



UNIVERSITY OF KWAZULU-NATAL

Monitoring and evaluation of eye health service delivery: A public-private case study in the uMgungundlovu District, KwaZulu-Natal

by

Haseena Majid

Student Number: 211549760

**A thesis in fulfilment of the requirements for the
Degree of Doctor of Administration**

**School of Management, Information Technology & Governance
in the
College of Law & Management Studies**

Supervisor: Professor M Subban

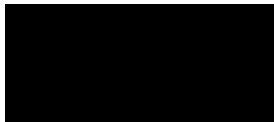
2023

DECLARATION

I, Haseena Majid declare that:

The research reported in this thesis, except where otherwise indicated, is my original research;

- (i) This thesis has not been submitted for any degree or examination at any other university;
- (ii) This thesis does not contain other persons' writing, unless specifically acknowledged as being sourced from other persons; and
- (iii) This thesis does not contain text, graphics or tables copied and pasted from the Internet, unless specifically acknowledged and the source being detailed in the thesis and in the reference section.



Haseena Majid (Student Number: 211549760)

01 December 2023

ACKNOWLEDGEMENTS

I am deeply grateful to the following persons without whose contributions this academic achievement would not have been possible:

- My Father – Everything is possible with your support, and on your firm shoulders I stand tall.
- My academic mentor and supervisor, Professor M. Subban, for her unwavering and expert academic knowledge and constant support, nurturing approach, and her meticulous attention to completing this thesis. I could not have asked for a better supervisor. You are simply the best!
- Special thanks to the College of Law and Management Studies and the Scholarships Office of the University of KwaZulu-Natal for the doctoral grant towards finalisation of my studies. I appreciate the doctoral scholarship award!
- Staff in the Postgraduate Office of the College of Law and Management Studies at the University of KwaZulu-Natal for assistance with administrative aspects and queries during the study period.
- Professional language editing services provided by Ms E Ross.
- Mrs Johannette Fraser, a friend and mentor, for her support throughout this journey.

DEDICATION

“Education is the passport to the future, for tomorrow belongs to those who prepare for it today.” – Malcolm X

This study is dedicated to my sons, Muhammad Aadam, Hammaad and Maahir, who have taught me that learning is not about knowing the answers, but rather asking the right questions. My inspiration to seek sustainable systems for health access rests in the hope that I could, in some small way, contribute to a brighter and more equitable world for you to thrive in.

ABSTRACT

Public health service delivery in South Africa is plagued by a myriad of challenges which has intensified in the last decade. Exploring barriers to service delivery is fundamental for problem-solving, and evident that solutions to healthcare challenges cannot be addressed by government alone. Collaborative efforts between public, private and civil society sectors are imperative if national development goals and international pacts are to be honoured. The empirical study looked into public-private partnerships (PPPs) to improve delivery of cataract surgery in the uMgungundlovu District, KwaZulu-Natal. Cataracts are one of the leading causes of avoidable blindness globally. Inequitable distribution of resources, fiscal limitations, neglect of infrastructure, amongst others, led to considerable delays for surgery, rendering people avoidably blind. The study explored health-related administrative and management barriers to effective public eye health service delivery establishing if a public-private health forum implemented in the district contributed to improved service delivery. Theorised within the Logic Model and 5C Protocol, it allowed for reflection and connection between policy and practice. Qualitatively, the study was conducted through interviews of Public-Private Eye Health Forum stakeholders including healthcare workers and managers. Results were analysed using content and thematic analysis. Emergent themes included lack of reliable patient information systems as a hindrance to eye health service delivery, and the benefit of PPPs to address cataract surgery burden in the public sector. Health forums as a means to improving access to health service delivery must leverage strengths and resources of each sector. It is recommended that a partnership model for such forums be designed with monitoring and evaluation indicators built into formative planning processes, observed and managed throughout implementation. Whilst guidelines for PPPs exists in theory, unique construct of forums in practice ought to consider administratively sound frameworks for successful implementation. Uniformity in processes and reporting systems are necessary for successful collaborative engagements.

Key Words: Public-private partnership, public eye health service delivery, health forums, monitoring and evaluation, collaborative engagements

Table of Contents

DECLARATION.....	ii
ACKNOWLEDGEMENTS.....	iii
DEDICATION	iv
ABSTRACT	v
Table of Contents.....	vi
List of Figures	xiii
List of Tables	xiv
List of Acronyms and Abbreviations.....	xv

CHAPTER ONE: OVERVIEW AND GENERAL ORIENTATION OF THE RESEARCH

STUDY	1
1.1. INTRODUCTION.....	1
1.2. BACKGROUND AND RATIONALE OF THE STUDY	2
1.2.1 Rationale of the study.....	6
1.3. AVAILABILITY OF EYE HEALTH SERVICES	6
1.4. STATEMENT OF THE PROBLEM	11
1.5. RESEARCH QUESTIONS	14
1.6. AIM AND OBJECTIVES OF THE STUDY	15
1.6.1 Aim	15
1.6.2 Objectives	15
1.7. CONCLUSION	16
1.8. STRUCTURE OF THE THESIS	17

CHAPTER TWO: THEORISATION OF PUBLIC HEALTHCARE MANAGEMENT AND PUBLIC ADMINISTRATION PERSPECTIVES.....

2.1. INTRODUCTION.....	21
------------------------	----

2.2. LEGACY OF APARTHEID, CHALLENGES AND DEFICIENCIES IN THE SOUTH AFRICAN HEALTH SYSTEM – IMPLICATIONS FOR PUBLIC HEALTH SERVICE DELIVERY	22
2.3. OVERSIGHT MEASURES AND RECORD KEEPING	25
2.4. GOVERNANCE RISKS ASSOCIATED WITH PUBLIC HEALTH.....	25
2.5. HEALTH SYSTEMS: STAKEHOLDERS AND SYSTEMIC INFLUENCES.....	26
2.6. FRAMEWORK INFORMING THE HEALTHCARE SYSTEM	27
2.7. THEORETICAL FRAMEWORK OF THE PUBLIC HEALTH SYSTEM IN SOUTH AFRICA	28
2.7.1 Contextualising the National Development Plan, 2030 for health service delivery .	29
2.7.2 Utilising the Logic Model for public health service delivery	30
2.7.3 Relevance of the Logic Model for the performance monitoring of eye healthcare ..	31
2.7.4 The 5C Protocol theory for eye healthcare service delivery	33
2.7.5 Creating Public Value: Bridging Theory and Practice in Public Health Service Delivery	36
2.8. POLITICS-ADMINISTRATIVE DICHOTOMY AND IMPACT ON PUBLIC SERVICE DELIVERY	37
2.9. THE 'E' ASSOCIATED WITH PUBLIC ADMINISTRATION	39
2.10 NEW PUBLIC MANAGEMENT AND NEW PUBLIC GOVERNANCE.....	41
2.11 THE THEORY OF PUBLIC ADMINISTRATION.....	44
2.12 PUBLIC ADMINISTRATION, PUBLIC POLICY AND THE HEALTH RESPONSE TO THE PANDEMIC.....	45
2.13 TOWARDS IMPLEMENTATION OF HEALTH EQUITY	48
2.13.1 Batho Pele Principles <i>vis-à-vis</i> public health service delivery	52
2.14 CONCLUSION.....	56
 CHAPTER THREE: EYE HEALTH SERVICES ACROSS SOUTH AFRICA'S PUBLIC AND PRIVATE SECTORS	 58
3.1. INTRODUCTION.....	58

3.2. GLOBAL PERSPECTIVES ON EYE HEALTHCARE	59
3.3. HEALTH SYSTEMS IN SOUTH AFRICA	62
3.4. CHALLENGES TO THE HEALTHCARE SYSTEM IN SOUTH AFRICA	64
3.5. THE EYE HEALTH LANDSCAPE IN SOUTH AFRICA.....	68
3.5.1 Eye health services in the public health sector	70
3.5.2 Human resource challenges and disparities in the public sector.....	72
3.5.3 Systemic challenges within public eye health services	74
3.5.4 Barriers to provision of eye care services in South Africa	76
3.5.5 Innovative approaches in the delivery of eye care	77
3.6. Monitoring and evaluation of eye care services in South Africa	78
3.6.1 Monitoring and evaluation to enhance governance in the eye care sector.....	80
3.6.2 Monitoring and evaluation for performance-based governance	81
3.7. Exploring best practices and policy Initiatives in South African eye health service delivery	84
3.8. Role of public administration in improving eye health services	87
3.9. Public-private partnerships in eye care service delivery in South Africa	90
3.10 The role of public-private partnerships in health and eye care.....	90
3.11 A public-private forum as a tool to achieve eye health needs.....	93
3.12 Monitoring and evaluation of public-private partnerships in the eye health sector	95
3.13 CONCLUSION.....	96
 CHAPTER FOUR: RESEARCH DESIGN AND METHODOLOGY	98
4.1. INTRODUCTION.....	98
4.2. RESEARCH SETTING.....	98
4.3. RESEARCH DESIGN.....	99
4.4. PHILOSOPHICAL ORIENTATION AND PARADIGM OF THE STUDY	101
4.4.1 Qualitative research	103

4.4.2	Population and target population	105
4.4.3	Sampling strategy, sample size and participant selection	106
4.4.4	Sampling adequacy	109
4.4.5	Interviews	110
4.4.6	Interview design	112
4.4.7	Data collection.....	112
4.4.8	Case study	114
4.4.9	Data analysis.....	116
4.5.	THEMATIC ANALYSIS	116
4.6.	PILOT STUDY	117
4.7.	RELIABILITY AND VALIDITY.....	118
4.8.	DATA SATURATION	119
4.9.	ETHICS CONSIDERATION	120
4.10	LIMITATIONS TO THE STUDY	121
4.11	SIGNIFICANCE OF THE STUDY IN PUBLIC HEALTH DELIVERY	122
4.12	CONCLUSION.....	123
 CHAPTER FIVE: DATA ANALYSIS AND DISCUSSION		124
5.1.	INTRODUCTION.....	124
5.2.	FINDINGS.....	125
5.3.	EMERGENT THEMES	125
5.4.	DEMOGRAPHIC INFORMATION OF PARTICIPANTS.....	126
5.5.	KNOWLEDGE AND PARTICIPATION IN PUBLIC-PRIVATE FORUM FOR CATARACT SURGERY	129
5.6.	CATARACT SERVICE DELIVERY OVERBURDENED IN PUBLIC HOSPITALS	134
5.7.	PUBLIC-PRIVATE PARTNERSHIP FOR CATARACT SURGERY SERVICES IN PUBLIC HOSPITALS.....	136

5.8. CHALLENGES FACED IN PUBLIC-PRIVATE EYE HEALTH SERVICE DELIVERY..	138
5.9. UNDERSTAFFING AND EQUIPMENT PROVISIONING HINDRANCES TO CATARACT SERVICE DELIVERY	140
5.10 LACK OF A RELIABLE PATIENT INFORMATION SYSTEM AS A HINDRANCE TO EYE HEALTH CARE DELIVERY	145
5.11 MEASURES FOR SERVICE DELIVERY OF CATARACT SURGERIES.....	149
5.12 EYE HEALTH SERVICE DELIVERY BARRIERS FROM CLINIC REFERRALS TO HOSPITALS.....	152
5.13 DISCUSSION OF FINDINGS.....	155
5.14 CONCLUSION.....	157

CHAPTER SIX: PROPOSED MODEL FOR PUBLIC EYE HEALTH SERVICE DELIVERY INTERVENTIONS..... 158

6.1. INTRODUCTION.....	158
6.2. CONCEPTUAL MODEL FOR EVIDENCE-BASED PPPs TO INFORM DECISION-MAKING FOR EYE HEALTH SERVICE DELIVERY	159
6.3. ANALYTICAL HIERARCHY PROCESS IN PPPs FOR HEALTH SERVICE DELIVERY...	160
6.3.1 Data-driven comparisons.....	161
6.3.2 Informed resource allocation in eye health service delivery	161
6.3.3 Incorporation of stakeholder input	162
6.3.4 Transparent decision process.....	163
6.3.5 Alignment with research findings	163
6.4. RATIONALE FOR AN EVIDENCE-BASED FRAMEWORK FOR PPPs IN EYE HEALTH SERVICE DELIVERY	165
6.5. BUILDING A DATA-DRIVEN HEALTHCARE FUTURE: ROLE OF PUBLIC-PRIVATE EYE HEALTH	170
6.6. COMPONENTS OF PROPOSED MODEL.....	174
6.6.1 Public-private partnerships	174

