	C1	Lamola	Deborah	National	National Department of Health	NDOH
UP	C1	Mbewu	Muvyisi	National	National Department of Health	Manager
UP	C1	Moonasar	Devanand	National	National Department of Health	Director: Malaria
UP	C1	Phiri	Rapule	National	National Department of Health	Deputy Director: Inspectorate
UP	C1	Tsaagane	Lydia	National	National Department of Health	Compliance Inspector
UP	C3	Segwai	Karabelo	North West	Bojanala Platinum	Acting PHC Manager - Moretele Health subdistrict (NWDOH)
UP	C2	Leburu	Ncanyana David	North West	Dr Kenneth Kaunda	Clinical Manager
UP	C2	Shakung	Michael Jacob	North West	Dr Kenneth Kaunda	Medical Manager
UP	C3	Sesinyi	Ockie	North West	Dr Kenneth Kaunda	Assistant Manager Nursing PHC - Maquassi Hills Subdistrict
UP	C1	Letong	Olaotse	North West	Dr RSM District	Clinical Manager Dental
UP	C2	Seshaeng	Amogelang Dorah	North West	Dr Ruth MoMpati	Assistant Manager: Pharmaceutical Services

University	Cohort	Surname	First Name	Province	District	Current Position
UP	C3	Setlhodi	Tumediso	North West	Dr Ruth Mompati	Chief Executive Officer - Taung District Hospital
UP	C1	Masudubele	Senei	North West	National Department of Health	Dentist
UP	C1	Seleke	John	North West	Ngaka Modiri Molema	PHC Manager
UP	C1	Dintwa	Dineo	North West	NW Head Office	Assistant Manager PHC
UP	C1	Setlhare	Itumeleng	North West	NW Head Office	Registrar
UP	C2	Serapane-Setlhare	Kesenogile	North West	Procv HOD	Deputy Director
UP	C2	Tuge	Tshwanelo Yvonne	North West	Procv HOD - Nutr	Deputy Director
UP	C3	Manyetsa	Elizabeth Dibueng	Northern Cape	Frances Baard	Deputy Director - Department of Health, NC
UP	C3	Links	Albert	Northern Cape	Frances Baard	Chief Executive Officer - Department of Health NC
UP	C3	Moncho	Thapelo	Northern Cape	Frances Baard	Chief Executive Officer - West End Specialist Hospital
UP	C3	Grootboom	Daniel	Northern Cape	Namakwa	Chief Executive Officer - Springbok Hospital
UP	C3	Lesenjane	Obakeng	Northern Cape	NC Head Office	Director, Auxiliary Services - Department of Health
UP	C3	Titus	Charl Angus	Northern Cape	NC Head Office	Senior Manager - Dept of Health
UP	C3	Tsholo	Vincent Gobusamang	Northern Cape	NC Head Office	Acting Director Human Resources - Dept of Health,
UP	C3	Huna	Thobeka	Northern Cape	Z F Mgcawa District	District Clinical Specialist - PHC Deapartment of
UFH	C1	Rakumakoe	Jacob	Northern Cape		District Hospital CEO
UP	C1	Kommal	Terrence	PRIVATE	National Department of Health	CEO - Medical Expert Consulting Group
UP	C1	Hlaba	Doris	PRIVATE	Provincial Head Office	Hospital Services Manager

Appendix 10: ASELPH UFH and UP Fellows assessment

Appendix 10: UFH and UP fellows assessment

UFH fellow self-assessments and 360-degree reviews

	Level of competence	UFH Cohort 1			UFH Cohort 2			UFH Cohort 3
		Baseline (percent)	Final (percent)	360-degree (percent)	Baseline (percent)	Final (percent)	360-degree (percent)	Baseline (percent)
1. People Management and Empowering Environment: Must be able to manage and encourage people in a collaborative environment, advocate for team work, optimize their outputs and effectively manage relationships in order to achieve organizational goals.								
	Not yet competent	2	0	0	10	0	0	0
	Below average	2	33	0	0	0	2	0
	Average	46	67	29	30	0	15	63
	Above Average	44	0	29	50	71	27	26
	Fully competent	6	0	42	10	29	57	11
2. Self-Management: Must be able to recognize one's learning style, personal attributes, professional development needs, be good with time management and taking initiative.								
	Not yet competent	0	0	0	0	0	0	0
	Below average	0	0	4	6	0	0	0
	Average	48	0	8	63	0	14	67
	Above Average	39	50	50	6	59	37	26
	Fully competent	13	50	38	25	41	49	7
3. Honesty and Integrity: Must be committed to honesty and integrity, build and displays high standards of ethical and moral conduct, apply self-corrective measures and be reliable and accountable.								
	Not yet competent	0	0	0	0	0	0	0
	Below average	0	0	4	0	0	0	0
	Average	17	17	8	6	0	9	23

