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Case Study of the Ebony Park/Kaalfontein Community Health Centre

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Acronyms and Abbreviations

Capex	Capital Expenditure
CBD	Central Business District
CHC	Community Health Centre
COGTA	Cooperative Governance and Traditional Affairs
CoJ	City of Johannesburg
DHC	District Health Council
DHS	District Health System
DWC	Development Works Changemakers
GDS	Growth and Development Strategy
GVA	Gross Value Added
HDI	Human Development Index
ICT	Information Communication Technology
IDP	Integrated Development Plan
JDA	Johannesburg Development Agency
MEC	Member of the Executive Council
MMC	Member of the Mayoral Committee
MOU	Memorandum of Understanding
NHI	National Health Insurance
PHC	Primary Healthcare
SACN	South African Cities Network
SDBIP	Service Delivery and Budget Implementation Plan
SMME	Small Medium Micro Enterprise
USDG	Urban Settlements Development Grant

Introduction

The case study is set in the City of Johannesburg and deals with the upgrading of the Ebony Park/Kaalfontein Ideal Clinic into a community healthcare centre (CHC). The key distinction between these two healthcare facilities is that a CHC offers 24-hour services because it has casualty and maternity and obstetrics units. Furthermore, the case study scope is limited to infrastructure development, which includes extensions to existing structures but excludes furniture, fixtures, equipment and staffing.

Primarily healthcare delivery is based on an integrated "one-government" approach. The district healthcare system, which is the governance mechanism for delivering primary healthcare, is based on local and provincial government working closely together. However, joint planning, budgeting and infrastructure delivery are difficult for a host of reasons, including poorly synchronised decision-making structures, competing interests, and narrowly defined mandates and competencies of each government sphere. Consequently, the case study primarily explores the effect of intergovernmental relations between the municipal and provincial health departments on providing communities with the healthcare infrastructure that they require.

Another governance aspect of the case study is the power of community participation to hold government accountable for delivering infrastructure that is National Health Insurance (NHI) compliant. The case study touches on community activism being a catalyst for organisational change. Community pressure to address the delivery gap resulted in city and provincial officials working together, which fostered establishing relationships that have endured after the clinic was upgraded. These relationships have helped officials to work more collaboratively, even though the processes remain the same. Lastly, the case study looks at community credibility and trust of the city, which is held accountable for poor government service delivery but often has neither the mandate nor competency to address the community needs alone. It also lacks the convening power to get the other spheres of government involved before communities raise persistent delivery issues.

The case study is based on three principles. First, the case study is framed as a nuanced and local, city-specific insight on governance, as it is a vehicle for local practitioners to tell their stories in their own voice. Second, the governance focus is not on rule-based compliance, but on understanding how a system's configuration informs the selection, implementation and outcomes of interventions. Third, the case study is co-created with stakeholders, and this knowledge creation process encourages participation, reflection and co-ownership.

The first section briefly describes the city's spatial form and socioeconomic challenges, outlines its development strategy and provides a political overview that examines the impact of coalition politics on the city's ability to implement its development strategy. The second section delves into the Ebony Park/Kaalfontein Clinic case study, providing background information and unpacking governance themes based on the SACN's four pillars, and concludes with governance insights drawn from the themes. The conclusion includes a high-level overview of governance focus areas that can form the part of a future governance agenda.

Municipality Overview and Contextualisation (2016–2020)

Technical Considerations

The City of Johannesburg has seven administrative regions, each with a distinct socioeconomic profile (COGTA, 2020):

- Region A: The northern region whose economic centre is Midrand and the location of telecommunications, professional services and distribution/logistics companies, with the townships of Diepsloot and Ivory Park lying on the outskirts.
- Region B: The established central northern business districts (e.g. Parktown, Randburg and Northcliff) where economic activity has stagnated since 2008, that are home to mostly middle-income suburbs (including Riverlea, a former "coloured" township).
- Region C: The West Rand whose main hub is Roodepoort and contains the Kagiso informal settlement and Northcliff area, which divide the more affluent areas from the informal settlements (e.g. Doornkop) that are concentrated in the region's southern area. Large-scale industrial and warehousing activities are predominant in this region.

- Region D: The location of the majority of informal settlements and includes Soweto. It has attracted large industry, mostly manufacturing, but since 2008 socioeconomic conditions have deteriorated, as manufacturing jobs were lost. The region has the highest unemployment and poverty rate and the second lowest human development index (HDI) in the city (CoJ, 2020c).
- Region E: A microcosm of South Africa's stark socioeconomic differences, which contains Sandton, the economic powerhouse of Africa, home to blue-chip companies and the Johannesburg Stock Exchange (JSE), and Alexandra, one of the country's oldest and poorest informal settlements.
- Region F: Once the economic hub of the city, which includes the Johannesburg Central Business District and areas (such as Alberton) that border the City of Ekurhuleni. Since 2008, economic activity (manufacturing) and the inner city have declined.
- Region G: In the south, the city's second most populated area includes densely populated areas, such as Eldorado Park, Ennerdale, Lenasia and Orange Farm, with poor socioeconomic conditions and the lowest HDI in 2019 (CoJ, 2020c).

Figure 1: Regions in the Johannesburg Metropolitan Municipality

Source: COGTA (2020: 8)

Demographics

In 2019, the city's population was 5.7 million people (CoJ, 2020a), of which about 40% were 25–44 years old (COGTA, 2020). The majority of the population is classified as semi-skilled labour, but trends indicate a shift toward a higher skill base. The population profile reflects Johannesburg, as the cultural, economic and innovation hub of South Africa where people, many from other provinces, come looking for opportunities. Approximately a third of the population were born in other provinces (CoJ, 2020a). Migration patterns have significantly affected the city's development path, which has ramifications for service delivery demands and financial sustainability. Between 2011 and 2019, the annual population growth rate steadily declined, from 3.5% to 2.4% (COGTA, 2020).

Socioeconomic trends

The City of Johannesburg is the largest metropolitan municipality in South Africa in terms of population size and economic activity measured as gross value added (GVA). However, an unsustainable growth path, macroeconomic shocks and spatial inequality have created a cycle of high unemployment, poverty and inequality.

The JSE, which is the largest stock exchange on the continent and the sixteenth largest globally, is the bedrock on which a sophisticated finance sector has been built. This sector is the largest contributor to GVA and employment in the city: in 2018, the sector accounted for 28.1% of total GVA and 21.6% of formal jobs, or 77% of total employment (COGTA, 2020). The sector also has a substantial indirect impact on the economy through the provision of professional services and conferences, etc.

The rate of unemployment has steadily increased, reaching its highest level of 32.7% in the October–December 2019 quarter. A combination of factors is responsible for this high rate:

- The creation of too few jobs to absorb people entering into the job market because of a falling economic growth rate, which was 0.97% in 2019 compared to 2.5% in 2011 (CoJ, 2020c).
- A mismatch between the skill profile of the population and the demand for highly skilled workers in the formal sector, which arises from a structural change in the nature of economic activity and the poor education system.
- An underdeveloped informal sector, which means people are restricted to formal sector options.
- The majority of the population living in high-density, isolated residential areas on the periphery of the city, where services and jobs are limited and with inadequate access to safe, reliable transport into social, economic and cultural centres scattered across the city.

Basic service provision

The city has a strong track record[1] of basic service delivery. In 2018, delivery to formal and informal households reached over 90%: 98.8% for piped water, 96.4% for sanitation and 92.3% for electricity (CoJ, 2020a). However, these rates masked significant service backlogs in townships "where less than half of the households have access to basic sanitation" (ibid: 34). In contrast to other basic services, refuse removal backlogs, as a percentage of total households, have increased from 2007 to 2016, since when they have plateaued at 5.2%. (CoJ, 2020a).

Table 1: Delivery of basic services to households (2018)

Basic service	Households serviced	Approximate household backlog (number)	Service backlog
Housing (formal)	75.15%	448 200	24.90%
Water	98.80%	22 200	1.20%
Sanitation	96.40%	66 601	3.60%
Electricity	92.30%	133 540	7.70%
Refuse removal	92.90%	131 352	7.10%

Note: Households serviced and service backlog is a percentage of total households
Source: CoJ (2020a: 35)

Another issue facing the city is providing households with reliable services in an environment where ageing infrastructure requires constant maintenance or replacement under a constrained budget. The logic applies both to energy provision now and to waste and water management systems in the near future.