6.6.2	Monitoring and evaluation	174
6.6.3	Eye health services	174
6.6.4	Understanding the demand	174
6.7.	BRIDGING THE HEALTH SERVICE DELIVERY GAP THROUGH ADMINISTRATIVE SOLUTIONS	175
6.8.	CONTRIBUTION TO THE BODY OF KNOWLEDGE OF PUBLIC ADMINISTRATION VIS-A-VIS PUBLIC HEALTH DELIVERY	176
6.9.	CONCLUSION	176
	CHAPTER SEVEN: CONCLUSION AND RECOMMENDATIONS	178
7.1.	INTRODUCTION.....	178
7.2.	INSIGHTS INTO FUNCTION OF THE FORUM.....	179
7.2.1	What are the administrative and management barriers to effective eye health service delivery?.....	179
7.2.2	How can a public-private health forum contribute to improved public health eye service delivery and performance?	180
7.2.3	What are management and organisational approaches for the public-private health forum?	182
7.2.4	How effective and efficient are the implemented M&E solutions, as well as the current reporting systems which are in place?	183
7.3.	RECOMMENDATIONS EMANATING FROM THE STUDY	184
7.3.1	What are the governance approaches used by the forum to address challenges encountered in the public eye health service delivery?	185
7.4.	STANDARDISED MODEL FOR HEALTH FORUMS TO ADDRESS PUBLIC EYE HEALTH SERVICE DELIVERY	186
7.5.	PROPOSED STRUCTURE OF A HEALTH FORUM.....	186
7.6.	CROSS-CUTTING RECOMMENDATIONS.....	190
7.6.1	A standardised multisectoral forum	190
7.6.2	A standardised database for health service information.....	191
7.6.3	Uniform tools for eye health service delivery reporting.....	192

7.6.4	Public administration, efficient and effective eye health service delivery.....	192
7.6.5	Mapping of eye health services at district and provincial level	193
7.6.6	Absence of a dedicated directorate for primary eye care providers	194
7.6.7	Establishment of a dedicated research office for eye health services	194
7.6.8	Public-private partnerships between academia and public health.....	195
7.6.9	Record keeping for information management	196
7.6.10	Documentation of best practices at both institutional and individual level	197
7.7.	ASPECTS FOR FUTURE RESEARCH.....	199
7.8.	CONCLUDING REMARKS	199
Bibliography		201
ANNEXURES		249
Annexure A: Approval		249
Annexure B: Language Certification		250
Annexure C: Gatekeeper’s Letter.....		251
Annexure D: Interview consent.....		252
Annexure E: Interview Schedule.....		257
Annexure F: Ethics Approval		270

List of Figures

Figure 2.1: Logic Model.....	31
Figure 2.2: Logic Model.....	33
Figure 2.3: The 7Cs Protocol for efficient healthcare management	36
Figure 3.1: Causal loop of public health system challenges affecting service delivery	65
Figure 6.1: Cyclic recurrence of issues affecting eye health services	168
Figure 6.2: An evidence-based model for PPPs in eye health service delivery.....	172
Figure 7.1: Eye Health Forum structure	189

List of Tables

Table 1.1: Social determinants of health in uMgungundlovu	8
Table 1.2: uMgungundlovu district population projection 2016.....	9
Table 1.3: Number of health facilities in uMgungundlovu, 2016/17	10
Table 2.1: The Eight Principles of Batho Pele	54
Table 3.1: A ten-step process	81
Table 4.1: Research population categories	108
Table 5.1: Categories of participants in the public-private health forum uMgungundlovu District.....	127

List of Acronyms and Abbreviations

ACM	-	Active Citizens Movement
AHP	-	Analytical Hierarchy Process
ART	-	Antiretroviral Therapy
BHVI	-	Brien Holden Vision Institute
CEHTF	-	Child eye health tertiary facility
CHC	-	Community Health Centre
CMV	-	Cytomegalovirus
CSDH	-	Commission on Social Determinants of Health
CSR	-	Cataract Surgery Rate
DM	-	Diabetes Mellitus
DHC	-	District Health Council
DHS	-	District Health System
DoH	-	Department of Health
DPME	-	Department of Monitoring and Evaluation
DR	-	Diabetic Retinopathy
HCP	-	Health care professional
HFA	-	Health For All
HPCSA	-	Health Professionals Council South Africa
HReH	-	Human Resources for Eye Health
HSS	-	Health Systems Strengthening
IAPB	-	International Agency for the Prevention of Blindness
ICT	-	Information and Communication Technology
IIROSA	-	International Islamic Relief Organisation of Saudi Arabia
IT	-	Information Technology

KZN	-	KwaZulu-Natal
LMICs	-	Low-and-Middle-Income-Countries
M&E	-	Monitoring and Evaluation
MEC	-	Member of the Executive Council
MoU	-	Memorandum of Understanding
MTEF	-	Medium-Term Expenditure Framework
NCD	-	Non- Communicable Disease
NDOH	-	National Department of Health
NDP	-	National Development Plan
NGO	-	Non-Government Organisation
NHI	-	National Health Insurance
NHP	-	National Health Plan
NPM	-	New Public Management
NPG	-	New Public Governance
NPO	-	Non-Profit Organisation
PHC	-	Primary Health Care
PPPs	-	Public-Private Partnership
SDG	-	Sustainable Development Goals
SIPS	-	Strategic Integrated Projects
UHC	-	Universal Health Coverage
URE	-	Uncorrected Refractive Error
WHO	-	World Health Organization
WOPC	-	War on Poverty Campaign

CHAPTER ONE:

OVERVIEW AND GENERAL ORIENTATION OF THE RESEARCH STUDY

1.1 INTRODUCTION

The delivery of cataract surgery as an essential service to the uninsured population in South Africa, reliant on state resources for public health services, is a recognised imperative by the South African government. Cataract surgery, crucial for the aging population, patients with chronic health conditions, individuals born with cataracts, and those with cataracts resulting from trauma, constitutes a significant health need. Despite national commitments articulated in Vision 2020 and endorsed by World Health Assembly resolutions, South Africa has consistently fallen short of meeting these targets. While existing literature attributes this shortfall to inadequate equipment, human resources, and budgetary constraints, scant attention has been paid to the inequitable service delivery model. The persistent challenge of disproportionate public health service distribution is rooted in structural and systemic inequities, both between and within local communities, elucidated in the empirical research to be presented. This chapter introduces the broader context of the availability of eye health services in South Africa, examining the governmental recognition of cataract surgery as essential, the demographic groups most in need, and the systemic barriers hindering effective service delivery. It underscores the necessity of addressing these challenges through a multi-faceted approach, which this research aims to contribute to by exploring the potential of Public-Private Partnerships (PPPs) and scrutinising their efficacy in achieving public eye health service delivery objectives. Additionally, this chapter sets the stage for the subsequent sections by highlighting the gaps in current literature and the research questions that will guide this study's investigation into improving eye health service delivery in South Africa.

1.2 BACKGROUND AND RATIONALE OF THE STUDY

The World Health Organization (WHO) describes health inequity as avoidable inequalities between, and within, countries and societies. It is linked to the social and economic conditions of such countries and societies, including the determination of their risks of illness, and the actions which can be taken to prevent, and/or treat, them (CSDH, 2008). The well-being of people compromised by their limited access to the social determinants of health, and its burden on micro and macro economies, perpetuates cycles of inequity. The absence of systematic, downward, responses, at a governance level, hinders the availability of, and accessibility to, opportunities in education, employment, health and a dignified living environment (WHO, 2012).

Public health challenges and inequities arise from two root causes, namely: (i) Institutional and systemic systems which organise the distribution of power unequally along the lines of race, class, gender and other forms of group or individual identities; and (ii) Unequal distribution of resources and power which negatively impacts on the social determinants of health. These determinants of health encompass the various aspects of individuals' lives, including their living conditions; education; employment; healthcare systems; housing; income; physical environment; public safety, and social environment, which includes transportation. These factors play a significant role in shaping overall, individual well-being and health outcomes. It stands to reason that health inequity influences health, functionality and the quality-of-life outcomes, and their associated risks.

In the build-up to the finalisation of the National Health Insurance (NHI) model (currently a major focus in the South African health sector), prioritisation of the social determinants of health has resurfaced. Widespread inequities in health services in South Africa have resulted in high mortality rates, and have been further compounded by the challenges brought about by increasing poverty, unemployment, and the high burden of disease (Scott, Schaay, Schneider & Sanders, 2017:79). Since the democratic election in 1994, there has been a shift to address disparities in healthcare access and outcomes. South Africa has placed significant emphasis on formulating and executing policies. This commitment to tackling health inequities reflects the country's dedication to promoting fairness and equality in the field of

healthcare provision. Unfortunately, despite having inherently good and constructive policies in place, implementation evidently remains a challenge for the government, for a multitude of reasons. To this end, addressing the social determinants of health for the mass population, and fixing them as the foundation for change, was, and continues to be dampened by economic and fiscal strategies implemented in the immediate period following the democratic change in leadership, which in retrospect, may have served to widen the inequity between societies within the country (Omotoso & Koch, 2018:2).

To successfully deliver the NHI, capacitation programmes should be monitored and evaluated with a focus on ethical conduct, operational effectiveness, and the prioritisation of rights-based solutions provided in the national agenda for equity and transformation, as informed by the former presidency (2007). In a public statement, made by the current presidency in February 2020, the president highlighted the inequity and inequality which exists in the country, and the increasing need for responsible and structured approaches, including collaborative public-private strategies between the government, civil society organisations and the private sector, as a cornerstone to achieve the global goal of universal health coverage by 2025 (Republic of South Africa, 2020). In this regard, the Presidential Health Compact generated from the presidential health summit, held in Johannesburg in late 2018, presents a national example of an ongoing multi-stakeholder forum, which has been implemented to monitor and evaluate the immediate needs of health facilities, including personnel, medication and equipment (National Department of Health, 2018). Commitment to consult all sectors at every stage of the process is indicative of the awareness present within upper governance structures to create an inclusive platform in its preparation to respond to the health needs of a diverse and unequal country (Republic of South Africa, 2019b). Forums for service delivery around the country currently exist to address challenges within various sectors. In health, there have been several forums to address service delivery challenges, with a view to establish reasonable and effective solutions to overcome them.

In light of this context, this study sought to monitor and evaluate a potential PPP response through a forum, to address the eye health service delivery challenges in the uMgungundlovu district in the KwaZulu-Natal (KZN) province where the public

sector has experienced considerable barriers in achieving its target of preventing avoidable blindness through cataract surgery services.

Eye health services are necessary for the avoidance of blindness and the prevention of diseases, and are not detached from the broader challenges currently faced by the state-funded health systems in the country. Inequitable distribution of eye health services, predominantly located in urban settings, and the lack of cataract surgical services in many rural and deep rural settings, adds to the ongoing challenges of delivering much-needed services.

In 2023, the International Agency for the Prevention of Blindness (IAPB) estimates that vision loss would increase by 55% globally, linked to the foreseeable lack of sustainability in current eye health services to meet the demands of increasing inequalities and an increase in the ageing community, coupled with an increase in diabetes and other chronic health conditions (IAPB, 2023). The global increase in blindness from 3.92% in 2010 to 4.34% in 2020, despite lessons emerging from the limitations of VISION 2020 and the implementation of the Universal Eye Health: Action Plan 2014-2019, is indicative of the shortcomings in the global health plan to respond to eye health within the burden of disease (Forrest, Mercado, Engmann, Stacey, Hariharan, Khan & Cabera, 2023:2). These rising statistics gives more credence to the study and calls for evidence-based policy interventions to address this rampant problem in public eye health service delivery.

In 2022, the WHO estimated that over 2,2 billion people globally lived with visual impairment, of which a staggering 1 billion people had varying degrees of vision impairment and blindness. Uncorrected refractive error accounts for 88.4 million people; cataracts a substantial 94 million; and glaucoma 7.7 million people. The report further included diabetic retinopathy, trachoma and unaddressed near vision as significant contributing factors to visual impairment and visual blindness (WHO, 2022), highlighting a huge gap in eye health service delivery.