	Level of competence	UFH Cohort 1			UFH Cohort 2			UFH Cohort 3
		Baseline (percent)	Final (percent)	360-degree (percent)	Baseline (percent)	Final (percent)	360-degree (percent)	Baseline (percent)
	Above Average	45	50	46	63	44	16	58
	Fully competent	29	33	42	31	56	75	19
4. Client Orientation and Customer Focus: Must acknowledge customer rights and be committed to a client orientated approach to service delivery according to Batho Pele principles.								
	Not yet competent	0	0	0	0	0	2	0
	Below average	0	0	4	0	0	0	0
	Average	28	0	29	25	0	14	19
	Above Average	45	50	29	31	56	29	70
	Fully competent	27	50	36	44	44	55	11
5. Communication: Must be able to use verbal and written communication competently, be committed to the exchange of ideas, sharing of ideas and practices both internal and external communication effectively and consistently.								
	Not yet competent	0	0	0	0	0	0	-
	Below average	6	0	0	0	0	1	-
	Average	25	17	17	44	0	17	-
	Above Average:	47	50	50	56	41	24	-
	Fully competent	22	33	33	0	59	58	-
6. Resource Management and Allocation: Must be able to manage the human resources, physical resources and materials of the organization in accordance to strategic plans of the organization and within the legal and policy framework.								
	Not yet competent	0	0	0	0	0	0	0

	Level of competence	UFH Cohort 1			UFH Cohort 2			UFH Cohort 3
		Baseline (percent)	Final (percent)	360-degree (percent)	Baseline (percent)	Final (percent)	360-degree (percent)	Baseline (percent)
	Below average	4	0	4	0	0	0	0
	Average	48	17	33	71	6	24	67
	Above Average	42	66	38	29	41	32	26
	Fully competent	6	17	25	0	53	44	7
7. Financial Management: Must be able to compile and manage budgets, control cash flow, institute risk management and administer tender procurement processes in accordance with generally recognized financial practices in order to ensure the achievement of organizational objectives.								
	Not yet competent	4	0	0	0	0	0	7
	Below average	13	0	4	0	0	3	19
	Average	51	6	25	33	9	27	48
	Above Average	21	65	50	25	65	27	19
	Fully competent	11	29	21	42	29	43	7
8. Problem Solving and Analysis: Must be competent at the systematic identification, analysis and resolution of existing and anticipated problems on a timely basis and manage the risk appropriately.								
	Not yet competent	0	0	0	0	0	0	0
	Below average	4	0	0	0	0	0	4
	Average	38	17	46	58	5	24	52
	Above Average	51	66	38	42	56	27	33
	Fully competent	7	17	17	0	39	49	11
9. Programme and Project Management: Must be able to develop, implement, evaluate and adjust plans to achieve desired objectives, while ensuring the optimal use of resources.								

	Level of competence	UFH Cohort 1			UFH Cohort 2			UFH Cohort 3
		Baseline (percent)	Final (percent)	360-degree (percent)	Baseline (percent)	Final (percent)	360-degree (percent)	Baseline (percent)
	Not yet competent	0	0	0	0	0	5	4
	Below average	8	0	0	0	0	0	0
	Average	47	33	33	50	0	18	70
	Above Average	36	50	50	50	61	24	22
	Fully competent	9	17	17	0	39	53	4
10. Community/ Partnership Collaboration: Must be able to align the organization's priorities with the needs and values of the community, implement the governance framework and ensure stakeholder involvement and networking.								
	Not yet competent	0	0	0	0	0	6	4
	Below average	0	0	0	8	0	0	4
	Average	30	0	46	92	0	22	63
	Above Average	58	67	25	0	65	25	22
	Fully Competent	12	33	29	0	35	47	7
11. Knowledge Management Must be able to promote and share knowledge, information, and lessons learnt, and applying theory into practice.								
	Not yet competent	0	0	0	0	0	0	0
	Below average	5	0	8	25	0	1	4
	Average	28	33	46	67	0	26	41
	Above Average	56	17	38	8	61	33	44
	Fully competent	11	50	8	0	39	40	11
12. Strategic Leadership: Must be able to provide vision, give direction and inspire others in order to deliver from an organizational mandate.								