The housing backlog[2] is a challenge and households living in informal settlements have steadily increased since 2017. In 2018, "the formal dwelling backlog was 24.9% […] and the backlog as a proportion of total household dwelling units has been growing at a rate of about 1.81% annually" (CoJ, 2020a: 34). A conservative estimate of the housing backlog is 448 200 units, whereas on average 3500 housing units are delivered annually (CoJ, 2020a).

Financial performance

Roughly half of the city's revenue comes from service charges (water, electricity, refuse removal and sanitation), while property rates and government grants each contribute about a fifth to the city's revenue (CoJ, 2020b). The city's capacity to generate revenue is under pressure because of macroeconomic and city-level factors. South Africa's economic fundamentals are weak and deteriorating, and have negatively affected individuals' disposable income. With less disposable income, individuals consume fewer municipal services and battle to pay for them.[3] Another factor is the poor condition of the city's asset base: "City Power and Johannesburg Water continue to have above normal levels of technical losses that is above the industry norms and warrant aggressive interventions" (CoJ, 2020b: 144). In addition to technical weaknesses, financial-administrative systems dealing with billing for services and revenue collection are problematic, despite the city implementing many corrective interventions.

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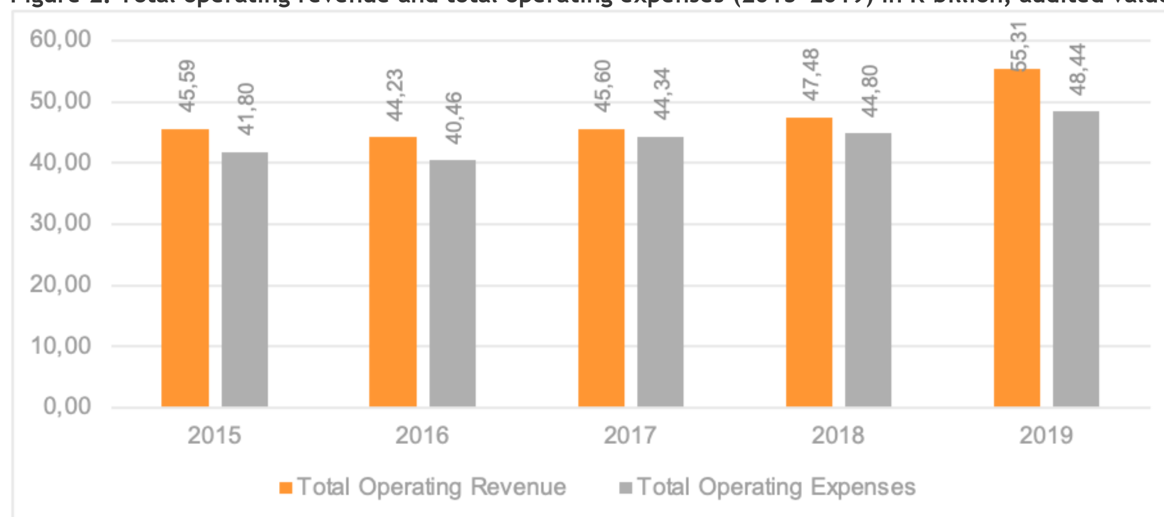
[1] Since 2007, the water and sanitation backlogs as a percentage of total households have steadily declined but started to plateau from 2016.
[2] In its 2020/2021 IDP, the city defines the housing backlog as informal settlements, overcrowding in the hostels, non-regulated backyard rentals, inner city overcrowding and homeless people in general.
[3] The city's total consumer debtors increased by 12% from 2017/17 to 2019/18 (CoJ, 2020b: 348).

Figure 2: Total operating revenue and total operating expenses (2015–2019) in R-billion, audited values



Source: https://municipalmoney.gov.za/profiles/municipality-JHB-city-of-johannesburg/

The city's liquidity level is under strain because net revenue growth is poor and payment for services is slow (Table 2).

Table 2: Financial indicators (2015/16–2018/19)

Description	Metric	2015–2016	2016–2017	2017–2018	2018–2019	National Treasury target to achieve green status	Status
Cash coverage	Ratio	1.3	0.8	0.6	1.3	Above 3 months	
Operating budget spending	%	-5.8	-2.1	-4.4	-5.2	Between 0% to 5% of budget	
Capital budget spending	%	-4.9	-22.55	-6.87	-5.1	Between 0% to 5% of budget	
Repairs & maintenance spending	%	2.92	4.6	4.03	4.6	Above 8% of property, plant & equipment value	
Current ratio	Ratio	0.87	0.7	0.76	1.07	Greater than 1.5	
Liquidity ratio	Ratio	0.31	0.18	0.15	0.36	Greater than 1	
Current debtor's collection rate	%	92.29	89.08	92.4	90	Greater than 95%	

Source: https://municipalmoney.gov.za/profiles/municipality-JHB-city-of-johannesburg/

The city is implementing a cost containment strategy,[4] focusing on the wage bill and maximising operational efficiency gains. However, to strengthen the financial position will require breaking the dynamic between low net revenue (Figure 1), tighter liquidity and lower expenditure on maintaining/upgrading revenue-generating assets. This dynamic is common across metropolitan municipalities (metros), and breaking it requires an intervention beyond the city level because it involves revisiting the premises underpinning the municipal finance model (e.g. new revenue sources and broader financing mechanism for capital programmes).

Strategic development approach

The Joburg 2040 Growth and Development Strategy (GDS) is the long-term strategy that informs its Integrated Development Plan (IDP). The GDS has four outcomes (CoJ, 2020a: 63):

> Outcome 1: Improved quality of life and development-driven resilience for all to enable self-sustainability, improved health and life expectancy, and real social inclusivity by implementing interventions that target poverty reduction, food security, development initiatives to enable self-sustainability, improved health and life expectancy, and real social inclusivity.

[4] According to the CoJ (2020a: 143) "With the consequences of decisions of the past materialising in the 2020/21 medium term budget, there is a need to introduce measures that should contain the outpacing of expenses in line items such as employee related costs and contracted services to at least match the growth rates of the revenue sources. First and foremost, the ratio between operational and capital expenditure in line with Circular 71 of the MFMA needs to be maintained".

> Outcome 2: Provide a resilient, liveable, sustainable urban environment – underpinned by smart infrastructure supportive of a low carbon economy where the city leads the establishment of sustainable and eco-efficient infrastructure solutions in housing, basic services and ICT.
>
> Outcome 3: An inclusive, job-intensive, resilient, competitive and smart economy that harnesses the potential of citizens.
>
> Outcome 4: A high performing metropolitan government that proactively contributes to and builds a sustainable, socially inclusive, locally integrated and globally competitive Gauteng City Region.

To achieve these outcomes, the city has identified 11 strategic medium- and short-term priorities that were selected "to accelerate service delivery, create an enabling environment to stimulate economic growth, create liveable urban spaces, create an administration that is resilient and sustainable for future residents of the City" (CoJ, 2020a: 64):

- Priority 1: Financial sustainability,
- Priority 2: Good governance,
- Priority 3: Integrated sustainable human settlements,
- Priority 4: Sustainable service delivery,
- Priority 5: Economic development,
- Priority 6: Safer city,
- Priority 7: Job opportunity and creation,
- Priority 8: Active and engaged citizenry,
- Priority 9: Sustainable environmental development,
- Priority 10: Smart City, and
- Priority 11: Minimising the impact of the COVID-19 pandemic.

An infrastructure-led model underpins the city's development approach, whereby the city's core responsibility is to create a conducive investment environment in order to attract and retain private sector capital. The common theme running through the 11 strategic priorities is that the city needs to lead capital investment, as investing in primarily infrastructure (basic and business) and creating a polycentric urban form[5] will produce an environment that unlocks private capital.