Cataracts are the leading cause of avoidable blindness, specifically in low-income and developing countries. Other major causes of blindness are uncorrected refractive error, which accounts for 21%; and glaucoma at 8%. Despite the various

initiatives across the world to increase awareness about visual impairment from a public health perspective, coupled with overall increased opportunities to access eye care services, the estimated number of visually impaired people in the world in the coming years, continues to remain alarmingly high. This is a major cause for concern to health authorities and governments (Bourne, Flaxman, Braithwaite, Cicinelli, Das, Jonas, Zheng & 2017: 895).

Visual impairment in Africa is reported by the WHO's Regional Office for Africa to be a significant health problem that demands immediate attention. Trachoma, corneal opacity, and onchocerciasis have been added to the causes of visual impairment. While the opportunity to prevent visual impairment exists for all people, the situation in Africa remains challenging, due to a lack of eye care services to the poorest-of-the-poor sectors of society. This has resulted in approximately 26.3 million people suffering from visual impairment. Low vision accounts for 20.4 million cases, and blindness remains at 5.9 million. Risks of visual impairment from infectious diseases, like trachoma and onchocerciasis, are decreasing, with increased interventions through strategic programmes. However, the risks of visual impairment associated with non-communicable disease (NCDs) continues to increase (WHO, 2020). This is having a profound effect on the quality of life in rural and poor communities.

South Africa, regarded as a 'giant' on the African continent, is no exception to eye care challenges and increasing visual impairment statistics. Eye healthcare remains a misunderstood and, at times, an undervalued aspect of public healthcare in the country. Despite vision playing a vital role in almost 80% of our daily lives, there continues to be a perceived lack of prioritisation of eye care within the public health sector by both individuals and healthcare providers (Jolley, Mafwiri, Hunter & Schmidt, 2017: 6).

In South Africa, there have been historical imbalances in accessible eye care exacerbated by unequal human resource distribution across the country. This has, to some extent, resulted in the perception of eye care, and the access thereto, as a service for the privileged; or one relied upon. This is largely, in the event of a significant, symptomatic decrease in vision, or the presence of symptoms such as pain, burning, headaches and discomfort. Furthermore, there appears to be a lack of

understanding about the role of caregivers and the capacities within which they can offer such services (Lilian, Railton, Schaftenaar, Mabitsi, Grobbelaar, Khosa & Peters, 2018:10).

1.2.1 Rationale of the study

The South African government recognises the need to deliver cataract surgery as an essential service to the uninsured population dependent on state resources for public health services. Cataract surgery is most needed by the ageing population; patients with some chronic health conditions; people born with cataracts, and cataracts secondary to trauma. Despite the national commitment to Vision 2020 (NDOH, 2017) and World Health Assembly resolutions (WHO, 2019), South Africa has continually failed to meet these targets. While the literature suggests that this is due to inadequate equipment and human resources, and budgetary constraints, little has been said about the inequitable service delivery model. The disproportionate location of public health services remains a challenge, which is premised upon structural and systemic inequities between and within local communities, as pointed out in the empirical research in this study. A better approach, through a more capable administrative system, as presented in this new contribution to knowledge, could capacitate PPPs to achieve the desired public eye health service delivery goals.

1.3 AVAILABILITY OF EYE HEALTH SERVICES

Evidence has shown that health services availability differs from urban to rural, and from informal settlement to suburbs in South Africa (Malakoane, Heunis, Chikobvu et al., 2020; Lalla-Edward, Mosam, Hove et al., 2022); and districts in the province of Kwazulu-Natal are no exception to this mal-distribution and uneven allocation of human resources for health, much-needed funding and governmental support to the public health sector.

Magagula, Mukonza, Manyaka, and Moeti (2019:1), elicit that the South African local government comprises metropolitan, district, and local municipalities, each operating within the framework established by the Constitution of the Republic of South Africa, 1996, and supporting legislation such as the Local Government: Municipal Structures Act 117 of 1998. Metropolitan municipalities function as autonomous local

authorities, while district municipalities share responsibility for local governance with their constituent local municipalities. These entities collectively play a vital role in the development and transformation of communities throughout South Africa. The division of responsibilities between district and local municipalities aims to ensure equitable access to resources and services across all communities.

In South Africa, the Constitution lays down the fundamental principles, structures, and mechanisms of governance, delineating the roles and responsibilities of national, provincial, and local government levels, with health services designated as a concurrent functional area at both national and provincial levels. The National Health Act (underscores the importance of cooperative and effective governance while also providing for the establishment of the district health system (DHS) Republic of South Africa, Act 108 of 1996).

Tshabalala and Rispel (2023:2) elaborate that according to the Act, the provincial government is tasked with delivering primary healthcare (PHC) services within health districts, which align with local government or municipal boundaries. In practice, both provincial and local governments, particularly in metropolitan areas, play roles in providing PHC services. Section 31 of the Act outlines the framework for establishing governance structures for the DHS, known as district health councils (DHCs). In accordance with the Act, the Member of the Executive Council (MEC) for Health, or provincial health minister, in collaboration with the MEC for Local Government, are responsible for appointing DHC members. The DHS serves as the primary conduit for PHC delivery, which forms the cornerstone of the South African health system.

An extract from the 2018-2021 district health plan shows the unequal and inequitable distribution of services in the uMgungundlovu district (see Table 1.1). The skewed access to the basic social determinants of primary healthcare is observed in the statistics presented for the district.

Table 1.1: Social determinants of health in uMgungundlovu

Sub-Districts	Data Source	Umkhathali	Umgeni	Mpofana	Impendle	Msunduzi	Mkhambathini	Richmond	District
Unemployment rate	Census 2001	44%	34%	44%	74%	48%	44%	43%	47%
	Census 2011	6.1%	10%	8%	5.2%	11.3%	6.9%	6.7%	9.8%
	C / S 2007	35%	26%	25%	30%	38%	43%	74%	35%
	C / S 2016								
Total number of households	Census 2001	23 993	20 486	9 607	8 258	130 292	12 550	12 533	217 558
	Census 2011	28 636	30 141	8 846	7 471	164 746	13 500	16 361	270 701
	C / S 2007								
	C / S 2016	29 082	37 352	11 648	7873	180 196	17177	17 624	300 953
Percentage of population living below poverty line of R400 per month	Census 2001								
	Census 2011	20.7%	11%	19%	14%	13%	20.6%	19%	14.7%
	C / S 2007								
	C / S 2016								
Number of households in informal dwelling	Census 2001	1 159	1 660	229	5,640	16 315	194	1 9020	21 546
	Census 2011	1 033	2 723	226	15	13 493	435	463	18 388
	C / S 2007	15,466	20,426	7,460	5,640	128,102	7,100	10,412	177,958
	C / S 2016	1797	2985	120	590	15 118	669	1 226	22 508
Number of households in formal dwelling	Census 2001	12 559	16 221	6 880	39	90 025	5 779	5 301	140 113
	Census 2011	27 091	27 767	10 226	8 187	150 499	14 500	16 005	254 278
	C / S 2007								
	C / S 2016	16 369	32 365	9 392	4740	144 463	11 038	12 236	230 604
Households with access to sanitation	Census 2001								
	Census 2011	93.7%	98%	92.7%	98%	98%	92%	96%	97%

Sub-Districts	Data Source	Umkhathali	Umgeni	Mpofana	Impendle	Msunduzi	Mkhambathini	Richmond	District
	C / S 2007								
	C / S 2016	40%	84%	64%	9%	65%	11%	30%	58%
Households with access to potable water	Census 2001	30%	94%	67%	9%	65%	37%	25%	47%
	Census 2011	22 511	27 996	5 954	6 358	154 762	9 171	13 079	242 361
	C / S 2007	19%	89%	65%	16%	74%	19%	25%	40%
	C / S 2016	80%	88%	76%	77%	99%	82%	93%	93%
Percentage of Households with access to electricity	Census 2001	54%	95%	54%	55	86%	44%	56%	74%
	Census 2011	73%	85%	76%	83%	92%	69.5%	81%	86.5%
	C / S 2007	59%	73	69%	77%	98%	47%	62%	72%
	C / S 2016		89%	81%	96%	96%	92%		99%
Adult literacy rate	Census 2001	NA	NA	NA	NA	NA	NA	NA	NA
	Census 2011	NA	NA	NA	NA	NA	NA	NA	NA
	C / S 2007	NA	NA	NA	NA	NA	NA	NA	NA
	C / S 2016	NA	NA	NA	NA	NA	NA	NA	NA

Source: uMgungundlovu District Health Plan 2018-2021 (DoH-KZN, 2018)

While it can be argued that the greatest resources are allocated to the most populated areas, it is necessary to bear in mind that accessibility to facilities, the conditions of said facilities, and the availability of infrastructure, including public sector human resources, remain a huge challenge. With a population of over one

million people, the four hospitals which provide most of the medical services comprise two district hospitals, one regional hospital and one tertiary hospital. Three of these facilities are currently in the greater Pietermaritzburg area. The disproportionate number of hospitals within the district, as evidenced, mirrors the inequitable distribution of people, with those most in need of health and other essential services situated furthest from them. Table 1.2 displays the population spread across the district.

Table 1.2: uMgungundlovu district population projection 2016

Sub-District	Total Population	% pop uninsured	Uninsured Population (Number)	Population density / km ²
kz Richmond Local Municipality	70 639	85	59 337	46
kz Mkhambathini Local Municipality	59 202	85	50 322	56.1
kz Msunduzi Local Municipality	670 107	85	569 591	75.6
kz The Impendle Local Municipality	32 678	85	27 776	63.13
kz Mooi Mpofana Local Municipality	37 628	85	31 984	1 042.8
kz Umgeni Local Municipality	99 409	85	84 498	62.4
kz Umshwathi Local Municipality	116 402	85	98 942	22.4
District	1 086 066	85	924 023	23

Source: uMgungundlovu District Health Plan 2018-2021 (DoH-KZN, 2018)

The Constitution of the Republic of South Africa, 1996 (RSA Constitution, 1996) mandates that the government is responsible for advancing, honouring, and safeguarding the rights enshrined in the Bill of Rights. In respect of health, it further prescribes that the state should undertake measures that are reasonable, and within its resources, to realise the rights to healthcare (RSA Constitution, 1996). To achieve this, the South African Government has, since 1998, undertaken to increase the number of Community Health Centres (CHCs) and Primary Health Care (PHC) centres to promote equal access to public healthcare services in the country (Lalla-Edward et al., 2022; NDOH, 2017). Whereas the justification to establish facilities based on population numbers, amongst other indicators, as determined by the National Department of Health is understood, the impact of the current staffing roles within community and primary level structures requires more discussion. The health

needs within communities continue to remain unmet due to the misalignment and shortage of suitably skilled healthcare professionals (HCPs). Table 1.3 provides the distribution of healthcare facilities in the uMgungundlovu district.

Table 1.3: Number of health facilities in uMgungundlovu, 2016/17

Sub-districts	Ward based outreach teams	Fixed Clinic	CHC	District Hospital	Regional Hospital	Central / Tertiary Hospitals	Other Hospitals
Mshwathi (Kz221)	2	7		1			
Umngeni (Kz222)	1	3					
Mooi Mpofana (Kz 223)	1	1	1				
Impendle(Kz 224)	2	3					
Msunduzi (Kz 225)	3	24	2	1	1	1	5
Mkhambathini (Kz 226)	2	4					
Richmond (Kz 227)	2	4					
District	13	50	3	2	1	1	

Source: uMgungundlovu District Health Plan 2018-2021 (DoH-KZN, 2018)

In the provision of cataract surgery in uMgungundlovu, the health equity argument is evidenced in the disproportionate and unequal availability of services. Cataract surgery for the district is only conducted at the three major hospitals in the Pietermaritzburg area.

Government hospitals work on a criterion for cataract surgery, to ensure that the greatest need is met first on a priority basis and the use of essential public resources. This means that patients, from the time of diagnosis (where access to eye health services exists), to the time they access surgery, need to live with varying levels of visual impairment. Patients on the waiting list for surgery, especially those who live, work and age in service-compromised areas, are at times excluded from the cataract surgery camps offered by private hospitals and non-government organisations (NGOs) in urban areas. This could be based on their location, access to marketing coverage for camps, and transportation issues when presenting for surgery at short notice. The limitations to accessing services are rooted in the

challenges to the social determinants of health which govern their lives. Notwithstanding these challenges, there is no specific policy governing corporate social responsibility and public-private initiatives which stipulates the prioritisation of vulnerable populations, or rural populations, as a compulsory beneficiary of such initiatives.