	Level of competence	UFH Cohort 1			UFH Cohort 2			UFH Cohort 3
		Baseline (percent)	Final (percent)	360-degree (percent)	Baseline (percent)	Final (percent)	360-degree (percent)	Baseline (percent)
	Not yet competent	0	0	4	0	0	0	0
	Below average	5	0	4	0	0	1	4
	Average	37	17	8	50	0	11	63
	Above Average	43	50	58	50	44	28	22
	Fully Competent	15	33	25	0	56	60	11
13. Change Management: Must be able to initiate and support organisational transformation and change in order to successfully implement new initiatives and deliver on service delivery commitments.								
.	Not yet competent	0	0	0	0	0	0	8
	Below average	4	0	0	8	0	2	12
	Average	43	33	14	92	0	12	38
	Above Average	44	50	42	0	56	15	38
	Fully competent	9	17	11	0	44	71	4
14. Service Delivery Innovation (SDI): Must be competent in process integration, policies and structures across the organization to achieve improved efficiency and effectiveness on SDI and implement new ways of performing tasks and develop the organizational as a whole.								
	Not yet competent	0	0	0	0	0	0	4
	Below average	17	0	4	0	0	0	15
	Average	44	33	42	34	11	14	58
	Above Average	33	50	33	58	67	14	23

	Level of competence	UFH Cohort 1			UFH Cohort 2			UFH Cohort 3
		Baseline (percent)	Final (percent)	360-degree (percent)	Baseline (percent)	Final (percent)	360-degree (percent)	Baseline (percent)
	Fully competent	6	17	21	8	22	72	0

SELF-EVALUATIONS: University of Pretoria (the values are % of those who answered)

		UP Cohort 1			UP Cohort 2			UP Cohort 3
	Level of Competence	Baseline (percent)	Final (percent)	360-degree (percent)	Baseline (percent)	Final (percent)	360-degree (percent)	Baseline (percent)
1. People Management and Empowering Environment: Must be able to manage and encourage people in a collaborative environment, advocate for team work, optimize their outputs and effectively manage relationships in order to achieve organizational goals.								
	Not yet competent	0	0	0	0	0	0	0
	Below average	9	0	0	9	0	2	8.5
	Average	47	8	20	47	22.5	24.7	44
	Above Average	40	84	60	29	34	43	42
	Fully competent	4	8	20	14.5	42.5	29.7	5
2. Self-Management: Must be able to recognize one's learning style, personal attributes, professional development needs, be good with time management and taking initiative.								
	Not yet competent	0	0	0	0	0	0	0
	Below average	6	0	0	14	1	2.5	13

		UP Cohort 1			UP Cohort 2			UP Cohort 3
	Level of Competence	Baseline (percent)	Final (percent)	360-degree (percent)	Baseline (percent)	Final (percent)	360-degree (percent)	Baseline (percent)
	Average	45	0	40	40	17.3	26.2	46
	Above Average	40	92	60	31	38.7	40	36
	Fully competent	9	8	0	14.5	43.2	30.75	4
3. Honesty and Integrity: Must be committed to honesty and integrity, build and displays high standards of ethical and moral conduct, apply self-corrective measures and be reliable and accountable.								
	Not yet competent	0	0	0	0	0	0	0
	Below average	0	0	0	7.5	0	2.75	2
	Average	17	8	0	22.5	7.2	16.7	27
	Above Average	55	25	80	42	26.2	36.7	51
	Fully competent	28	67	20	31.5	66.5	43.5	20.2
4. Client Orientation and Customer Focus: Must acknowledge customer rights and be committed to a client orientated approach to service delivery according to Batho Pele principles.								
	Not yet competent	0	0	0	5	0	1	2.7
	Below average	4	0	0	7.5	6	2.75	9.5
	Average	22	0	0	20	20.7	26.75	31
	Above Average	54	58	80	32	23	40	30.5
	Fully competent	20	42	20	37	52	32.2	13.7
5. Communication: Must be able to use verbal and written communication competently, be comm0itted to the exchange of ideas, sharing of ideas and practices both internal and external communication effectively and consistently.6								

		UP Cohort 1			UP Cohort 2			UP Cohort 3
	Level of Competence	Baseline (percent)	Final (percent)	360-degree (percent)	Baseline (percent)	Final (percent)	360-degree (percent)	Baseline (percent)
	Not yet competent	0	0	0	3	0	0	2.7
	Below average	0	0	0	14	4.7	5	19
	Average	40	8	20	26	19.7	24.2	35
	Above Average	49	50	40	38	28	38	37.5
	Fully competent	11	42	40	19	47.7	34.2	5.7
6. Resource Management and Allocation: Must be able to manage the human resources, physical resources and materials of the organization in accordance to strategic plans of the organization and within the legal and policy framework.								
	Not yet competent	0	0	0	1.5	0	.2	3.5
	Below average	15	0	0	12.5	5.5	3	17.2
	Average	47	58	20	41	23.2	34.2	50
	Above Average	32	25	60	28.7	31.5	41	26.5
	Fully competent	6	17	20	16	40	22.7	3.7
7. Financial Management: Must be able to compile and manage budgets, control cash flow, institute risk management and administer tender procurement processes in accordance with generally recognized financial practices in order to ensure the achievement of organizational objectives.								
	Not yet competent	15	0	0	8	3.7	1.5	10.5
	Below average	19	8	0	19	6.5	3	22