The Co-created Governance Narrative

The Ebony Park/Kaalfontein CHC

Since 1992, the community had been complaining that the Ebony Park/Kaalfontein five-room consultation clinic was inadequate to meet the demand for health services in Region A. The closest and best alternative healthcare option was Tembisa Hospital, in the City of Ekurhuleni, which is only accessible using limited and expensive transport. Therefore, the community asked that the Ebony Park/Kaalfontein clinic be upgraded to include a maternity and obstetrics unit and a 24-hour emergency facility. In addition, in 2013, the Head of Tembisa Hospital informed senior city and provincial leadership (director-level officials) that people from Region A "flooded" the hospital, resulting in an overflow of patients, and was especially problematic when the Ebony Park/Kaalfontein clinic closed at four o'clock and over weekends.

City officials also realised that the Ebony Park/Kaalfontein clinic did not meet community needs or comply with national healthcare standards, acknowledging that the facilities were small and would be made bigger using "the medium-term budget for local government" in order to "start accommodating the ideal clinic requirements in working towards the NHI standards".

In 2013, the city had not allocated a budget to upgrade the clinic despite the community expressing their need. Dissatisfaction reached its limit when the city did not respond to the petition submitted by the community. The community then "called the Member of the Mayoral Committee (MMC) to come and see the state of the facility at Ebony Park". After this, the clinic was "listed as a project that could be considered in the [city's] medium-term budget".

As a consequence, the city began the process to upgrade the Ebony Park/Kaalfontein clinic. A consultant was hired to design the facility in line with Ideal Clinic standards. On multiple occasions, the city invited the

[5] The city is allocating approximately 30% of the 2020/21 draft capital budget to spatially targeted investment areas, which is still in alignment to the strategic areas identified for development and investment, mainly the inner city, Corridors of Freedom, informal and deprivation areas and secondary economic nodes.

provincial Infrastructure Development Unit to participate in planning the clinic, "so that if you want to develop it into a community health centre from a clinic, we can draw a plan so we can have like a phase one, phase two and phase three". The city contacted various other provincial officials, including chief directors at the provincial head office and the Johannesburg District Office, to invite them to get involved. However, the city received no reply from province and so decided to proceed with the planning of the clinic. In addition to the initial communications sent to various provincial health department roleplayers, several follow-ups were made but did not have the desired results.

> There was very little that we [the city] could do. I mean, if you've written and then people are not responding, there is practically very little that we can do. You will complain about it and formalise a complaint, but that's where it ends.

These sort of challenges can be escalated to the District Health Council (DHC), which is chaired by the MMC for Health and embodies the political-administrative interface. Local and provincial government are connected through the DHC and the Provincial Health Council, which is chaired by the Provincial MEC for Health. However, the DHC was not fully operational when initial planning for the clinic took place, as "during this term of the administration, the process was put on hold, there were amendments being done in terms of terms of reference".

Political changes may have affected the dynamics of key structures at the time of planning and constructing the clinic, and some of these issues have been resolved since then. When the City of Joburg experienced coalition government for the first time, "with the DA and the EFF and other smaller parties in power", the feasibility study and budgeting for the Ebony Park project had been completed, and so the technical work could continue as planned: "it didn't affect anything with us in the administration side of the city to implement what we have embarked on". However, these political changes "may have contributed to difficulties to get alignment between how intergovernmental structures functioned".

> There might be political will in some instances to push certain projects in certain areas because of the political will, because of what is behind it all, I think we should say, that we normally use our 5-to-10-year plan, and we say this is what we are setting out to do, because we know the needs of the community. However, the political interface between the coalition government, and the provincial government which was the ANC, there could have been […] mis-communication, certain things that did not happen […] the Provincial District Health Council that did not sit […] the lack of communication between MMC and MEC.

Local government's mandate is to provide primary healthcare services and to meet community needs, such as a request to expand a small clinic.

> [The city is] purely running primary healthcare clinics that are more preventative and promotive, even though we are now doing the curative aspect in terms of the acute and chronic cases, like the hypertension, if they are controlled, they are managed at primary healthcare level, versus uncontrolled, which are hospital cases, and that is why there are different levels of care. There are different levels of care – health post, mobile unit, clinic, community healthcare centre, District Hospital, Regional Hospital and Academic hospital up to Tertiary levels.

The city has the mandate to build and operate an Ideal Clinic, which can have an emergency section with isolation, full antenatal services and a section to manage chronic and acute care, but not to provide a 24-hour healthcare service. The city can "extend service hours to accommodate the needs, but immediately when there is 24-hour maternity and obstetrics unit, that is the terrain of province". Only province has the mandate and capacity to run a 24-hour service. The city's limited mandate meant that it was powerless to intervene directly to address the community's needs. With no response or involvement from provincial government, the city signed off plans to construct an Ideal Clinic in accordance with NHI standards.[6]

In 2015/16, the city allocated a capital budget, and the construction of an Ideal Clinic for Ebony Park/Kaalfontein began. Prior to the clinic's completion, a senior city official gave the community a progress update. However, when the community realised that the new clinic did not have 24-hour services nor a maternity and obstetrics unit, they refused to accept the clinic. Political undercurrents in the community added to the challenges of getting traction.

> At Ebony Park there was also the political element because at that time the council was in the administration of the joint coalition of DA and ANC. […] And at that there was also a revolt from the community that was predominantly also from another political party to say that this clinic will never

[6] According to the NHI White Paper, an Ideal Clinic is a "clinic with good infrastructure (which is defined as: physical condition and spaces, essential equipment and information and communication tools), adequate staff, adequate medicine and supplies, good administrative processes and sufficient bulk supplies that use applicable clinical policies, protocols, guidelines as well as partner and stakeholder support, to ensure the provision of quality health services to the community".

> open, until we are assured of a 24-hour service including Maternity and Obstetrics Unit, casualty and maternity.

The community would not budge, as it

> felt that the project came in the old administration and the current coalition administration, they are not going to entertain them with just a piecemeal facility. And the new administration also wanted to show as local government that they could render a 24-hour service, which we indicated is the mandate of province. So, there was that backwards and forward.

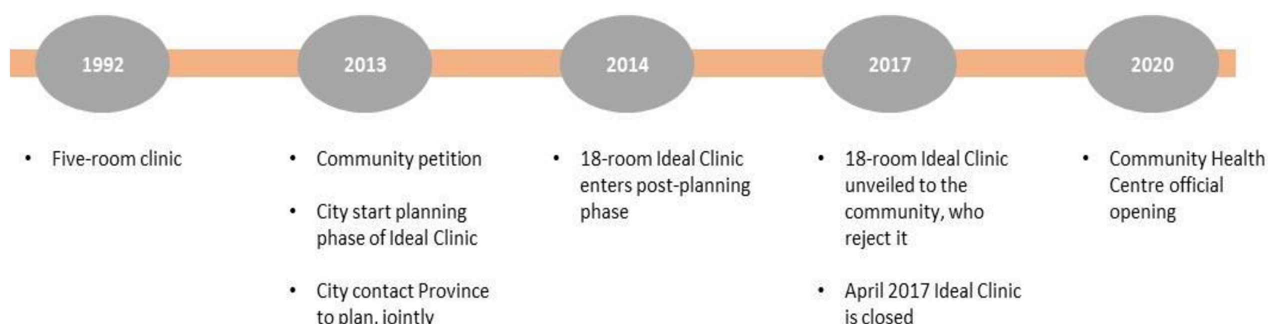
Facing a community backlash, a united city leadership contacted the Gauteng District Health leadership, which escalated the issue to the Office of the MEC. This resulted in the provincial government issuing a letter of intent for partnering with the city to deliver a CHC. On 20 February 2020, the Ebony Park/Kaalfontein CHC officially opened. Since then, the facility has been run jointly by the city and the province, demonstrating that local and provincial government can provide integrated service delivery and cooperate in joint operations.

> The city and province signed an SLA [service level agreement]. […] And the Chief Director of Province then […] wrote the letter of intent […]. And that then meant myself and my counterpart from province, together with [name of city official], sitting and saying how we're going to jointly manage the facility, because we knew that we [the city] cannot run a casualty and a maternity and obstetrics unit. Province had to then say, "leave that to us" […] and they brought the staff. […] They know the staffing requirements of providing a 24-hour service.