Forums for multi-sectoral responses to resolve priority issues in context-based settings are gaining momentum globally. Examples of these forums include the World Economic Forum and the WHO's forums for health and health research. The effectiveness of the solutions delivered by these forums is reliant on the sound management and organisational systems of the forum itself, which should be governed by a structured framework. To achieve this in South Africa, the Department of Monitoring and Evaluation in the Presidency developed a guideline for the creation of forums, which highlights the power-sharing dynamics within forums (Department of Performance Management and Evaluation, 2014). The District Health Planning and Monitoring Framework also addresses the establishment of forums and pathways to achieve district objectives (NDOH, 2017), while a Memorandum of Understanding existed between the uMgungundlovu District Department of Health and the Active Citizens Movement for the public-private health forum to serve as a means to address the obstacles faced in delivering eye health services to the rural poor. Despite its potential, there is limited knowledge regarding the forum's effectiveness in achieving this crucial objective, to address eye health service delivery challenges for the rural poor using the public-private health forum as a vehicle; and little is known about the role of the forum in achieving this important objective. This study was therefore, conducted to ascertain significant and appropriate ways in which the public-private health forum could be an effective means to address eye health services delivery in the uMgungundlovu district, Province of KwaZulu-Natal.

1.4 STATEMENT OF THE PROBLEM

Barriers to the delivery of an efficient cataract surgery service in the uMgungundlovu District include a poorly structured record-keeping system for patients on waiting lists for surgery. It also includes a high turnover of staff in state health facilities and poor

public procurement processes for the consumables needed for eye health services. These barriers particularly affect the acquisition and availability of intraocular lenses for cataract surgery and the equipment needed for theatre procedures; and lead to problems with delivering uniform screening services at PHC sites with a standardised referral pathway (anecdotal evidence – Dr Keith Wimble, June 2019), as part of government's mandate to provide accessible and quality health services to the public sector. The marginalisation of low-income groups, which have been previously disadvantaged, and is largely based on their race, class, and gender, through structured systems, affects their access to life-altering eye surgery services, and limited access to their basic rights. Addressing the issue of the cataract surgery backlogs at the district level allows for the structural failures to be addressed at a higher level, so that the proposed solution could have a broader benefit for all the people in the district, rather than a group of people dependent on the services of one facility (Dyer, 2006). In areas where primary health services are limited and patients have no access to eye health screenings, at the very least, undiagnosed cataracts cause avoidable blindness, which reduces able, independent people to being disabled and reliant wholly on the state for financial support. The situation invariably places an ongoing burden on the government to provide added resources for public health service delivery from the already constrained fiscus and state revenue fund, which necessitated the context and rationale of this research study.

Further challenges experienced lead to unintended consequences, particularly for patients from outlying rural areas who have been screened, diagnosed, and placed on waiting lists. The barriers to the uptake of services are due to logistical challenges; no reminders for appointments; the absence of caregivers in the home to assist; no accommodation for the night to allow the patients to present themselves for post-surgery consultation; and the rising cost of travel. Missed appointments for surgery means one less surgery is performed for the day, as this slot is not filled with another patient. Thus, backlogs continue to increase (Karumanchi & Ravilla, 2014:73). Such levels of inefficiency in eye health service delivery have a negative effect on the lives of the people, and those who live in rural areas suffer the most from interrupted primary eye healthcare. A systematic review of 36 studies (reviews) which empirically explored the impact of collaboration (PPP) between local

healthcare and non-healthcare organisations confirmed that such a partnership has the potential to bring about more tangible solutions and contribute to more efficient public health service delivery (Alderwick, Hutchings, Briggs & Mays, 2022:2), and should be encouraged.

In 2017, a non-profit organisation (NPO), called the Active Citizens Movement, initiated a public-private health forum to invite public and private stakeholders to convene and address the challenges associated with cataract surgery service delivery in the uMgungundlovu district. Aside from the annual reporting documents of the district and the National Eye Health Policy and Strategic Framework 2018-2022, it should be noted that there is a paucity of literature available which documents the challenges affecting the delivery of such a service in the district, especially to the disadvantaged and poor communities. A report from the Active Citizens Movement highlighted the unsustainable and inconsistent service delivery to be primarily due to the lack of co-ordination of care from an administrative level, which ultimately impacts the actual procedure and model for delivery on which it is based. The existing system fails to set priorities for the current demand for cataract surgery services (Wimble, 2019:1). This was found, secondary to the efforts of the forum's stakeholders to make available key resources, including equipment, human resources, and cataract surgery consumables, for weekend cataract camps to be held from July 2018 for three years as a significant intervention in the health crisis. The programme was stopped due to the inability to timeously quantify and contact patients on waiting lists at the three hospitals. The lack of a uniform database had far-reaching consequences, which included links to a malfunctioning public procurement process, the inequitable selection of patients, and an unstructured approach to delivering the relief strategy. The absence of a structured monitoring and evaluation (M&E) system in the Department of Health, as an essential part of this process, has resulted in a situation where the reporting of limitations appears to be disconnected from systematic and structural systems. This could be a contributing factor to the delay in the implementation of interventions to remedy the situation, and ultimately advance a more seamless and coordinated service delivery programme, considered as important aspect of public administration practice.

The South African government has made a considerable effort to restructure policies and systems to address the inequities which have resulted from the scourge of apartheid. The M&E of the policies to guide the change through initiatives led by the government, and supported by the private sector, and civil society, including the public, for effective implementation, remains an ongoing challenge. In a country with a rapidly growing population, the stagnant economy, and an increasing incidence and prevalence of diseases associated with low socio-economic communities, capacitation and support from all sectors is needed to ensure that the barriers to accessing the social determinants of health are mitigated.

The prioritisation to deliver a capable state sector, through new compacts between government, the private sector, and civil society organisations, envisioned by the National Treasury as a core element to achieve equity and transformation, is an affirmation of the ongoing need for well-balanced and sustainable PPP opportunities. A commitment by all sectors to support and implement government policies in the best public interest would be a basis to achieve a strengthened economy (Republic of South Africa, 2018), and without this being done, the country's economy continues to remain stagnant. In conducting this study, and led by its outcomes, a model to guide public-private interventions for eye healthcare services delivery has been advocated and put forward by the researcher as a new contribution in the research undertaken.

1.5 RESEARCH QUESTIONS

This study sought to examine and determine the extent of effectiveness of the public-private health forum to co-ordinate and address health service delivery, inequity, and challenges at a district level. The primary research question that the study was premised on is: "How can the public-private health forum be an effective means to address eye health service delivery in the uMgungundlovu district, KwaZulu-Natal?" To answer this question, the study focused on the specific intention of enhancing eye healthcare in the identified municipal area, and as such, the following research questions informed the study.

- What are the administrative and management barriers to effective eye health service delivery?

- How can a public-private health forum contribute to improved public health eye service delivery and performance?
- What are the governance approaches used by the forum to address challenges encountered in the public eye health service delivery?
- What are management and organisational approaches for the public-private health forum?
- How effective and efficient are the implemented M&E solutions, as well as the current reporting systems in place?

1.6 AIM AND OBJECTIVES OF THE STUDY

The aim and objectives that emanated from the key questions relating to the study are presented hereunder:

1.6.1 Aim

This study was conducted to monitor and evaluate the effectiveness of a public-private health forum to address ongoing health challenges and improve service provision in the public sector. The provision and improvement of equitable access to health services, which includes monitoring and evaluation with reference to eye care services in the uMgungundlovu district, is currently lacking, which impacts on the local communities' health and well-being. This gap has necessitated the research study to be undertaken.

1.6.2 Objectives

The objectives of the study are to:

- Identify the management and administrative barriers to effective public health eye service delivery.
- Determine if the public-private health forum contributes to improved public health eye service delivery and governance.
- Establish the governance approach used by the forum to address public eye health service delivery challenges.

- Identify the management and organisational approaches of the public-private health forum.
- Explore the effectiveness and efficiency of implemented M&E solutions and the current reporting systems in place.
- Create a model for district-level engagements which promotes effective management and organisational responses to health service delivery in addressing the public health needs of the local community.

1.7 CONCLUSION

Health inequity in South Africa has culminated in a negative cycle of public service delivery. Despite government's efforts to develop and implement policies to advance the goal of achieving equity, there remain challenges within the execution of these policies, with significant gaps in the M&E system. Public-private partnerships, as a globally recognised vehicle for collaboration to achieve solution-based outcomes for service delivery challenges, is an avenue which has been well-embraced in the South African context. These collaborations exist at various levels, from advocacy and policy design to the development and implementation sectors, and host multi-sectoral stakeholders. To this end, health forums have been growing in popularity to address and resolve the growing burden on the health sector in South Africa. While guidelines for the structure and constitution of such forums exist in theory, the unique design of forums in practice should possibly consider the 5C protocol and apply a Logic Model for potentially successful implementation, as explored in the theoretical exposition in the following chapter. The success or failure of forums to achieve their desired goals is not reflected in the relevant M&E processes, or the reporting systems. This research explored a case study focusing on a public-private health forum in the uMgungundlovu District Municipality in the KZN province, addressing the challenge of avoidable blindness in the district, due to a backlog in cataract surgery services. To conclude, the study aims to monitor and evaluate the efficacy of the forum in achieving its goal; and in so doing, improve the quality of life for local communities, as an important determinant of public administration.

1.8 STRUCTURE OF THE THESIS

The thesis is delineated into the following chapters:

Chapter One: Overview and general orientation of the research study

Chapter One presents the overview of the research. This chapter includes introductory sections to the study's background; a brief overview of the eye health situation globally, and particularly in South Africa; and a section which leads to the statement of the problem that was explored in the research. The aims and objectives and key research questions were presented prior to the theoretical framework informing the study. The chapter provides an overview and synopsis of the content of the thesis in this section.

Chapter Two: Theorisation of public healthcare management and public administration perspectives

Chapter Two focuses on the National Development Plan and the theory of healthcare management. This study is informed by the National Development Policy framework, the Logic Model and the 5C Protocol. Together, these policy constructs play a critical role in informing the theoretical perspectives of the research study that was undertaken. They are referred to in the data analysis and interpretation, and also support the discussion of the findings. For example, the National Development Plan, 2030, is critical for its key focus areas and determination to address the social determinants of health; and in providing for the socio-economic wellbeing of the citizens, which includes their physical health. Despite its slow implementation, the strategic plan serves, in this study, as a reference for attempts that the post-apartheid government has embarked on to promote equity in the country. The 5C Protocol is important in that it reminds one about key variables to consider when implementing a policy. For the purpose of this research, these areas include content; context; commitment; capacity; coalition support; and clients that are deemed critical and should be taken into consideration. The Logic Model, based on its structure using input, activity, outputs, outcome, and impacts approach, is used to guide the implementation process of the PPP. It is used in the analysis and discussion in the study.

Chapter Three: Eye health services across South Africa's public and private sectors

Chapter Three conceptualises and contextualises public healthcare management, and eye health service delivery within the paradigm of public administration, and underscores the challenges and opportunities for eye health service delivery improvement. The existing literature on the M&E of eye healthcare service delivery, found in non-conventional literature, peer reviewed journals, published and unpublished dissertations and theses from around the world, as well as in other parts of South Africa not covered in the case study, is reviewed. Key areas explored in the chapter are the global perspectives on eye health; the health system and the challenges that it faces in South Africa; the eye health situation and related service delivery in South Africa (with a focus on human resource-related challenges to service delivery); and the M&E of eye health service delivery in South Africa. The researcher also documented the proposed solutions to current challenges in the delivery of eye health services. This work supports the view that one of the best solutions to the eye health services delivery challenges could be the PPPs delivering the services, using the case study of the public-private forum as a tool to deliver the eye health service needs, as is explored extensively in the thesis.