		UP Cohort 1			UP Cohort 2			UP Cohort 3
	Level of Competence	Baseline (percent)	Final (percent)	360-degree (percent)	Baseline (percent)	Final (percent)	360-degree (percent)	Baseline (percent)
	Average	50	42	40	34	37.8	39.5	38.5
	Above Average	14	42	60	26	25.7	30	22
	Fully competent	2	8	0	13	27	26.2	5.7
8. Problem Solving and Analysis: Must be competent at the systematic identification, analysis and resolution of existing and anticipated problems on a timely basis and manage the risk appropriately.								
	Not yet competent	0	0	0	9	3	.5	3
	Below average	14	0	0	14.5	3.7	2.7	11.5
	Average	50	17	20	42.7	16	26.5	55.7
	Above Average	32	68	60	28.5	36	44	27
	Fully competent	4	17	20	11	42	25	2.7
9. Programme and Project Management: Must be able to develop, implement, evaluate and adjust plans to achieve desired objectives, while ensuring the optimal use of resources.								
	Not yet competent	0			7.5	0	0	4
	Below average	21		20	13.7	12.2	7	20
	Average	44	42	0	41	10.5	33	50
	Above Average	35	42	60	22	30.2	33	22.5
	Fully competent	0	17	20	14	47	24	3.5
10. Community/ Partnership Collaboration: Must be able to align the organization's priorities with the needs and values of the community, implement the governance framework and ensure stakeholder involvement and networking.								

		UP Cohort 1			UP Cohort 2			UP Cohort 3
	Level of Competence	Baseline (percent)	Final (percent)	360-degree (percent)	Baseline (percent)	Final (percent)	360-degree (percent)	Baseline (percent)
	Not yet competent	0	0	0	8.7	4	1.25	6.5
	Below average	13	0	0	10.7	6.5	6	25.2
	Average	35	45	20	36.7	19.5	35	47.2
	Above Average	37	45	80	28.3	23.2	35	18
	Fully competent	15	10	0	14.2	44	20.2	3
11. Knowledge Management: Must be able to promote and share knowledge, information, and lessons learnt, and applying theory into practice.								
	Not yet competent	0	0	0	5.8	4	.5	6.5
	Below average	11	0	0	19	5.7	5.5	29.2
	Average	45	33	0	45.5	26.5	33.7	42.2
	Above Average	40	58	20	20	26.7	35	18.5
	Fully competent	4	9	80	10	37.8	25	3.5
12. Strategic Leadership: *Must be able to provide vision, give direction and inspire others in order to deliver from an organizational mandate.*								
	Not yet competent	4	0	0	.5	0	.2	1.7
	Below average	17	0	20	10	0	5.5	5.7
	Average	41	33	20	30	14	28	47.7
	Above Average	32	42	40	28.7	33.7	36.5	37.2

		UP Cohort 1			UP Cohort 2			UP Cohort 3
	Level of Competence	Baseline (percent)	Final (percent)	360-degree (percent)	Baseline (percent)	Final (percent)	360-degree (percent)	Baseline (percent)
	Fully competent	6	25	20	19	52.5	29.7	7.7
13. Change Management: Must be able to initiate and support organisational transformation and change in order to successfully implement new initiatives and deliver on service delivery commitments.								
	Not yet competent	2	0	0	3	0	0	1.5
	Below average	24	0	0	13.5	0	3.7	11.5
	Average	41	33	50	42	19	31.5	50
	Above Average	24	67	25	27.5	39.5	38.2	33.2
	Fully competent	9	0	25	12.5	41.5	27	5.5
14. Service Delivery Innovation (SDI): Must be competent in process integration, policies and structures across the organization to achieve improved efficiency and effectiveness on SDI and implement new ways of performing tasks and develop the organizational as a whole.								
	Not yet competent	7	0	0	3	0	0	.5
	Below average	30	0	0	11.3	4.5	5.5	10
	Average	48	33	40	47	20.5	24	56.7
	Above Average	11	67	60	25.3	29.7	39	29
	Fully competent	4	0	0	13.5	45.2	32	4

Appendix 11: ASELPH Evaluation

Albertina Sisulu
Executive Leadership
Programme in Health
Excellence, Innovation, Transformation

AN INDEPENDENT EVALUATION OF THE ASELPH PROGRAMME

The Albertina Sisulu Executive Leadership Programme in Health, also known as ASELPH, is a capacity development programme dedicated to improving South Africa's public health system. Founded in 2012 and launched by South African Minister of Health, Dr Aaron Motsoaledi, in May 2013, ASELPH is a groundbreaking international collaboration between South Africa's National Department of Health, the University of Pretoria, the University of Fort Hare, the Harvard T.H. Chan School of Public Health, and South Africa Partners. The ASELPH partners work together to provide world-class executive training to carefully selected leaders and managers responsible for healthcare provision and policy implementation in South Africa.