The city is in the progress of phasing out its involvement, and the provincial health department is expected to fully run the facility from March 2021.

> The whole facility will be rationalised to province because you cannot have two authorities running the same facility. The [city] is already in that process of phasing out. […] There is a task team working towards the handover. We are still one government. So, we hand everything over, the asset of the city. The only thing we continue as local government is to monitor those assets. So, they [province] will submit their monthly assessment report and we will send our asset officers to go and verify if their assets are still there in the facility, and when they reach their lifespan. The other issue we have agreed on is that once the city hands over the facility, province will then take over the payment of rates and taxes (water, electricity) and telephone calls.

Figure 3: Timeline of events



Source: Development Works Changemakers

Internal and External Governance Structures and Processes

The Ebony Park/Kaalfontein CHC is an example of how the mandates of local government and provincial government intersect to deliver services that meet the needs of communities.

City-level project planning, budgeting and implementing

The city's health team does not experience the budget process as being rigid, despite the city's clinic budget being "locked" for a three-year period, whereas NHI requirements for clinics and community needs are continuously evolving. There is scope for modifications after the budget and conceptual plan are approved, although a budget adjustment would be needed should the modifications require additional funding. Applying for this adjustment may delay the whole project and could reduce funding for other projects.

The health team has developed a four-stage prototype clinic infrastructure model that distils their learnings and experience. The stages are: site selection, feasibility (technical and environmental studies), planning and costing (conceptual blueprint and tender process) and construction. This model includes working with the Johannesburg Development Agency (JDA) as an implementing partner/project manager. Project learnings are

continuously incorporated into this model, and the city takes roughly three years to design and build an Ideal Clinic.

Coordination of city and provincial activities

Structures (e.g. district health committees and DHCs[7]) exist to enable information-sharing, communication, balanced decision-making and escalation of operational and project management issues to the political and administrative levels. The city health team's interaction and relationship with provincial officials was positive and responsive, except for the Infrastructure Development Unit, as one city official commented:

> Most of the time we struggle, even at our district meeting where we meet with province, to have their capital expenditure (capex) team being part of us, so that they can share [their medium capex plans] with us across the province to say which are capital projects that are earmarked so that we plan together. So, I think the way they are structured, it makes it very difficult.

Community engagement structures

The IDP participation process is the main vehicle for community engagement. For the city, this process strikes a balance between having "community conversations" and "vigorous identification of priorities". Needs are prioritised based on the areas of development that communities want the city to fund for the current financial year, after which the mayor visits and engages with communities "to get a sense of what their needs are". Other important structures are ward committees, clinic committees and CHC committees. Lastly, the Community Liaison Officer is the link between people on the ground and the healthcare facility.

The Governance Narratives

Cooperative governance

The challenges of mandates and the need for collaboration

The Ebony Park/Kaalfontein CHC story is to some extent a "metaphor for the frustrations of communities" and an example of how communities "are fighting it out with the state" at local government level. Local government usually bears the brunt of the anger of communities over service delivery, even when it does not have the resources or mandate to address the community needs. In the case of the Ebony Park/Kaalfontein CHC, the City of Johannesburg had neither the resources nor mandate and, despite navigating within the current intergovernmental system to access resources, received no response (as described below).

City sits with the full responsibility, but has limited resources and mandate

After approving the budget and land, the city reached out to the provincial infrastructure development team about jointly planning the healthcare facility. The city's intention was to plan ahead and to ensure that infrastructure being built today had the capacity to meet tomorrow's needs.

The city understood that provincial government might not have the budget available because "maybe our [city] prioritisation might not be the same". However, budgeting issues should not hinder joint building, as building the facility could be an incremental process:

> So we can build [an Ideal Clinic] and then maybe yours can be phase two and phase three [to build a CHC]. We thought if it is in the drawings, as and when they have money and then they can come in and add those sections.

As the provincial infrastructure development team decided not to plan jointly, the city drew up plans for an Ideal Clinic and did not include permutations for extensions to incorporate a CHC at a later stage.

> The city's challenge is we sit with the need, but satisfying it is outside our mandate and competency. And what we could do, we did. We went to province. We invited them to join the community meetings. To say to the community, is it doable or not. […] But we are willing, so are our politicians, at that time, and even now we're willing to say, let's hear from province; if province is willing, then it can be done.

Joint city-provincial planning and budgeting are crucial to address community frustrations by alleviating service delivery pressure points, especially in densifying urban areas where the population is growing rapidly and communities do not have access to 24-hour health services. Collaboration brings together the city's and

[7] Each district has a DHC, which is appointed by the MEC for health in consultation with the MEC for local government. The DHC includes representatives of the district, metropolitan and local municipalities. The council must "ensure co-ordination of planning, budgeting, provisioning and monitoring of all health services that affect residents of the health district" (Christmas, 2008: 1–2).

province's different strengths and is the only way to build healthcare infrastructure that meets community needs and NHI standards.

Province has access to financial resources, skills and the mandate to deliver a 24-hour healthcare facility, while the city is best positioned to understand the community's need for healthcare infrastructure because it has access to on-the-ground intelligence. Through local government structures, ward committees and the IDP consultation process, local government has direct access to communities and is able to collect granular data on their needs. Both province and the city appreciate each other's strengths and, in theory, see the need and want to develop infrastructure jointly.

> I think joint planning is very, very crucial for any project that involves a clinic. And I like the idea that she is saying we could be saying as local government, we have 15 million, and for this kind of facility, we [...] province would say if you want to have a community health centre, you will have to put an extra so much, and us as province, we could top up. That would be brilliant, and in future we […] if it can be like that, if we can address needs in communities, especially in areas where we are densely populated [where] there is no 24-hour service.

The ability to engage in joint planning is limited for both province and the city. Examples of joint action are sporadic and in response to pressure (usually an event). The reality is that city officials do not know the province's health infrastructure plans, and provincial officials do not know the city's health infrastructure plans. One city official commented "let the documents be available, so that we can also see what province is planning for infrastructure. That is where the alignment can also come, and the joint planning can be more emphasised".

The perceived hierarchy within the government spheres means that the provincial government may not always recognise the value of local government's data on community needs, which results in essential data on community needs "getting lost" in the system. The city is tuned into the needs of communities through ongoing communication with community structures, while community needs inform the IDP. However, local government does not have the mandate to deliver on all community needs and while the city may share its IDP, the provincial government has its own priorities.

> I think what I am taking home is that we need to make an investigation that says: "at what stage should province come in as far as infrastructure is concerned". Because we had similar cases, where we said, "Why can't we plan together? What makes province not to come to the party?"
>
> It does not make sense that we [provincial government] only respond when local government is having a crisis that they encounter.

Engagements with the city showed that joint planning opportunities are possible, provided officials are able to navigate the current system. Officials also feel more comfortable with a formal joint infrastructure planning system. However, while such a system has merits, its absence should not be the reason for not collaborating.

> The city's [healthcare infrastructure development] priorities are not aligned to provincial priorities and vice versa. [...] I am thinking we should put a system, I am saying a system specifically, a system of joint planning, we should put that in place, where we have a sort of an agreement, how we are pulling together.

Participants acknowledged the connection between substantive joint planning activities (which involve more than attending committees and commenting on plans) and building stronger working relationships based on trust and accountability. They also stressed that providing healthcare delivery in the future will become more complicated, as backlogs are growing, needs are evolving and the fiscal space is shrinking. However, on the positive side, local government's greater role in primary healthcare provision and technological developments create space for innovation. In the medium term, organisational innovation will be needed in order to manage the complexities of healthcare provision, by helping actors integrate insights, budgets, activities, procedures and systems across the spheres of government. Also important is to build the organisation's agility and flexibility, so that it is able to respond to environmental factors and adapt.

The need for city and province to work together is not limited to planning for health (and other) infrastructure. Under the one healthcare service, joint government action is required, as one sphere may build the facility, but another sphere operates it. As mentioned, plans are in place to transfer the CHC to province. However, poorly aligned operating systems and procedures have complicated this transfer, which raises the issue of harmonising operating systems. Efficiencies could be significantly enhanced through integrating operating systems across spheres, to ensure the holistic delivery of "one health system".