Chapter Four: Research design and methodology

Chapter Four outlines the research methodology that was followed in the study. This chapter discusses the research design and the justification for the adoption and use of a qualitative methodology for this study; the research setting; and the sampling strategy. This is followed by a breakdown, in detailed sub-sections, justifying the data collection and methodology, as well as the population selection method. Data collection, ethical clearance and the study's significance are key sub-sections presented within this chapter. Given the structure of the health system and its human resource challenges, both in terms of the number of staff employed and the high turnover of staff, a limitation to the study was its small sample size. Additionally, some forum participants beyond the public sector had completed their tenure within their respective organisations, leaving no forwarding information. Their departure, with no adequate recording at institution-level and collectively for participation and commitments made, has been a key barrier to the sustainability of the health forum.

This has largely informed the contribution this study intends to make to new knowledge that centralises a capable administrative system and a database for PPPs related to eye health service delivery. The chapter concludes with a short summary.

Chapter Five: Data analysis and discussion

Chapter Five presented the data from the qualitative study and the analysis that was interpreted inductively from the lived experiences of the participants. The process and procedure followed during the field work are presented under this section. The presentation is in the form of images, where the researcher was allowed to take photos, and drawings, to give a sense of what the research entailed, and how data collection was conducted in the field. In this chapter, the researcher's experience of the field work is also presented, followed with a self-reflective summary on the data presentation. For the qualitative data analysis in this chapter, the use of thematic analysis, following all its recommended steps, is presented. The results from the analysis are presented in the form of quotes (presented exactly as the participants reported), followed with their interpretation from the perspective of the researcher.

Chapter Six: Proposed model for public eye health service delivery interventions

Chapter Six is dedicated to the proposed model recommended for PPPs intending to address eye health service delivery challenges as part of the new contribution to the research. The model proposes a central, uniform database as a necessary administrative tool ahead of programme design and implementation. This is premised on the feedback from participants who have highlighted the absence of a database as a barrier to planning, procurement, and progress in the forum's intended efforts. The presence of a well-structured database should allow for the tracking of patients from diagnosis to discharge; enable quantification of the need per facility; mitigate the risk attached to duplicate bookings at multiple facilities; and fast-track the procurement process, thus reducing stock-outs of consumables and necessary equipment. Additionally, and more importantly, the database, in its design, should allow for replication across districts, so that it detects bottlenecks at various stages within the process, allowing for targeted interventions by PPPs.

Chapter Seven: Conclusion and Recommendations

Chapter Seven presents a discussion of the findings with arguments supported by literature in the field of eye healthcare services. Where no previous information exists to support the findings, the researcher used the information collected empirically in the data collection process as evidence; and this became necessary to address the gaps in the existing literature. Further, the chapter provides an integrative summary of the study and presents pertinent recommendations arising from the empirical research to health policy-makers; healthcare workers in particular; and the state in general. The chapter also presents a contribution to the body of knowledge of public administration, and how the research adds to the growing concerns surrounding a prioritised area of service delivery i.e., public health, given that the research revealed the manifestations of problems related to eye healthcare, by advocating for a new, three-pronged approach which includes a theoretical contribution connecting public administration to public health service delivery; an empirical contribution by linking primary responses to salient aspects that are linked to key questions raised in the study; and lastly, practical relevance in establishing a public-private health forum with key stakeholders, advocating for an infrastructure-based approach for efficient public eye healthcare. In this section, some concluding remarks are made and areas for future research are also put forward to comprehensively address this very significant area of public health service delivery, as the issues surrounding this dynamic area of eye healthcare are an evolving concern for both policy-makers in the public health sector and for the government.

CHAPTER TWO:

THEORISATION OF PUBLIC HEALTHCARE MANAGEMENT AND PUBLIC ADMINISTRATION PERSPECTIVES

This chapter delves into healthcare management and theoretical components which form foundational elements for the research study. The chapter draws upon the Logic Model and the 5C Protocol to inform its theoretical perspectives. The 5C Protocol underscores key considerations for policy implementation, including content, context, commitment, capacity, coalition support, and clients. Meanwhile, the Logic Model guides the implementation process of PPPs through its structured approach. Additionally, the chapter focuses on New Public Governance, New Public Management, Public Value Theory and the theory of public administration. Overall, these frameworks provide a robust theoretical foundation for the research study.

2.1 INTRODUCTION

The study of public administration has come a long way. The concept of New Public Management (NPM) was created during the decade, 1980-1990, by some academicians (Hood, 199:31; Boston, Martin, Pallot, Walsh, 1996). New Public Management is based on neo-classic economics and managerialism. In the NPM, the different techniques of management employed in the private sector regarding economic efficiency are applied in public administration. From 1990 onwards, several countries around the world started using the NPM in bureaucracy reform and it became the mainstream concept for research on public administration (Sriram, Misomnai, Metasuttirat & Rajphaetyakhom, 2019:33). Later the concept of New Public Governance (NPG) was suggested by some academicians (Osborne, 2010:377). This new concept focuses mostly on the variety of pluralism. According to Sriram et al. (2019:33), it is crucial for public administration to prioritise proactive network management in order to adhere to the principles of good governance. This involves designing a structure that enables effective co-ordination between various parties or sectors. Hence, the provision of public services is not perceived as the sole responsibility of the government; but instead, all sectors ought to be considered,

with the necessary responsibility to take part in the management and operations relating to service delivery.

In South Africa, the health system plays an important role in the well-being of the population; and it is made up of two distinct sectors, notably private and public. Broken down into primary, secondary, and tertiary healthcare services, the public health sector is monitored by the National Department of Health and managed by various provincial health departments (Malakoane et al., 2020:3). The public health sector has the mandate to deliver quality healthcare, and the delivery of quality healthcare is enshrined in the RSA Constitution, 1996 (Stuckler, Basu & McKee, 2011:165). The rise to power of the democratically elected government in 1994 led to various attempts to improve access to, and quality of, public services. Despite the commendable effort made by the government to improve healthcare service delivery, the delivery of services in public healthcare facilities failed to meet basic standards of delivery for all users, and substantial changes have been made in terms of policy and legislation to deliver quality care since the early formative years of transformation (Mogashoa & Pelsler, 2014:142; Moyakhe, 2014:80). This led users to lose trust in the health system, which was ostensibly portrayed as ruined and in urgent need of repair (Koelble & Siddle, 2014:1118; National Department of Health, 2013).

2.2 LEGACY OF APARTHEID, CHALLENGES AND DEFICIENCIES IN THE SOUTH AFRICAN HEALTH SYSTEM – IMPLICATIONS FOR PUBLIC HEALTH SERVICE DELIVERY

It has been reported that many of the problems faced by the health system were the legacy of the apartheid period. During this period, moreover, the health system was not only discriminatory, but also fragmented between four population groups of South Africa, notably African, Coloured, Indian and White (Baker, 2010). As a direct outcome of the segregationist policy, the African population was divided into ten Bantustans, each with its own department of health and professional organisation. As a result, poor communities have been the most affected by the deterioration of public health service delivery because of a severe lack of resources in previous years (Chassin & Loeb, 2013:481; Baker, 2010:92).

Substantial efforts to improve healthcare service delivery have been made by the South African government over the last three decades. Despite this, the delivery of quality healthcare service is far from being achieved and has faced several issues and challenges in recent times. These include long waiting times because of human resource shortages; a shortage of equipment; poor record-keeping; adverse events (death, disability or permanent damage, birth defect/congenital anomalies, prolonged hospitalisation, amongst others); an increase in medical malpractice litigation; poor hygienic conditions, and poor measures for infection control.

It can be said that human resources have not been the strength of the South African public health system, let alone in Africa. As compared to the global health workforce, Africa has the lowest number of healthcare workers, which is cause for concern in the health sector. According to the 2020 Report on Health (WHO, 2022), there were approximately 300,000 doctors and 1.2 million nurses in Africa, as compared with 3.4 million doctors and 7.4 million nurses in Europe. The western Pacific region, made up of countries such as Australia, China, Japan and Malaysia, recorded the highest number of doctors – around 4.1 million, and 7.6 million nurses (Ahmat, Okoroafor, Kazanga, et al., 2022: 3). Furthermore, Africa has a ratio of 1.55 healthcare workers per 1000 population, which falls well below the ratio of 4.45 (physicians, nurses, and midwives) healthcare workers per 1000 population recommended by the WHO for delivering essential health services and attaining universal health coverage (UHC) (Ahmat et al., 2022:3; WHO, 2016:42). Only four African countries, namely Mauritius, Namibia, Seychelles and South Africa, have densities above the WHO recommended threshold of 4.45 doctors, nurses and midwives to advance towards UHC (Ahmat et al., 2022: 3). However, because of the unequal distribution of healthcare workers in the South African health system, between the private and public sectors, the users of the public sector have access to a very limited number of healthcare workers (Barron & Padarath, 2017:4). Insufficient and inadequate healthcare workers, therefore, lead to long waiting times which, again, result in physical and mental exhaustion and may also place users of public health services in a far worse situation (Tana, 2013:82).

Concerns have been expressed over the impact of the shortage of equipment on delays recorded in cases of urgent surgery. It was reported that cancer patients, for

instance, in need of oncological treatment, experience extended delays because of the lack of equipment (TimesLIVE, 2018:5). This also applies to those who await surgery or diagnosis. It was reported that the extended delay before surgery increases the risk of further complications, including death. Public hospitals were described as “a death trap for the poor” (TimesLIVE, 2018:5). This highlights that insufficient equipment results in extended hospital stays, as patients must wait for the machinery to be repaired (Mokoena, 2017:55). Generally, public hospitals experience a scarcity of medical equipment, manifesting in the unavailability, substandard quality, and inadequate maintenance of the limited available equipment. This shortage had adverse effects on nursing care, the nursing profession, and the overall functioning of the hospital in terms of health service delivery. (Moyimane, Matlala & Kekana, 2017:1).

There have been many instances where users of the public health sector developed complications and died after being denied healthcare, or unfortunately being turned away from healthcare facilities (Maphumulo & Bhengu, 2019: 2). A few incidents are cited here to give further context to the discussion and the deficiency of public resources to meet the rising demands of public health needs: The family of a 35-year-old woman held tertiary hospital staff in the province of KwaZulu-Natal responsible for her death after she was turned away, despite being critically ill (Sunday Tribune, 8 March 2015:2). An incident was reported in Cape Town of a one-year-old boy who was turned away from more than two healthcare facilities and ended up losing his life on his grandmother’s back (Kama, 2017:2). Another unfortunate incident involved a teenager who was denied access and compelled to give birth outside the premises of a township healthcare facility (Kama, 2017:2).

A study conducted in a KwaZulu-Natal hospital reported that 13% of in-patients experienced adverse events such as falls, pressure ulcers, injuries and infections that were acquired whilst in the hospital, as well as medication errors (Mgobozi & Mahomed, 2021:4). The spate of events as a result of inadequate primary healthcare facilities for public health service delivery is distressing, and compromises the provision of sufficient, quality professional medical assistance in real time.

2.3 OVERSIGHT MEASURES AND RECORD KEEPING

These events associated with poor public service delivery highlight a lack of M&E and insufficient oversight measures to ensure that the policy issues are brought to the fore to be addressed by the relevant health authorities in the Department of Health. It was reported that poor record keeping is responsible for delaying patients from obtaining medical attention (Kama, 2017:84). This happens because healthcare workers do not approach the patients and explain to those whose files are either missing or lost. Instead, they merely let them wait for prolonged periods of time without attempting to find them a solution to the dire situation. Sometimes, the loss of files leads to the loss of the medical history of the patients, and this can cause further complications and sometimes results in the death of patients, especially when the illness is misdiagnosed (Kama, 2017:84). An incident at a district hospital in Pietermaritzburg was a case of neglect over the alleged loss of one of the twins born in the facility, while the surviving child had cerebral palsy due to negligence at the time of delivery (Regchand, 2015:2).

2.4 GOVERNANCE RISKS ASSOCIATED WITH PUBLIC HEALTH

There has been a noticeable rise in medical malpractice lawsuits filed against the Department of Health over the years. This exerts further strain on the constrained budget as it involves large pay-outs, and such litigation places an undue financial burden on the public health sector. In 2015, the health minister acknowledged that medical malpractice has been blown out of proportion, to the extent of becoming a crisis, as he declared that “the nature of the crisis is that our country is experiencing a very sharp increase - actually an explosion in medical malpractice litigation, which is not in keeping with generally known trends of negligence or malpractice” (Kollapen, Carnelly, et al., 2017:3). In 2015 alone, total litigation pay-outs amounted to nearly R500 million (Kollapen et al., 2017:16). A report in *The Outlier* (August 18, 2022) highlighted that, from 2014 to 2021, an estimated R9.7 billion was paid out to those instituting litigation and seeking relief through the law courts from the Department of Health. This proportion represents only 1.8% of medical malpractice claims, which amounts to a total of R536 billion for the period of discussion, and in the context of the study (Gatticchi, 2022:1).