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Albertina Sisulu
Executive Leadership
Programme in Health
Excellence, Innovation, Transformation

A centerpiece of the programme is the ASELPH Executive Fellowship. ASELPH Executive Fellows enroll in either a Master's Degree in Public Health at the University of Fort Hare (UFH) or a Post-graduate Diploma in Health Systems Management – Executive Leadership at the University of Pretoria (UP). ASELPH and its South African academic partners developed these postgraduate academic programmes with the extensive support of Harvard's T.H. Chan School of Public Health and their faculty, who offered their expertise and hands-on guidance. A unique feature of ASELPH's academic programmes is the use of specially developed South African case studies, using the Harvard case study teaching approach, which stimulate robust discussion and vitally needed problem-solving of the country's pressing and emerging health challenges.

ASELPH Executive and Emerging Fellows are selected from a diverse, competitive national pool of applicants based on academic qualifications, relevance of current professional position, and a letter of recommendation from their Provincial Department of Health (DOH), among other criteria.

Upon graduation, ASELPH Fellows become part of a growing alumni association that provides ongoing networking opportunities. ASELPH Alumni Fellows can choose to serve as Mentors for incoming Fellows, helping to instill key attitudes and approaches foundational to the ASELPH method, while also cultivating a sense of community amongst current and emerging leaders in the healthcare arena. ASELPH Fellows and Alumni also bring their valuable learning into their own workplaces, transferring knowledge and skills gained in the programme to their colleagues and employees, thereby helping to build internal capacity in these organisations and in the healthcare system at large. ASELPH graduates have even been recruited by the partner universities to assist with teaching modules that fall under their specific areas of specialisation.

Additionally, ASELPH offers a growing array of online E-learning components designed to enhance and supplement the classroom experience and deepen learning. These include online access to course materials and classroom lectures as well as opportunities for in-depth online exchanges with academic faculty as well as peers.

After four years of operations, ASELPH commissioned the Public Health Agency to conduct a wholly independent evaluation of the programme. This document offers a summary of their findings as well as background information on ASELPH.

"I came into a situation where the quality of health care was poor, infrastructure was neglected, and stakeholder confidence was low. Staff were angry and demoralised. ASELPH helped me to focus on the people, what we are supposed to be doing, and get people to concentrate on our core business of quality care. This, linked to operational efficiency, has led to a turnaround at the Frere Hospital Complex." – Rolene Wagner, ASELPH Fellow and CEO of Frere Hospital Complex, East London, Eastern Cape.

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BACKGROUND AND MANAGENMENT

ASELPH was founded to support the South African DOH, in its efforts to improve the nation's public health by transforming healthcare delivery. ASELPH and its partners are aiding in this transformation by educating and training leaders and executive managers in the public health sector. Envisioned as a flagship programme, ASELPH was designed to address critical competency gaps, while setting a new standard for executive-level education and training in South Africa.

ASELPH was named in memory of Albertina Sisulu, a beloved leader of the anti-apartheid struggle, who fought for freedom and equality for all South Africans. Revered by many, "Ma Sisulu" was also a nurse, educator, wife, and mother who worked to improve the health and well-being of her patients, students, community, and country.

ASELPH was established with funding from The Atlantic Philanthropies, ELMA Philanthropies, and the United States Agency for International Development. The programme is guided by a steering committee chaired by Dr Gail Andrews, the National DOH's Chief Operating Officer. The steering committee includes representatives from each partner organisation, the national and provincial DOH, key funders, and the Sisulu family, as well as independent health experts from the private sector and parastatal agencies. ASELPH was launched publicly in 2013 by South Africa's Minister of Health, Dr Aaron Motsoaledi.

GOALS, OBJECTIVES, AND PROGRAMME COMPONENTS

ASELPH's central goal is to improve South Africa's public health by training, developing, and empowering local and national healthcare leaders and managers, thereby increasing their skills and strengthening their abilities to respond effectively to contemporary health challenges. Working in consultation and partnership with South Africa's National DOH, ASELPH:

- Builds capacity at South African universities to offer world-class postgraduate education and training in executive leadership and management in public health;
- Improves the healthcare system by building a critical mass of leaders who are capable of the sound judgment and decision-making necessary to improve the delivery of health services;
- Conducts applied research in crucial public health issues and policy initiatives;
- Hosts policy seminars and roundtables on vital public health concerns, reaching the broader professional community.