> There is no interoperability between province and local government, in terms of systems, because we had a challenge to determine whether we are rolling out the e-health or the health patients registration system. So, there are standards, which have been developed by the National Department of Health,

> which should allow for interoperability within the Health Act, and which speaks to the health information exchange. If province had to build to standards, […] when we are rolling out to a facility, we should not be having debate on which should be managing the system, whether it is local or provincial. So, I think that has to come out. That has not been resolved […] when it comes to the interoperability and the sharing of information between the two spheres of government.

The selection of operating systems also has implications for how infrastructure is designed. For example, the infrastructure planning will be different for a health facility that uses an e-Health system and for one that keeps manual records. A sub-theme to emerge in the case study is that planning for health facilities need to take into account future technological developments and requirements. The reality is that for productivity and efficiency to improve significantly will require enabling the interoperability standard, which harmonises different systems from different suppliers, meaning that the patient record can be accessed from any technology or system.

> That is the foundation. What keeps on happening is a recurring theme, all the way from national all the way down to facilities […] they have different systems, which are not inter-operating. […] So, I think when it comes to interoperability, the people who are making some of these decisions on the systems need to consult more widely, so that the theory of interoperability is achieved. […] interoperability is very different from an integrated system. An interoperable system is like your laptop, where you stick any device into it and it starts working. In the old days, if you stuck a device into your laptop, it would not work. We need to go into the future with an interoperable system, because technology changes on a daily basis. What works today won't work tomorrow.

Capacity of the State

Intergovernmental collective action enhances the capacity of the State

The delivery of health facilities in a city does not take place in a vacuum. Demographic trends determine what, where and when health infrastructure is needed. Health facilities are located in communities and form a part of the larger infrastructure picture for human settlements. Therefore, planning for health facilities should form an integral part of human settlement planning and, at the very minimum, the city health team should partner with human settlements when designing, planning and implementing infrastructure projects, and be a key participant in processes that inform the long-term spatial form and footprint of the city. Funding from the Urban Settlements Development Grant (USDG) was used to upgrade the Ebony Park/Kaalfontein clinic, and human settlements was instrumental in accessing these grants.

The city and provincial human settlements departments regularly interact on project management and monitoring issues. In addition, the city organises an annual integrated strategic planning session, usually in August, at which city departments and municipal-owned entities advise their planned projects for the next three years. After the session, the development planning department conducts one-on-one engagements with departments. Projects and their priority level are also captured on an electronic platform, the Joburg Strategic Infrastructure Platform (JSIP). Theoretically, the city's coordination mechanisms should ensure that the health department is drawn into strategic conversations and involved in the setting of medium-term priorities for the spatial planning and human settlement developments. However, despite asking to participate on many occasions, the department is not included in spatial planning discussions, unless health officials initiate it.

> From where we are sitting, even in terms of human settlements, we are the ones in most incidences who are going out asking to be part and parcel of their meetings so that we begin to understand, just in terms of human settlement development where in the next three years are, they going to be building and in their spatial planning.

The health department's limited involvement in spatial planning and human settlement conversations has compromised its ability to provide services. It has resulted in the development of densely populated townships with no space to build a CHC. For example, the health department has "been battling for the last 10 years to 15 years to find a site in Cosmos City". For health officials to be able to fulfil their NHI obligations and provide vulnerable communities with accessible healthcare services, an integrated planning approach is required.

> We have asked them all the time. Can we please have a site to build a clinic because where you are developing houses, you need to have a site that is ringfenced for social amenities, but it's not happening, from us as health, we just a small voice [...] we say "guys, please consider, remember to have a site, where we can ideally have like a multipurpose centre where you can have social development offices, health, etcetera, where it's easy for the community to access those types of services". But no, it's still all very vertical planning. […] I've never been invited to a spatial planning meeting. […] It is still happening in a very fragmented, vertical way.

The city health department also feels that they do not have the clout to ensure that sites (land) for health facilities are made available as part of the development planning. Although integrated strategic planning and prioritisation mechanisms are in place, closer cooperation is needed between the city's human settlements and health departments.

> That is why the name was changed from housing to human settlements. It was exactly that it must not just look at one component of a human being, that a person has a variety of needs [...] but where is our best practice where this has actually happened.

An intermediary can bolster the capacity of the State

The health department uses the Johannesburg Development Agency (JDA) as an implementing agent. Working with JDA has increased efficiencies across the healthcare infrastructure value chain, which in turn has reduced delivery timeframes and costs, without sacrificing quality. Key efficiencies include simplified procurement processes and instant access to a wider range of pre-vetted, quality specialist services. Improved service delivery performance has resulted in greater budget allocations, which has enabled the health department to expand its infrastructure development programme.

The JDA–health department's infrastructure development model incorporates a "reflection and learning" process and is informed by national standards for primary healthcare facilities. A streamlined infrastructure development model has resulted from the combination of being under pressure to meet regulatory standards and updating lessons into the model. Implementing this model enables the city to initiate and complete an infrastructure development project within a five-year planning and budget cycle. End-to-end activities along the value chain are grouped into three sequential phases, and the duration and budget for each phase is defined. A predictable process allows the city and its partners to focus on what they do best and avoid overlapping mandates and duplicated efforts.

Having a streamlined infrastructure development model and a partnership with an intermediary enabled the city and province to respond quickly to the community's demands, and to convert the Ebony Park/Kaalfontein Ideal Clinic into a 24-hour CHC. This conversion required structural changes to be made to the clinic, which was funded by the provincial health department and supervised by the JDA.

> JDA was involved in an advisory capacity to work with the provincial infrastructure development technicians and specialists around terms of the building design and where they can break and not break [...] I think even the contractor was invited just on an advisory basis, so they can guide wherever they wanted to break.

> The project leader from JDA was very accommodating. […] They held regular meetings to keep us informed and include us in all aspects., such as sending over samples, accommodating high density files, signage inside the clinic. So, they will be able to adjust here and there in terms of their budget and to accommodate our needs and still remain within the budget. There was a lot of consultation and they knew that they cannot just do anything without us.

Based on the Ebony Park/Kaalfontein experience, health officials recognise that their infrastructure development model needs to include more community engagement, especially during the pre-planning and planning phases. Officials also see an opportunity to draw on the JDA's facilitation unit to improve community consultation processes and engagements. Furthermore, in the spirit of greater intergovernmental collaboration, the city sees the provincial government as their partner with working with JDA facilitators.

> The facilitation unit […] would get certain properties projects ready so that when we are ready to go to feasibility, planning and implementation, they would then come on board. [...] I think there is definitely more that we can do to push the planning, if we bring the JDA's facilitation people on board. And with the province, maybe even their central people that deal with projects, bring them on board. Maybe through our intergovernmental relations, we can also push for that.

Ethics and trust

Integrated service delivery through one health system cannot take place when cooperative governance among spheres fails, which negatively affects trust between the community and government. In addition, service delivery is about providing communities with the services they require, not with services that are designed to meet departmental service delivery and budget implementation plan (SDBIP) targets. The importance of this distinction is highlighted in the Ebony Park/Kaalfontein CHC case study. The city needs to be able to balance delivering services to (national) government standards (e.g. as articulated in the standards for the Ideal Clinic) and delivering services that meet the needs of communities. The city complied to NHS standards and is proud of having delivered according to these standards, but delivering health infrastructure "in the right way" is not enough if "the right service" does not meet the community's needs.

> The city, in terms of governing the deployment of Ebony was quite a high achiever, but in parallel with that, you can say that [from the perspective of the community] it was a low achiever. People can pick up that we have an anomaly here […] we think we are governing well, but perhaps we aren't.

The Ebony Park/Kaalfontein experience demonstrates the power of community participation as an oversight mechanism to hold officials and politicians accountable for delivering NHI-compliant infrastructure. The

community took action when poor intergovernmental cooperation between the city's health department and the province's infrastructure development team resulted in the delivery of healthcare infrastructure that was below the community's requirements as captured during the IDP participation process. The community's action had a catalytic impact on overcoming poor vertical intergovernmental linkages that were ingrained in the system (see box).