Regarding poor hygienic conditions and poor measures for infection control, public healthcare facilities were described as having extremely old and poorly maintained facilities, and poor measures to help curb the spread of infectious disease (Young, 2016:20). Furthermore, most public healthcare facilities run into challenges inherent in the management of cleanliness, waste management, grounds and equipment maintenance (Dunjwa, 2016:1; South African Medical Association, 2015:36). For instance, on the waste management side, a study conducted in public healthcare facilities in Gauteng province reported that “only 11.7% of healthcare waste officers are guided by the Occupational Health and Safety Act to develop their healthcare waste management plans, with only 29.5% with healthcare waste minimisation strategies in place (Ramodipa, Engelbrecht, Mokgobu & Mmereki, 2023: 1). Another study conducted among patients and staff highlighted the existence of some departments with physical environments which were not conducive (for example unclean toilets) to the delivery of quality healthcare services. The existence of these multiple challenges highlights the shortcomings inherent in the structures responsible for the administration of public healthcare.

2.5 HEALTH SYSTEMS: STAKEHOLDERS AND SYSTEMIC INFLUENCES

The WHO describes health systems as consisting of “all the people and actions whose primary purpose is to improve health. They may be integrated and centrally directed, but often they are not” (WHO, 2000:1). Doctors, nurses, and other professional are part of a multiplicity of stakeholders whose practices require the involvement of occupational therapists, physiotherapists, or nutritionists, to provide comprehensive healthcare that extends beyond symptomatic relief; instead adopting a healthcare approach that is preventive and holistic for better sustainability. There is more to the health system than the human resource aspect. Mayes (2004:2) indicated that the system of a country is not only “the product of one, logical policy-making experience” but also “the manifestations of many years of historical development”. Hence, the health system of a country is deep-rooted in its cultural administration, political management, and financial and economic abilities (van Rensburg, 2004:3-5).

2.6 FRAMEWORK INFORMING THE HEALTHCARE SYSTEM

The framework informing the health care system is based on some of the emerging basic designs that have been refined in the last century (WHO, 2000:13). Kgasi (2022: 1) posits that the South African health care system is facing unprecedented challenges in its ability to deliver health services due to systemic challenges, including those impacting the leadership, governance and healthcare delivery frameworks. Katuu (2018:134) asserts that a health care system extends beyond being a derivative of policy only to include the historical context it originates from. Kgasi (2022:28) highlights that a health care system fundamentally includes broader systems beyond health service delivery that impact how people live, and ultimately how they uptake services. Jarvis (2020:1) elaborates on this idea to situate healthcare systems and public health systems in contrast to each other despite the existence of frameworks to conceptualise healthcare systems. The framework for health systems have been categorised into common typologies based on basic designs including the Cockerham-Steven's framework model; the Roemer framework model; and the Santerre-Neun framework model (Roemer, 2001:367; Santerre & Neun, 2010:103; Cockerham, 1992; Stevens, 2010, as cited by Katuu, 2018:139).

The fee-for-service model characterising the two-tiered South Africa health sector model allows for healthcare providers in the private sector to be re-imbursed for services delivered. This is based on the Cockerham-Steven's framework model where the free-market healthcare system is centred on wider free-market principles with nearly no state intervention. In this system, the financing and healthcare service delivery depends on users' purchasing power for the private sector and welfare provision for the public sector (van Rensburg, 2004:14). The Cockerham-Stevens model has four categories that include the free market system, the socialised medicine system, the decentralised national healthcare system, and the socialist medicine system (Katu, 2018:140).

The Roemer framework model, emerging in the 1970s crafted during the 1970s, reflects the healthcare systems that encourages efficiency and preventive care through its matrix approach centred on economic levels of people. These include the

affluent and industrialised, developing and transitional, very poor, and very resource rich (Katuu, 2018:140).

The Santerre-Neun framework encompasses various systems that comprise socialised insurance, NHI, public contracting and pluralism (Santerre & Neun, 2010:103). Within the socialised insurance system, healthcare is funded through government-mandated contributions from employers and employees, and the delivery of healthcare is carried out by private providers (Katuu, 2018:141). It takes on a value-based approach, prioritising the improvement of patient outcomes while controlling costs.

While these models represent different approaches to structuring healthcare payment and delivery, each with its advantages and challenges. The choice of model often depends on the goals of the healthcare system and the balance between cost control and quality improvement. The ongoing efforts to reform South Africa's healthcare system, aimed at achieving Universal Health Coverage (UHC), underscore the critical importance of addressing leadership and governance weaknesses. Despite the policy emphasis on accessible, equitable, and quality healthcare, the existing challenges, including poor healthcare quality and insufficient stakeholder engagement, highlight the need for comprehensive reforms. Recognising the diverse social and economic realities of communities is paramount in tailoring reforms to cater to the unique needs of the population. This shift requires a multi-dimensional framework that not only considers healthcare access and financial protection, but also acknowledges the broader interdependencies between health and the overall functionality of environments. Reforming the health system is not merely about addressing immediate healthcare concerns; it is a strategic imperative to enhance the overall well-being of the population and align healthcare services with the broader socio-economic context (Kgasi, 2022:360).

2.7 THEORETICAL FRAMEWORK OF THE PUBLIC HEALTH SYSTEM IN SOUTH AFRICA

The theoretical framework guiding this research study is informed by the South African National Development Plan (NDP), 2030, covering the advantages, failures,

and opportunities that it presents concerning service delivery in post-apartheid South Africa (SA). The study is theorised within the Logic Model and the (5C) protocol (with added emphasis on two additional Cs) of healthcare management, which are described as content; context; commitment; capacity; clients/coalitions; communication; and co-ordination. The argument in this chapter, and within the entire thesis, suggests that eye health service delivery can be improved through the implementation of these 7Cs, which are not being implemented in all sites where public healthcare services are delivered. An emphasis on this aspect adds to the new contribution from this research study.

2.7.1 Contextualising the National Development Plan, 2030 for health service delivery

Initiatives and processes for improving health systems and access to healthcare services, specifically access to, and utilisation of, eye care, cannot be discussed without reference to the NDP framework. This research is therefore, informed by the NDP, as one of the first attempts by the South African Government to address the social determinants of health, and ultimately improve the lives of its citizens. The NDP, 2030 proposes building a capable and developmental state, as alluded to in the RSA Constitution, 1996. A capable state is one that can formulate and implement policies effectively for the general welfare of its citizens, as a cornerstone of good public administration. To effectively achieve the objective of promoting overall well-being, it is essential to establish a culture centred on wellness. This culture should be ingrained within the community from the outset. To deliver on this mandate, the government is expected to take the necessary measures to address health service delivery in this context (RSA NDP, 2011d). Through the NDP, the South African government recognises that health is a fundamental right, which must be equitably distributed by 2030 (South African Government, 2021). The NDP states that the government must “provide affordable access to quality healthcare while promoting health and wellbeing” (South Africa NDP, 2021:24). However, studies in South Africa indicate that healthcare services are not evenly distributed, especially to impoverished communities. Moreover, the desired health outcomes are not realised by all people; hence the need to revisit the NDP, which calls for the inclusion of different sectors of society to realise better health outcomes. Equally, the South

African government sector runs Eye Care Awareness programmes that usually run from 21 September to 18 October each year. This indicates that the government could play a significant role in addressing eye healthcare equity, especially for the poor and disadvantaged sectors of society. The South African government recognises that 75% of all cases of blindness are avoidable, either through prevention or through treatment (South African Government, 2021).

It is expected that the effectiveness of the public-private health forum as a 'vehicle' to address the inequitable access to eye health services will depend on how the forum is structured, and its capacity to share tasks and manage accountability amongst its stakeholders. The guidance offered by the RSA Constitution, 1996 with its founding principles, and the degree to which its principles are adopted and implemented, will have an influential role in the identification of key challenges and appropriate responses thereto.

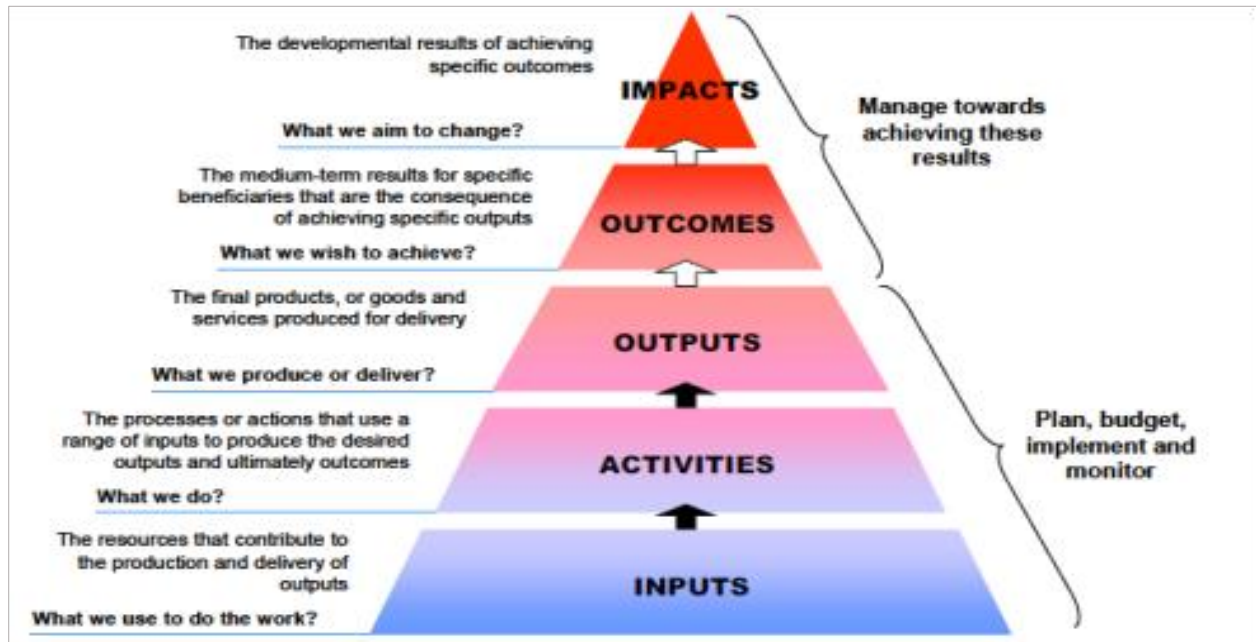
This is founded on the premise that segregated systems in the history of the country have always served to limit access to healthcare to certain groups of people. While the basis for the inequality varied from race to class and gender, under the previous national regime, it is currently based on the socio-economic status of communities and households, and the ability for individuals to afford healthcare services. This is contrary to the constitutional rights afforded to citizens of the Republic, which afford them the right to healthcare, free from discrimination based on race, gender, religion, and socio-economic status.

2.7.2 Utilising the Logic Model for public health service delivery

In 2005, the South African government authorised the Policy Framework for the Government-Wide Monitoring and Evaluation System (GWMES). This framework emphasises the improvement of performance and evaluating accountability for making informed decisions for enhanced service delivery. Through the implementation of GWMES, public officials can address policy and programme implementation. The model is employed to situate the scope of eye healthcare delivery and pinpoint gaps by establishing a causal connection between activities, outputs, outcomes and impacts, as depicted in Figure 1.1. Evaluating whether the

intended work outcomes were realised and discerning the factors contributing to the success or failure of these outcomes is crucial to this study (RSA Department of Performance Management and Evaluation, 2011).