ASELPH strives to accomplish its overarching goal by focusing on six strategic objectives, each with specific key programme components and activities.

Objective One: Assist current and emerging national, district, and local healthcare leaders and managers to develop essential leadership skills, core competencies, and critical knowledge.

Key Programme Components and Activities

- Establish and maintain the ASELPH Executive Fellows programme, the Postgraduate Diploma at the University of Pretoria, and the Master's Degree Program at the University of Fort Hare;

- Develop a viable E-learning platform, including video-learning capabilities;
- Establish a mentoring programme.

Objective Two: Improve policy implementation strategies through advancing understanding of political and organisational contexts as well as of crosscutting issues that underpin decision-making and implementation.

Key Programme Components and Activities

- Conduct policy seminars and roundtable discussions on relevant policy issues;
- Ensure that ASELPH is responsive to current events, emerging health problems, and relevant political issues.

Objective Three: Promote and maintain high standards for service delivery at the national, district, and community level.

Key Programme Components and Activities

- Develop academic faculty who are able to conduct original research into strategic health policy issues and health system challenges, contributing to broadening academic literature on South African and global health system theory.

Objective Four: Build a pipeline for executive leadership, ensuring the continuous development of new healthcare talent, by increasing the capacity of South African educational institutions and their faculties to provide outstanding training and education. This includes increasing faculty capacity to develop curricula and to offer effective distance learning by training them in distance teaching techniques and the utilisation of new technology.

Key Programme Components and Activities

- Develop faculty capacity;
- Develop courses and relevant case studies;
- Offer management oversight on course preparation and instruction.

Objective Five: Manage ASELPH efficiently and effectively through good governance, accountability to funders, maintaining partnerships, and clear communication.

Key Programme Components and Activities

- Convene regular partner and steering committee meetings;
- Establish memoranda of agreement;
- Maintain positive funder relations and seek new funding opportunities;
- Conduct monitoring and evaluation;
- Provide financial and narrative reports;
- Develop and implement communications plans.

Objective Six: Insure ASELPH's sustainability beyond the initial funding period.

Key Programme Components and Activities

- Develop a stakeholder network;
- Manage and promote alumni relations;
- Maintain quality assurance of the academic programme;
- Develop an effective system for knowledge management.

ASELPH's high-level international partnerships have enabled the programme to make meaningful strides in building the capacity of individuals and organisations within the healthcare sector, while increasing the academic expertise needed to expand executive-level training within the country.

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EVALUATION

The Public Health Agency took a consultative and participatory approach to conducting their evaluation of ASELPH. At the evaluation's inception, consultative workshops were held with representatives from the three universities as well as South Africa Partners. The preliminary data analysis was followed by a broader consultation with all ASELPH stakeholders to determine the scope and focus of the evaluation, clarify the programme's logic and principles, identify existing data and lists of potential key evaluation participants, and deliberate on what evaluation activities were feasible to conduct with the allocated resources, as well as to prioritise evaluation questions.

The Public Health Agency conducted individual and group interviews as well as observational site visits with multiple stakeholders and beneficiaries directly and indirectly associated with ASELPH. A total of 90 people were interviewed, including current ASELPH Fellows and Alumni and their professional colleagues, core and emerging faculty, other academics, programme partners, and funders.

Additional data studied included: case studies; 360-degree feedback reports; individual course evaluation reports from students; student assessment results and progress reports; evidence of implementation of student projects and how these have strengthened systems and/or improved health outcomes; programme documents such as work plans; policies, procedures, job descriptions, and partnership agreements; quarterly and annual reports; budget and expenditure reports; evidence of capacitation of faculty; E-learning upgrades; video-conference seminars; and minutes of E-learning meetings.

The evaluation was intended as an outcomes assessment, yet the time ASELPH Fellows and Alumni have had to implement initiatives (a maximum of 18 months) was too limited a duration in which to achieve significant organisational change and resulting major improvements in public health. Nonetheless, positive impact has been achieved and observed.

LESSONS LEARNED

In response to key questions about the ASELPH programme: What worked well? What did not work so well? What are the key lessons? The most commonly expressed views included:

1. ASELPH's approach to both teaching and learning is exceptional.

   All respondent groups described the pedagogy employed in the ASELPH Fellows programme in glowing terms. Outstanding features cited included: the ways in which ASELPH promotes peer learning; the applicability of tools and methods taught to real life situations; and the focus on training executive leadership rather than a generic approach to public health that includes leadership training.