A positive spinoff from the Ebony Park/Kaalfontein experience is greater community empowerment. The community had to organise themselves, appointing leadership and creating communication structures that fed into formal community structures, such as ward committees and the district healthcare committee. By galvanising a unified government response, these grassroots structures gained credibility in the eyes of the community and the government. Over the years that it took to convert the Ebony Park/Kaalfontein Ideal Clinic into a CHC, these community structures have remained strong and active. Engaged community participation is essential for realising the benefits of the "one government healthcare approach". When communities holds officials accountable for delivery, it motivates interdepartmental collaboration and joint delivery teams.

> Communities are very vocal in terms of the Constitution around the issues of community development and participation. Communities are now saying you cannot do anything without consulting us, and that is very, very clear. That is why, even for a project to kick start in the community. You should have done all the spade work. The ward councillors should know, you must go to public meetings called by the ward councillor to address communities and tell them the plan. When the project starts, you need to bring JDA to come and present at a public meeting to communities to say: "This is the project, what is the cost of the project, and how is it going to benefit communities".

City officials realise that communities do not distinguish between government spheres and that the State should deliver services as one. Communities should not be burdened by which sphere of government is responsible for delivery services, when services that do not fall within the city's mandate are not delivered.

> I don't think it is the responsibility of the community to understand the dynamics between the two spheres of government. It is the responsibility of the government to come together and sort out their differences so that they render quality services to the community. We need to have a roundtable and say where do we meet each other, who must provide what services. I will give you an example using the Ebony Park/Kaalfontein clinic. Provincial government was supposed to say to local government: "how much money do you have to build a day clinic? We will top up in order to extend to 24 hours during the planning, so that when we implement, we implement jointly, one project". And as a community member, when I come to a clinic, I don't want to be given an explanation that says "this is local government, this is provincial government"; I just need a service.

The failure to deliver what the community needed was not due to a lack of communication between the various parties. There was communication between the city and the community, between the city and province (although this was not very effective), and between the city administration and politicians. The city was willing to listen to the community to understand their needs and to work with the province to deliver what the community needed, but was constrained by its limited mandate that did not extend to providing 24-hour services.

> We kept on informing communities that 24-hour service unfortunately is not a competence of local government; however, your issues will be taken up. So, it's not like we totally failed our community in terms of lifting their needs. […] we knew very well that the community wanted a 24-hour service which is a competency of province. I just wanted to highlight that it was not that we were not seriously taking the need of the community into consideration.

The power of community action to hold officials accountable and promote intergovernmental cooperation

When the city opened the Ebony Park/Kaalfontein Clinic, based on national Ideal Clinic requirements, the community saw a service delivery gap and immediately voiced their frustration, telling the city to "go tell them [province] we want a Community Health Centre". The city engaged with the Director of Health at the District Office, who in turn informed the Chief Director. Gauteng District Health executives consulted with the Office of the MEC and agreed that the community's request for a CHC with 24-hour services needed to be honoured because it was raised during the IDP process.

Once political buy-in was secured, the Chief Director of Province wrote a letter of intent indicating that province wanted to partner with the city to ensure that the community gets a 24-hour healthcare facility. This letter of intent galvanised joint planning and cooperation between the two spheres of government. Both parties sat down and figured out how they would reconfigure (including extending) the existing 18-room Ebony Park/Kaalfontein Ideal Clinic to accommodate the additional services and how they would jointly manage the facility until it was transferred to province.

The power of the community resulted in the two government spheres pooling their resources to deliver NHI-compliant health infrastructure and services. As the city did not have the mandate to run a 24-hour casualty service or a 24-hour maternity and obstetrics unit, province stepped in. They reconfigured the design of the clinic, provided equipment and managed staffing requirements.

The experience also illustrates that community engagement is an invaluable source of information that can improve delivery efficiency and provided an opportunity to rebuild trust. Regular community engagement sessions were held, attended by the executive leadership from the city (director-level and MMC for Health or Social Development) and from the province (Chief Director). At these sessions, the community was informed about the rebuilding process in order to avoid any misunderstandings and address misaligned expectations when they surfaced. These sessions were also an important mechanism to show that the government has heard the community voice – "we've heard their request, there are processes in place that are looking at meeting this request, but it will not necessarily happen like immediately you know".

Governance Insights

The Ebony Park case study provides the opportunity to reflect on what a one health system means in practice and the best way to move towards that ideal. For a one health system to become a reality, cooperative governance structures at various levels in the system must function as intended. The case study shows how the four SACN governance pillars are not mutually exclusive but interact dynamically. It highlights the importance of cooperative governance within the city and among different government spheres for planning and delivering services. Given that cities have the mandate to respond only to certain needs and have limited budgets, joint service delivery must take place to enhance the capacity of the State. For example, by both local and provincial government providing budget for building and delivering infrastructure.

Local government cannot meet all the needs of communities

The Ebony Park/Kaalfontein CHC case study demonstrates clearly that it is impossible for local government to meet all the needs of communities that emerge from consultation processes, due to not only resource constraints but also the different legislated mandates. Efficient and effective intergovernmental cooperation is needed to enable government to address historical service-delivery backlogs, which in urban spaces are exacerbated by the continuing trend of in-migration.

> We as officials, both provincial and in local government, have a good understanding of what the needs of the community are […] we continue to serve those communities and we provide the projects that's needed. It's a lack [of resources], maybe we need to build 10 clinics in a year, but we can only build two. I'm saying that based on the resources at our disposal.

Although local government does not have the resources to address all community needs, especially those of under-serviced, marginalised urban communities, it bears the brunt of citizens' dissatisfaction with service delivery. The sense of "powerlessness" of local government to influence priorities at provincial level emerged in many discussions with city officials. Other spheres of government appear not to value sufficiently the detailed and current local-level data, suggesting a mindset that views the three government spheres in a hierarchical manner. For example, does a "higher" sphere of government regard local government data about

community needs as "less important" than the information on which its planning is based. These issues need to be interrogated.

To ensure that government as a whole delivers on community needs, cooperative governance systems and structures need to work as intended, irrespective of which political party (or coalition of parties) is in power, at different spheres of government.

Cooperative governance mechanisms exist but do not always work as intended
Better ways need to be found to leverage the potential inherent in existing cooperative governance mechanisms. There are many pressure points in the system, and relatively small imperfections within the system can contribute to a less-than-ideal situation. In the case of the Ebony Park/Kaalfontein CHC, community consultation structures were in place and worked, and the IDP process was thorough and recognised the needs of the community. Yet, despite systems and structures being in place within the city to align strategic planning and priorities, the city's health department experienced challenges in working in an integrated way with the human settlements department to plan community developments.

> [W]e have the planning frameworks, what should happen on paper. But in reality, it is not happening [...] we are not in a position to demand [from] province or national [...] the spatial planning framework it is very clear, but this is not happening […] there are various tools that are there from provincial and national, maybe the city strategic unit can take it to a different platform and pose that question.
>
> We do have the processes in place, it is a matter of implementing what we have [...] to close the gaps we have.

Similarly, although the IDP and health facility needs are communicated to the province through the appropriate channels, various factors limit the city's ability to influence provincial priorities. These include apparent "competition' or slight differences between local and provincial priorities, and the impact of political changes on intergovernmental structures. In theory, it should not matter which political party (or coalition) is in power, but it seems that these dynamics could affect the efficiency of intergovernmental collaboration.

An implementing agent can enhance the State's capacity to deliver
A key feature of the case study is how the JDA, as an implementing agent, enhanced the capacity of the State to deliver efficiently – and this relationship can be used even more efficiently in future, also in community engagements.

The political-administrative interface is crucial
While the power of the community was central in getting the provincial government involved in ensuring that the community received the required service, the importance of the political-administrative interface should not be under-estimated. The connection between local and provincial political structures assisted in getting the province involved.

Communities expect integrated service delivery
If service delivery is aligned to the needs of communities, there is potential for enhancing trust between citizens and government. Citizens expect integrated service delivery from government and, even when they are aware that different government spheres have different mandates, they still expect to receive the services they need, irrespective of which sphere is responsible.