Figure 2.1: Logic Model



Source: Republic of South Africa Department of Performance Monitoring and Evaluation, (2011: 5)

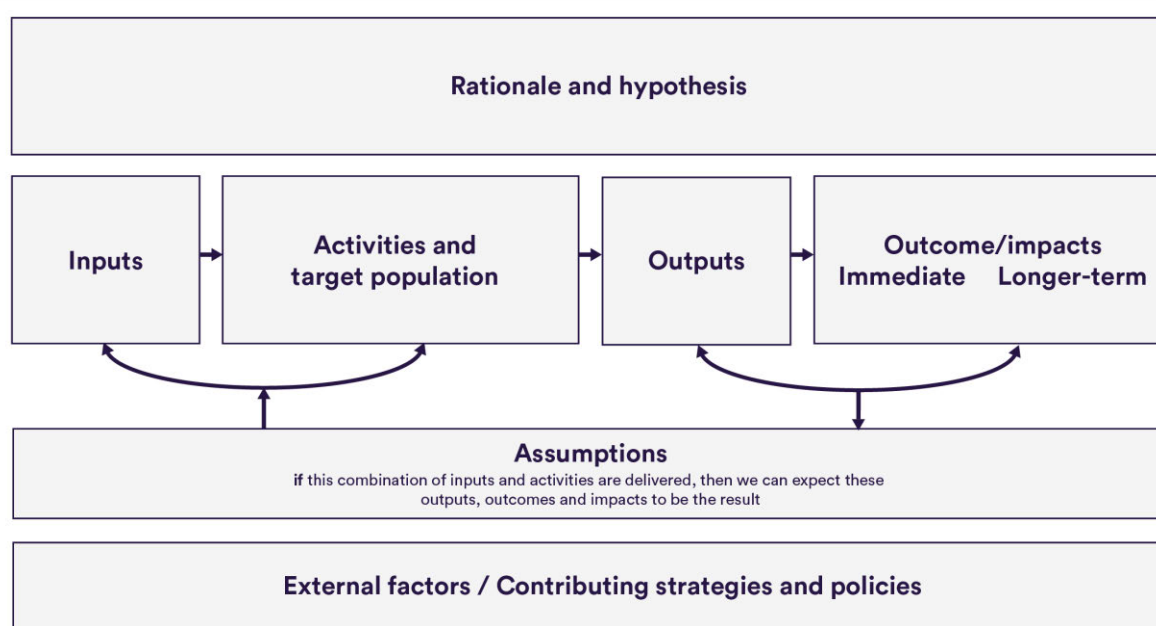
2.7.3 Relevance of the Logic Model for the performance monitoring of eye healthcare

A Logic Model is a credible and logical representation of how the programme would operate within specific environmental conditions to address identified issues (McLaughlin and Jordan, 2015:8). It can serve as a convincing approach to providing insights into the expected performance of a programme, shedding light on the problems faced by the programme in how they may be dealt with, and highlighting how it is the only possible way to address it. The Logic Model is made up of factors such as resources, outputs, activities, and longer-, intermediate-, and short-term outcomes (Wholey, 1987). Other factors such as relevant external context and customers reached can be added (McLaughlin and Jordan, 1999:67). This model can be a useful tool in eye healthcare services, especially in light of the status quo of

the public health sector in the province of KwaZulu-Natal in particular, and the country in general.

The public healthcare providers, in partnership with private role players, must collaborate to fight the healthcare challenges in poor communities by utilising the essence of the Logic Model (Suarez-Balcazar, 2005). The Logic Model creates the road map that outlines the shared relationships of all role players (researchers, eye health service providers, patients) and resources (Tabriz, Flocke, Shires, et al., 2020:752). Furthermore, the Logic Model highlights programmes that could yield the desired change for the people (in this instance, eye healthcare recipients). The model evaluates the outcomes; the lifecycle of a policy, programme, or initiative; and how people can be integrated into the decision-making process regarding services (Watson, Broemeling, et al., 2009:36). Additionally, the model shows how the eye healthcare programme's activities must be implemented in a supportive practice environment; for instance, by the sharing of decision-making by all relevant stakeholders. The model evaluates the resources (funding, human resources, infrastructure) used to implement healthcare programmes, outputs, and results (Watson et al., 2009:34), which are fundamental for good public administration practices. This study adopted the following Logic Model, as illustrated in Figure 2.2, to evaluate innovative eye healthcare programmes in the South African context.

Figure 2.2: Logic Model



Source: Kumpunen (2020)

2.7.4 The 5C Protocol theory for eye healthcare service delivery

There are several key variables in policy implementation that have emerged in the global debates among scholars (Paul, 2010:15). The current research only draws on Brynard and De Coning's (2006) five key variables for comprehending policy implementation. These five variables are known as the 5C Protocol (standing for content; context; coalitions; commitment, and capacity), described by Brynard and De Coning (2006:194) as "a '5C' protocol that makes sense of the complex nature of the policy implementation process, simply on the basis that each of the five variables is linked to, and influenced by, each other". Each variable will be discussed in the data analysis and discussion chapters that follow in the thesis.

To assess the effectiveness of a health forum to address eye health service delivery, the input-output-outcomes-impact approach of M&E was conceptualised and contextualised in theorising the study. With role players from governance, including the private sector and civil society, emphasis is on the 5C Protocol Model in the public policy discourse on the level of effectiveness of service delivery, albeit within the context of eye healthcare service delivery. This model is dependent on context, content, coalitions, commitments and capacity for the implementation of public

policy, so that policy goals satisfy the needs of the public, and an integrated management approach can be implemented (Sibiya & Subban, 2018:12). The M&E of a public-private health forum would expand to include the analysis of roles and capacities of all stakeholders, and the risk-sharing between them, and would include the principles which underpin the service delivery goals, with a view to equity and efficacy. Thus, qualifying and quantifying their input, output, activity, outcomes, and the impacts of the coalition of clients, or in this case, the partners is apt.

Regarding its contribution, the 5C is described as an important tool for any healthcare service provider (in the context of this research study), which can be used to evaluate performance. It is associated with caring attributes such as compassion; competence; confidence; conscience, and commitment (Pusari, 1998:56). A further extension of the 5C protocol into two further protocols strengthens the construct for healthcare management. To demonstrate this, Roach (2013) speaks about the sixth caring attribute, termed comportment. This caring attribute is relevant and focuses on the conduct of healthcare professionals towards patients and their families, and includes factors such as respect, truth, inclination to care, and professionalism. Communication has been incorporated as an additional caring attribute, recognised as a crucial element in the delivery of public healthcare services within a given context. It is characterised as pivotal to fostering successful caring relationships and facilitating effective teamwork (St. Catherine University, 2017). Similarly, it is relevant since, being capable of listening to someone, noticing his or her problems and needs, and being with him or her when problems must be solved, especially from a health perspective, is a fundamental imperative (Dobrowolska, Slusarka, et al., 2014:856). The South African eye care industry is not proportionately distributed: the public sector is more burdened than the private sector (Majid & Subban, 2021:477). It is hence possible that the attributes of caring may be affected by this imbalance. A variation of the 'Cs' is provided by some literature, and include content; context; commitment; capacity; clients/coalitions; communication, and co-ordination (Burger, 2015:24; Cloete, de Coning, et al., 2018). These seven caring attributes, which also include compassion; competence; confidence; conscience; commitment; comportment, and communication, are described as seven interlinked variables which play a key role as a catalyst for understanding public policy implementation

more effectively (Skhosana, 2019:1). They are deemed most apt for theorising public healthcare service delivery, with particular reference to eye healthcare, as is the focus of this study.

Healthcare management is a planned and scientific process that should facilitate the smooth running of institutions (Kenneth, Lakhawat, Agymen, 2017:513). As such, healthcare facilities must be run in a scientific manner to yield the desired outcomes of efficient and effective functioning; for instance, by ensuring that staff members are adequately trained and managed. As such, there is a need for efficient healthcare administrators and staff who have, or demonstrate, compassion; competence; confidence; conscience; commitment; comportment, and communication. Figure 2.3, which follows, highlights the 5Cs needed for efficient healthcare administration. These include personal factors such as a combined framework, team, community context and influences.

Figure 2.3: The 7Cs Protocol for efficient healthcare management



Source: Couper and Hugo (2002:4)

2.7.5 Creating Public Value: Bridging Theory and Practice in Public Health Service Delivery

Public Value Theory emphasises the creation of societal value through public sector activities, prioritising outcomes that are valuable to the public. It suggests that public organisations should not only focus on efficiency and effectiveness but also on achieving outcomes that contribute to overall societal well-being and development. This approach underscores the importance of addressing societal needs and aspirations while operating in a transparent, accountable, and citizen-centric manner (Virtanen and Jalonen, 2023).

Whereas New Public Management (NPM) emerged in the 1980s and 1990s, advocating for applying private sector management principles to the public sector through improved efficiency, effectiveness, and accountability by emphasising results-oriented management and the use of market mechanisms in public service delivery, among others, it shares some common goals with Public Value Theory, such as improving the performance of public organisations and enhancing service delivery, but its focus remains primarily on market-oriented reforms and performance measurement (Mongkol, 2011).

In contrast, New Public Governance (NPG) emphasises collaboration, networked governance, and citizen participation in public administration. Further, it emphasises the importance of relationships and networks in addressing complex public policy issues and promotes trust, cooperation, and social capital in governance (Nel, 2015).

Public Value Theory aligns with both NPM and NPG in certain aspects. It complements NPM's focus on efficiency and effectiveness by emphasising the broader societal value created by public organisations. Similarly, Public Value Theory resonates with the collaborative and participatory principles of NPG by emphasising citizen-centricity and democratic legitimacy in public service delivery (Virtanen and Jalonen, 2023). Overall, it provides a comprehensive and holistic approach to improving public health service delivery that is compatible with the goals of both NPM and NPG. It underscores the importance of creating value for society through transparent, accountable, and citizen-centric public sector activities, contributing to improved health outcomes and societal well-being.

2.8 POLITICS-ADMINISTRATIVE DICHOTOMY AND IMPACT ON PUBLIC SERVICE DELIVERY

Over time, the dichotomy of administration and politics has been at the centre of much debate amongst scholars and practitioners in the field of public administration (Stillman, 1973; Svava, 2001:176). This is believed to be sparked by the quote by Woodrow Wilson who stated that, "*It is getting harder to run a constitution than to frame one*" (Baker, Miller & Bratton, 2015:130). In other words, in the realm of public administration, a definitive answer to the question of how to assess its success or

failure remains elusive. It always seems challenging to distinguish between political and administrative roles at the municipal level in South Africa, as a case in point. Amongst scholars, there is no consensus on this matter: some perceive no separation between politics and administration, while others believe they are separable and every effort must be made for them to remain so (Akindele, 1994:303; Svara, 2001).

The existing political system in South Africa operates on the principle of dividing powers among three independent branches or spheres of government. These are the legislature, executive, and the judiciary. It is worth highlighting that this principle is not only applicable to the three arms of government, but also to all government institutions, as well as municipalities. Yet it is stipulated in Chapter Three, Section 40, of the RSA Constitution, 1996, that the three spheres of government are interdependent, inter-related and mutually inclusive in terms of intergovernmental relations. Overall, in terms of intergovernmental relations, the principle of separation of powers requires that each sphere of government governs its respective matters. As a result of this, the internal structure of municipalities is divided into two divisions as far as governance is concerned (Vilakazi & Adetiba, 2020:49). The governance of municipalities depends on its two political and administrative divisions. Grant (2014:87-88) reveals that these two spheres differ in nature and mandates as far as municipal governance is concerned.

Maloba (2015:83) reports that misuse of power impedes the growth of municipalities and affects people's well-being. Likewise, the principle of separation of powers is neither clearly applied nor respected in municipalities. The misuse of this principle not only violates the law and leads each section or division in a municipality to be regarded as collaborative, but is also associated with some negative outcomes. It leads to poor municipal governance and creates political and administrative dissension (Govender & Reddy, 2015:19). It impacts policy development and implementation, since those who develop policies are believed to be the right people to provide instructions on how implementation should be carried out (Signe, 2017:10). It results in jurisdiction tensions between both spheres, since the political sphere deploys its cadres in some positions, based on their loyalty to the political in

power, while the responsibility for appointing administrative personnel belongs to the administrative sphere (Vilakazi & Adetiba, 2020:51).

Although public health is not a municipal function, but rather an unfunded mandate, their involvement in the provisioning of mobile health services, and their involvement to indirectly improve health and life outcomes for their people, requires an alignment with national health goals. The interdependence between the national Department of Health and municipalities is thus a crucial relationship for effective health service delivery. From the provincial-municipal perspective, the discussions on intergovernmental relations and the political-administrative dichotomy are particularly relevant to the provisioning of eye health services. The deployment of personnel, loyalty considerations, and governance challenges within municipalities, may influence how eye health services are organised and delivered at the local level. Addressing these challenges and ensuring a harmonious intergovernmental relationship is crucial for an effective and efficient public health service delivery system in South Africa.