2. There are tremendous benefits from an academic strategy to drive development.

   ASELPH was conceptualised as a development programme that uses a unique academic training approach as the vehicle to contribute to improved health service delivery and, ultimately, improved public health outcomes. The focus during its first phase has been on establishing the academic programme and monitoring its progress as well as self-reported changes in leadership competency.

3. Partnership with the National DOH allows ASELPH to fulfill its mandate of responsiveness.

   One particular strength of ASELPH's model is the integral involvement of the National DOH as a partner and

having a DOH representative chair the ASELPH steering committee. This direct engagement makes it easier for ASELPH to fulfill its mandate of being responsive to DOH's policy imperatives and implementation priorities, and therefore makes ASELPH even more relevant for its Fellows.

4. Partnership requires collective ownership and responsibility and the continual strengthening of all partners.

The ASELPH academic partners were chosen deliberately for their individual strengths as well as with a long-term goal of equity, utilising the programme to further strengthen a historically disadvantaged university. Since UFH has fewer resources in terms of staff and infrastructure than its counterparts, more focus needs to be placed on UFH to enhance its capacity to deliver a quality ASELPH experience.

5. The careful selection of Fellows enhances the overall quality of the learning experience.

The ASELPH Fellows selection criteria and process is working well. There is real professional diversity in the programme, including representation from hospitals, health programmes, support systems, human resources, and finance as well as a mix of policy makers and implementers. This enhances the Fellows' understanding of the public health system as a whole and also illuminates their own role within it.

6. Support from senior provincial DOH managers is vital and enables ASELPH Fellows to bring constructive change to their workplaces.

This support should be continued and should be cultivated and strengthened where necessary, as it is vital in ensuring ASELPH Fellows can fully apply what they have learned from the programme.

7. There is a need to measure faculty development.

The South African ASELPH faculty, as well as the Fellows, report increased competence and confidence from their involvement in ASELPH. Still, it is important to create a framework and establish criteria for faculty competency against which development can be measured over time as a result of exposure to ASELPH.

8. Local research would strengthen case studies.

Information gleaned from the applied research conducted by ASELPH Fellows could be used to develop new case studies and inform course materials, thereby helping to ensure that the ASELPH curricula remains relevant and up-to-date.

"Through ASELPH, I gained sound understanding of the evolving South African healthcare system and I am equipped with the skills and competencies necessary to make decisions based on sound evidence that responds to the healthcare service needs." – ASELPH Fellow

RECOMMENDATIONS

The Public Health Agency, in summation of their independent evaluation, *strongly recommended that ASELPH's programme and partnership continue.*

Other recommendations include:

1. Now that ASELPH's academic programme has been established successfully, consider reviewing the partnership model in order to determine the best fit for the next phase of the programme. For example, it may be time to establish an independent body to house ASELPH, which would also provide an opportunity to review governance and build a framework to monitor and support the partnership as an integral component of this unique model.

2. Attention should be given to ensuring that ASELPH adopts an equity approach within the programme itself. This would mean establishing and/or strengthening the systems at UFH and UP and providing assistance and support as required for the effectiveness of the programme as well as to maintain the integrity of ASELPH as a whole.

3. ASELPH should enhance its potential to contribute to the South African health policy space by continuing to arrange policy seminars and roundtables on timely, topical issues. These could be decentralised to the provincial level and written up as policy briefs. Consideration should be given to registering these events for continuing professional development points and providing them as podcasts to increase exposure and application.

4. ASELPH should continue nurturing and expanding its relationship with the DOH at both the national and provincial levels. There should be interactions and report-backs to showcase programme achievements and to continue garnering support. ASELPH Fellows and Alumni should play an active part in these activities.

5. It is important to find a way to maintain the unique dimension that Harvard brought to the classroom. In addition to its quality assurance role, Harvard should still play a teaching role, even if reduced, as ASELPH Fellows valued very highly the interaction with Harvard faculty.

6. ASELPH should develop a more systematic and formalised approach to South African faculty development.

7. Blended learning, which incorporates both online E-learning and university-based learning, needs to be implemented evenly across the entire programme, in order to achieve a good balance between classroom education and the goal of reducing the number of days that ASELPH Fellows are away from their workplaces.

8. The mentoring component of the programme should be further developed and formalised both for ASELPH Fellows and faculty.

9. Knowledge management should be strengthened, specifically in monitoring ASELPH Fellows' activities outside of the classroom. This should include revisions based on 360-degree assessment pilots as well as the documentation of the ASELPH story and sharing lessons learned. Consideration should also be given to a follow-up evaluation of ASELPH Fellows once they have graduated (at three years and five years, for example) in order to monitor their progress and their contributions to the public health system.

10. The ASELPH Alumni Network should be formalised in order to ensure continued interaction between past, current, and future ASELPH Fellows.