Conclusion and Governance Agenda

The National Health Act (No. 61 of 2003) created a single health system where national, provincial and local governments have a role. National government provides strategic direction through policy and frameworks, while provincial and local governments are responsible for implementation. Provincial government is accountable for service delivery, including primary healthcare and the district health system, which is the governance mechanism for delivering primary healthcare and is based on provincial and local government working together. This system comprises "health districts whose boundaries coincide with district and metropolitan municipal boundaries[8]" (Christmas, 2008: 1).

The design of the healthcare system has resulted in primary healthcare delivery being a contested area arising from the provincial and local governments having overlapping powers and functions. Local government

[8] However, "the MEC for health in the province, in consultation with the MEC for local government, is entitled to divide these districts into subdistricts, depending on the need in a particular area" (Christmas, 2008: 1).

provides environmental health services and some preventive services, as well as clinic-based primary healthcare in metropolitan areas (often in parallel with provinces).

Four governance issues are typically cited as the reasons for insufficient and ineffective delivery: conflicting views on roles and responsibilities, unfulfilled responsibilities, insufficient resourcing and weak intergovernmental relations (i.e. top-down approach, ineffective communication and a lack of cooperation).

The case study found that intergovernmental relations were weak for specific activities in the infrastructure development value chain, i.e. pre-planning and planning. In other areas of infrastructure development and primary healthcare functions, the working relationship between city and provincial health officials is strong. The city has developed and implemented the Ideal Clinic prototype infrastructure model with the JDA, which acts as an intermediary agent and "project implementer". This has reduced the time city health officials spend on project management without compromising delivery or city oversight protocols. In fact, drawing on the skills of project management experts has streamlined end-to-end infrastructure delivery in an environment where legislation is demanding more onerous standards. Embracing structure means that stakeholders have the space to focus on their areas of expertise and reduces city monitoring activities.

Interdepartmental collaboration between the health department and other city departments affects the pace and quality of healthcare infrastructure delivered. Key bottlenecks include capital funding constraints and the lack of space for a CHC in densely populated, lower-income areas. At a very minimum, the city's health department needs a closer working relationship with human settlements and to have a voice in co-creating strategic spatial planning policies and programmes.

The case study highlights the power of community participation as an oversight mechanism to hold officials and politicians accountable for delivering the 'right' infrastructure. A fundamental lesson is that a unified community can catalyse the delivery of infrastructure that they need, rather than infrastructure that is easier for the government system to deliver because of split functions and pressure to meet SDBIP or capex targets.

Community participation also caused the government to adopt a new working style. The barriers, which make it difficult for the city and province to plan, mobilise resources and build a CHC together, evaporated. Through working as one team, the two government spheres gained a better understanding of the other's environment, challenges and strengths. For example, the city understands community needs, due to its relationship through on-the-ground community structures and the IDP process, but province has better access to tangible and intangible healthcare resources.

The architects of South Africa's primary healthcare approach recognised the value of community participation and accountability – it is a guiding principle that informs the National Health Act (No. 61 of 2003), the PHC (primary healthcare) Re-engineering Strategy (2010) and National Core Standards (2011). Nevertheless, the case study showed that community participation structures need to evolve, as they are effective for recording community needs but less effective for creating impetus for delivery (i.e. getting the city to allocate budget and mobilise resources), especially when coordination within and among government spheres is limited.

Provincial and city healthcare officials and politicians identified three ways in which national regulation and legislation will affect the scope and nature of their work:

(i) A more comprehensive primary healthcare delivery approach, with greater emphasis on community participation. Since 2010, national government has released the PHC Re-engineering Strategy, the Ideal Clinic Initiative and the NHI White Paper, all of which stress the importance of primary healthcare as the bedrock of an integrated healthcare system, especially community-based and preventive strategies. Furthermore, the revised system will draw on ward structures extensively to reach communities.

(ii) A unified healthcare system based on (PRIMASYS, 2017: 12)

> A continuum of care approach from community outreach, PHC level based on the Ideal Clinic model, health promotion and prevention to other levels of curative, specialised, rehabilitative and palliative care. Health service benefits will be provided and described in terms of the types of services to be provided at each level of care with guidance on referral mechanisms.

(iii) The NHI initiative, which is placing primary healthcare providers under pressure to invest in upgrading services across the health delivery value chain, from infrastructure to equipment, management systems, ICT and skills. For instance, NHI standards require primary healthcare to have integrated electronic patient and management information systems.

These changes have far-reaching implications for healthcare delivery, intergovernmental relations and funding flows. Under the current configuration of the district healthcare system, resources and decision-making are mostly centralised at the provincial level (ibid). As the revised healthcare system is phased in, more authority will be delegated to the district level, which will change how districts are organised and governed in the medium to long term (ibid).

The devolution of power and greater role for primary healthcare may create the opportunity for cities to play a more equal role and take greater responsibility for planning healthcare infrastructure with province. To seize this opportunity will require cities having an integrated planning capacity. One of the biggest challenges is being able to anticipate a community's future needs and compliance with NHI readiness norms and standards, so that the infrastructure built today meets the supply and demand conditions in five years' time.

Highlighted Governance Focus Areas

Participants identified three governance areas that require reform in order to address bottlenecks and enhance innovation. However, they felt that it was premature to suggest specific action points or steps without having more information, especially as the far-reaching legislative changes in primary healthcare have created sector uncertainty and actions taken today may become irrelevant tomorrow. The primary healthcare reforms, in particular national government's drive to implement a unified primary healthcare system with an integrated "one government service delivery response" will redefine the city–province working relationship. Legislative changes will touch every aspects of the primary healthcare system. For example, the scope and standard of services, which affect how services are delivered and have a knock-on effect on the city roles and responsibilities of the city and province and, therefore, intergovernmental relation protocols.

Improve joint healthcare infrastructure pre-planning and planning between the city and province

Joint planning needs to be improved in order to ensure that any infrastructure built complies with the NHI and satisfies the needs of communities.

- **Explore the communication and information barriers between the city's health department and province's infrastructure planning department.** City-province cooperation in this area does not seem to function as well as in other health areas. For city officials, developing a formal joint planning system is a first step and would improve transparency by enabling both sides to see and include each other's capital projects in the pipeline. Greater transparency of the province's medium-term capex plans is vital because incorporating city planning jointly with province "is what the IDP demands […] knowing what are the capital projects that province is running with, so that we don't duplicate efforts".
- **Provincial officials need to be brought into the IDP process, to be closer[9] to the needs of the community.** A recurring issue raised throughout the governance dialogues is that the province is removed from communities' needs and planning is a purely technical exercise. Sharing the IDP with the province is not enough, and intergovernmental barriers would recede if the province had greater insight and had a better understanding of community needs.
- **The centralised nature of infrastructure development complicates capital allocation.** It makes it more difficult to get a sense of the big picture for Johannesburg. Although not explored further in the roundtables, a different approach was suggested:

> Infrastructure planning could be devolved to the Johannesburg provincial office for the Johannesburg infrastructure planning. The MMC who would then be the chair of the DHC for the whole of Johannesburg and province facilities and local government facilities, and would then be able to take all the priorities, put them together, and present them at the Mayoral Committee and also present them at the Provincial Health Council. When the DHC chair puts the needs to the provincial health council it is for the whole of Johannesburg to be prioritised, so that province begins also to align with the needs of the chair of the District Council, which would be what the MMC has put on the table, and in that way all parties can begin to see some synergy.

Evolve the Ideal Clinic prototype infrastructure model

The model should include a community engagement starting from the pre-planning phase and drawing on the JDA's facilitation unit.

[9] "if we all come and listen to those community conversations, not only local government, and that the IDP conversations are not only attended by local government officials let the invitation be extended to province, so that they can inform their five-year plan. Already they have listened, and they know where the pressure points are in terms of local government as the coalface of service delivery."