11. ASELPH has the potential to make significant contributions to the health system and, ultimately, to help improve public health in South Africa. Therefore, there should be concerted efforts to mobilise the additional resources needed to support the continuation and consolidation of the programme as well as the adaptation and strengthening of weaker components.

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EVALUATION CONCLUSION

ASELPH has established itself as an important and necessary health executive leadership training programme, unique in method and content. Already, ASELPH is making a real contribution to strengthening South Africa's public health system and it has the potential to impact health even more significantly going forward, particularly if attention is given to the E-learning and post-classroom support components.

The establishment and maintenance of the Masters Programme at the University of Fort Hare and the Post-graduate Diploma at the University of Pretoria play a significant role in the programme sustainability.

ASELPH should definitely continue and strong efforts should be made to mobilise resources to support the next phase of the programme.

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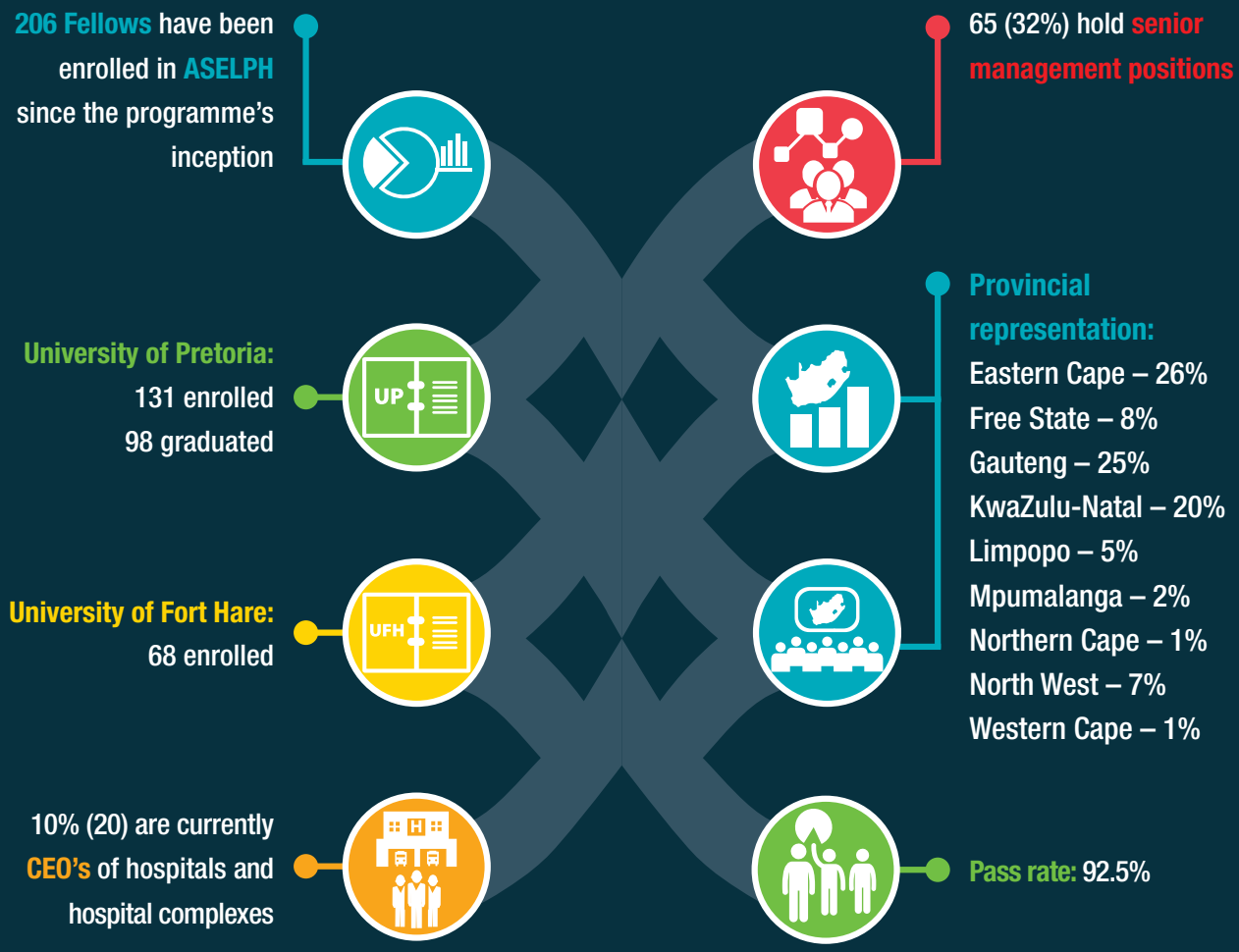
ASELPH STATISTICAL SNAPSHOT (2016)



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