Coordinate city spatial planning, human settlements and health functions

The need for a more integrated, futuristic planning approach between city spatial planning, human settlement and health functions was highlighted. The focus should be on coordinating planning, investment and infrastructure delivery. An assessment of city documents, such as annual reports and IDPs, suggests that the city's IDP and budget allocation processes meet the conditions of the. Local Government: Municipal Structures Act (No. 117 of 1988) and the Local Government: Municipal Systems Act (No. 32 of 2000), while engagements confirmed that the city has established strategy and planning process in place. Therefore, the reason for insufficient horizontal collaboration cannot be attributed solely to structures, processes and systems. The implication is that a shadow, informal system may be at play where departments that have worked together in the past tend to continue working together.

Appendices

Engagement Methodology

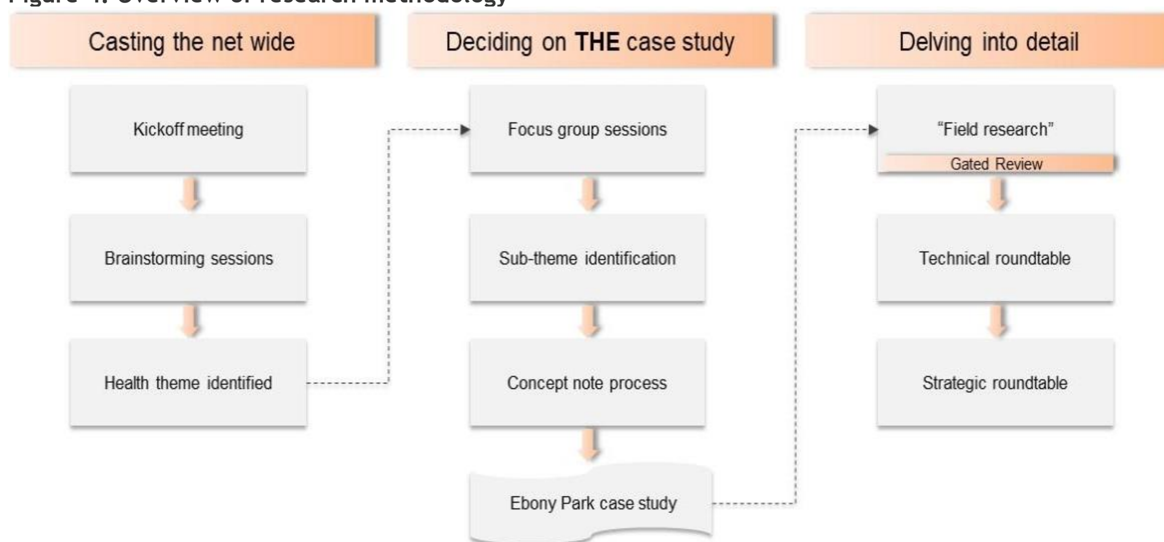
A participatory, qualitative approach

A core principle informing the methodology is giving stakeholders the space to tell their own governance story in their voice and facilitating a process of introspection. This process is geared toward helping a stakeholder group see the multi-faceted dimensions of the governance story (e.g. tensions and ambiguity) and to feel how other stakeholder groups internalise that story. The need for reflection prompted DWC to design the methodology based on co-creation and co-ownership principles. The methodology best suited a qualitative approach based on semi-structured discussions with individuals, focus groups or facilitated workshops. All engagements were virtual because of the COVID-19 outbreak. The research process began in February 2020 and ended in November 2020, and was divided into three phases.

Phase one: Casting the net wide

The purpose was to facilitate conversations that embraced a wider governance framing beyond rules and regulations, and to use this framing to brainstorm possible case studies. After four brainstorming sessions with the research team and three officials from the Strategy and International Affairs Department, five potential themes for the case study emerged. The top three themes were inner city infrastructure development, waste management delivery (the Pikitup intervention) and healthcare service provision. The city officials unilaterally chose healthcare service provision as the case study theme and provided no explanation for their selection.

Figure 4: Overview of research methodology



Phase two: Deciding on the case study

The purpose was to select a healthcare service provision case study that would be the best vehicle to explore the four dimensions of the SACN's governance framework and provide governance insights for other cities. The integrity of the research process rests in ensuring that the city takes ownership for selecting the case study. With this principle in mind, the research team designed the case study selection process to be city-led and interactive, where its role was to guide and support, not influence the case study selection.

Two focus groups were held with city health department officials to uncover the technical details and transformative impact (i.e. reflection and learnings) of potential case studies. This involved (i) understanding how the operating environment affects the initiation, implementation and management of projects; and (ii) acknowledging "what works", "what is innovative" and "what can be done differently". These exploratory discussions covered potential cases that fell into three areas: e-Health implementation, the health infrastructure programme and service delivery improvements (i.e. NHI readiness and extended clinic service hours). The focus group participants decided to explore case studies orientated towards service delivery improvement. The research team drafted a concept note for each potential case study to facilitate further internal discussion and debate among city health officials. These three options were:

i. The creation of a prototype clinic infrastructure development model. A case study as an example of how the city can build health infrastructure, which is aligned with national standards (e.g., Ideal Clinic and NHI standards) and suits communities' needs, in a faster, more efficient and cost-effective manner through forming strategic partnerships.
ii. The delivery of clinic infrastructure under rapidly changing demand conditions. A case study that touches on two connected themes: delivering services with long lead times in a rapidly changing environment; and adopting a more future-oriented, service delivery planning approach.
iii. Improvements and innovations in clinic services. A case study that showcases the city's responsiveness to engage with communities and make an effort to hear their needs and address them, while achieving prescribed healthcare standards and practices.

Elements of these three options resonated with the city. The selected case explored infrastructure development in the context of national standards and the need to deliver infrastructure to meet community needs in an environment of overlapping and split government mandates. At the end of phase two, the selected case study was the delivery of clinic infrastructure under rapidly changing demand and supply conditions, using Ebony Park as an example.

Phase three: Delving into the detail

The primary purpose was to gain a systemic understanding of the governance bottlenecks, enablers, challenges and opportunities that shaped the development of the Ebony Park CHC from the perspectives of stakeholders. Another aspect was capturing stakeholders' narrative in their own voice and reflecting it back to them. This reflective process was designed to stimulate going beneath the surface of what is happening and questioning why the same patterns keep remerging and what can be done differently to break these patterns.

Four one-on-one interviews were held with city representatives: senior management healthcare professionals at the city, the MMC for Health and a Clinic Liaison Officer. Two roundtables were also held:

(i) A technical roundtable, to gather information for co-creating the governance narrative. Participants included individuals directly involved in the programme's design, operations, reporting and oversight. The members involved reflected the roundtable's primary diagnostic focus (roughly 70% of discussion) and a secondary reflection focus (i.e. what did we learn and what can be done differently). During the facilitated session, the DWC team:

- clarified "how the case study works" and filled in any knowledge gaps,
- tested the proposed case study governance narrative(s) "goodness of fit" in terms of resonating with participants as well as its accurateness and completeness,
- worked with participants to tailor the governance narrative and obtain consensus that this "new" narrative is "fair", "accurate" and "complete", and
- unpacked the governance narrative in terms of its sequence of events, relationships among stakeholders, story elements as well as stakeholders' actions and their impact.

(ii) A strategic roundtable, which was designed to reflect and confirm participants' interpretation of the governance information gathered from all engagements (including the technical roundtable). The strategic roundtable had an equal diagnostic and reflection focus, as "this should not only be a diagnostic session. It should focus on the advantages, the opportunities and the things that are working on governance in that local government as much as on the challenges" (SACN, 2019: 12). Consequently, the roundtable targeted individuals[10] who had a more strategic perspective (e.g. involved in oversight or evaluation functions) and were familiar with the operations of the case study. During the facilitated session, the DWC team:

- presented the case study's governance narrative and tested whether it was a fair reflection, factually accurate and complete,
- obtained participants' feedback on narrative, which included capturing their concerns, suggestions, gaps and missing content,
- facilitated conversation around the governance challenges that the narrative showcases as well as possibilities to addresses them, and
- facilitated conversation on possibilities and innovations to change local governance circumstances, and explored how points raised during this conservation can be taken forward at a strategic level.

[10] Strategic roundtable participants included senior managers from the city's health department, city officials responsible for development planning, senior managers from the Provincial Health Department, and an official from the Office of the MMC for Health in the City of Johannesburg

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