2.9 THE 'E' ASSOCIATED WITH PUBLIC ADMINISTRATION

English words beginning with the letter 'E' are used to determine the quality standards of public administration. These include efficiency; effectiveness; economy; equity; equality; and ethical and (empirical) evaluation (Baker et al., 2015: 131). Within eye health service delivery, the E's can be interpreted as the earliest access to primary health services for screening, diagnosis and, when required, referral for specialist care (efficiency). Effectiveness is associated with the ability to provide the most services at the earliest entry point to the system. This includes preventive healthcare approaches and timeous surgical interventions with reduced waiting times (effectiveness). The direct and indirect costs to the patients in seeking care, including transport; time taken off from work for those in employment; and the need to access primary eye care services in the private sector, where these are not available in the public sector, even more so in rural areas, is connected to economy. Adequate planning and procurement, in a well-structured health service delivery programme, mitigates financial risks through overspending (economy). The availability of eye clinics at community level would mean that people in peri-urban

and rural areas have increased opportunities to access care with the least amount of effort and expense (equity). The uniform positioning of eye health services across the urban-rural sectors, at the same service delivery level, would enable equality. The presence of a well-designed database would reduce the risks of a negative information cycle through better identification of indicators aligned with the national eye health mandate. This would yield better ethical and empirical evaluation, which this study has identified as a gap impacting public eye health service delivery.

In public administration, efficiency is used to measure factors such as funds or work hours with the outcomes of efforts made by the public sector (Baker et al., 2015). Effectiveness involves answering the question of whether the public programme achieves the desired changes that society initially aimed for in the development of public policy (Baker et al., 2015:133). The resources of a region or country are the main administrative tools to improve the economy, compared to wealth. Equity refers to the notion of being fair and impartial, or the value of the shares issued by a company (Baker et al., 2015:136). Both descriptions of the concept of equity in public administration deal with the assessment of fairness in the distribution of benefits and resources inherent in the public sector. Concerning equality, there are equal rights in terms of rights, opportunities, and status. Ethical evaluation is related to the discipline or moral principles addressing the ethical aspect of public administration. Empirical evaluation is characterised as developing a conception of the quantity, number or value and 'empirical' pertains to, is associated with, or can be verified through observation or experience, rather than through theory or pure logic (Baker et al., 2015:140).

Efficiency; effectiveness; economy; equity; equality; ethical and (empirical) evaluation of public administration are perceived as factors that can enable public administration to attain excellence. This perception is shared by theorists and practitioners, alike, who see the possibility for not only measuring, but also striving for and attaining excellence in, public administration. These expectations render public administration an integral facet of political dialogue and a defining factor of democratic governance (Baker et al., 2015:148). Public administration plays an important role in any country, and this leads to the perception that it could be instrumental in the formulation of universal laws (Baker et al., 2015). Hence, in order

to keep up with changes, public administration needs to evolve to provide an efficient and effective service to communities.

2.10 NEW PUBLIC MANAGEMENT AND NEW PUBLIC GOVERNANCE

The New Public Governance (NPG) is concerned with making public administration responsive, democratic, and efficient. It is suggested that the NPG does not seek to do away with the bureaucratic model, and NPM can be useful in the construction of the NPG (Osborne, 2010; Wiesel & Modell, 2014:176-177). However, the NPM seeks to increase efficiency, accountability, and responsiveness in the public sector by introducing managerial techniques and market-oriented reforms. In the context of health service delivery, it advocates for measures like privatisation, contracting out services, performance-based funding, and user choice to improve healthcare provision in conflict to NPG (Rubakula, 2014:86).

Public Value Theory, as a proposed alternative to NPM posits that the primary purpose of public organisations is to create value for citizens and society as a whole. It shifts the focus from merely achieving efficiency and effectiveness to achieving outcomes that benefit the public interest. Public value is created through the delivery of services, the promotion of social justice, and the enhancement of democratic processes. In the healthcare context, public value theory emphasises the importance of delivering high-quality, accessible healthcare services that meet the needs of diverse populations and contribute to improved health outcomes and social welfare (Naidoo and Holtzhausen, 2020:192).

In the South African context, these theories intersect and influence each other in shaping health service delivery. The legacy of apartheid has left enduring disparities in access to healthcare, with significant challenges related to resource allocation, infrastructure, and workforce distribution (Maphumulo and Bhengu, 2019). The implementation of NPM reforms in the post-apartheid era aimed to address these challenges by introducing market-oriented mechanisms and managerial practices. However, critiques of NPM have highlighted its limitations in addressing equity concerns and promoting inclusive governance (Nel, 2015:76).

In response to these critiques, there has been a growing recognition of the importance of NPG principles in South Africa's health governance (Van Ryneveld, Schneider, Lehmann, 2020). Initiatives such as district health systems, community health worker programs, and public-private partnerships reflect a shift towards collaborative and participatory approaches to health service delivery. Public value theory underpins these efforts by emphasising the need to prioritise outcomes that benefit the public interest and promote health equity.

The NPG is perceived as a model that is able to mediate interests in effective and efficient management and ensure the considerable involvement of democratic rules to develop, manage, and implement public policies (Bingham, Nabatchi, et al., 2005:548-549; Sorrentino, Sicilia, and Howlett, 2018:278). In more advanced countries, the involvement of several actors in governance processes is regarded as a better way to deal with complex problems (Sorrentino, DeMarco, Rossignoli, 2016:652). The participation of citizens in the public service is believed to make modern public administration more effective. The NPG is based on three fundamentals, which are: deliberative democracy; public value of decisions; and the co-production of decisions.

The concept of deliberative democracy is concerned with the way in which citizens rely on the rules of democracy (Pereira & Ckagnazaroff, 2021:114). It aims to design conditions that are conducive to legitimise democracy "where the discourse theory proposes an ideal procedure of deliberation and decision making" (Pereira & Ckagnazaroff, 2021;114). The democratic procedure assumes that results that stem from a flow of relevant information are trustworthy and can be used without hesitation (Faria, 2000, cited in Pereira and Ckagnazaroff, 2021:114). Furthermore, this procedure needs to be legitimate. This issue is addressed by Bohman (1996:183) as he explores this issue, asserting that the legitimacy of a law stems from an equitable and transparent participatory process open to all citizens, incorporating the publicly accessible justifications of these individuals. Regarding the public values of a society, Bozeman (2007:13) proposes that these relate to the entitlements, advantages, and privileges citizens should (and should not) possess, their duties towards society, the state, and each other and the fundamental principles that governments and policies should adhere to. Public value can be produced by

any actor in society, this is to say a private or public company, or a governmental organisation (Alford & Hughes, 2008:131; Jørgensen & Bozeman, 2007). It is not the producer that makes it public, but the consumer. Moore (1995:160) makes it clear that it is a public value, not when it is individually consumer by a customer, but when it is collectively done by citizens. Co-production is described as a group of activities that involves public agents and citizens who develop public policies and work together to find an efficient implementing approach for the best delivery of services (Pereira and Ckagnazaroff, 2021:115). For some, co-production is seen as a necessity in times of austerity, while others perceive it as a way of rethinking the role played by citizens, government, and civil society (Nabatchi, Steen, Sicilia, Brand, 2016:1). It is worth highlighting that public administration has shifted away from outdated bureaucratic institutions that would develop and implement policies in siloes. It has adopted a customer-oriented approach to ensure that citizens' needs are met, since they are involved from start to finish. Farrell, Hatcher and Diamond (2022: 119) state that, new governance has been prominent as public administration has shifted from public management to public governance in the evolving nature of public administration education. They assert that, the focus on democracy, equity and evidence need to be linked to the community, and emphasis needs to be placed on the need to solve public problems and challenges through collective action in order to protect the individual rights and health of individuals. The authors further state that the collective action of government is needed to ensure that public policies are in fact followed through (Farrell et al., 2022: 125).

The concept of NPG is deemed efficient as far as public service delivery is concerned and can revolutionise the eye care industry by addressing the challenges inherent in equitable distribution of services is concerned. Theorising the study within the 5C protocol and logic model, with an awareness of the NPG, is underpinned by the nature of the case study for eye health service delivery which is reliant upon multisectoral collaboration for successful outcomes aligned with the national eye health mandate. This requires decision-making, implementation, and other engagements to be made within and beyond the parameters of government systems, in conditions that may require context-specific solutions for both health service delivery and health service access. To adequately address the theorising of

public healthcare service delivery it becomes necessary to locate the discussion on public healthcare service delivery from an NPM approach to NPG and ultimately a post-NPG era.

2.11 THE THEORY OF PUBLIC ADMINISTRATION

Public administration theory constitutes a multifaceted domain within the scholarly discourse, synthesising insights from diverse disciplines to highlight the intricacies inherent in the management of public entities and the delivery of governmental services (Lamidi, 2015:1). Gerrit (2018) posits that public administration is situated at the nexus of political science, economics, sociology, and management studies, this theoretical framework endeavours to furnish a systematic apparatus for comprehending and refining governance mechanisms, decision-making modalities, and policy implementation paradigms. At its essence, public administration theory endeavours to furnish compelling models and frameworks conducive to effective governance and the efficient provision of public goods and services.

Central to the structure of public administration theory are a set of guiding principles underpinning the conception, operation, and evaluation of public institutions and policies. These principles encompass cardinal tenets such as accountability, transparency, equity, efficiency, and effectiveness. Accountability underscores the imperative for public officials to discharge their duties in alignment with the public interest, while simultaneously being held answerable for their actions and decisions. Transparency mandates the lucid exposition of governmental activities, fostering trust and conferring legitimacy upon the governance apparatus. Equity demands the equitable distribution of resources and services, thereby engendering fairness and justice within the societal fabric. Furthermore, efficiency and effectiveness dictate the necessity to attain desired outcomes with maximal impact and minimal resource outlays (Yadav, 2011).

Yang (2019) posits the importance of public administration theory lies in its ability to explain the complexities of governing in modern societies and suggest solutions for societal challenges. With increasing demands for services, limited resources, and complex policy issues, understanding public administration theory is crucial for

making wise decisions and effective management. Additionally, this theory provides a framework for dealing with the complexities of relations between different levels of government, collaborations with stakeholders, and adopting new governance methods.

The necessity for public administration theory becomes clear when it helps analyse and solve the unique challenges faced by public institutions. By understanding the fundamental principles and dynamics of public administration, policymakers and administrators can propose better strategies for creating, implementing, and evaluating policies. Moreover, public administration theory guides the design of organisational structures, decision-making processes, and methods for assessing performance, which improves the overall effectiveness and efficiency of public services (Igbokwe-Ibeto, 2019).

Silva, Macedo and Thompson (2024), emphasise the significant contribution of public administration theory to the field is evident in its impact on academic research, policy discussions, and managerial practices. The reliance of scholars and practitioners on theoretical concepts and frameworks to study real-world phenomena, evaluate policies is necessary to develop innovative solutions to governance problems. By enhancing the understanding of public administration dynamics and best practices, this theory enriches the knowledge base of the field, leading to continuous improvements in government performance and governance effectiveness. The application of public administration theory plays a crucial role in promoting good governance, improving public services, and strengthening democratic accountability in today's societies (Twala & Lues, 2017).

2.12 PUBLIC ADMINISTRATION, PUBLIC POLICY AND THE HEALTH RESPONSE TO THE PANDEMIC

The outbreak of the Corona virus (known as COVID-19) has impacted adversely on healthcare in many ways. The level of disruption caused by COVID-19 has had far-reaching effects on the health system, as well as other services, around the world (Haileamlak, 2021:1073), and it has clearly caused a seismic shift in the need for additional provisioning of resources to meet rising public health needs. It was

reported that provisioning for HIV services was disrupted in many countries, as access to medical supplies was severely compromised (Pillay, Pienaar, Barron, Zondi, 2021:714). As a result, fewer HIV diagnoses were made, and fewer people living with HIV were started on antiretroviral treatment. Similarly, services vital to tuberculosis testing and diagnosis were affected and this led to a substantial drop in reported cases in high-burden countries in 2020 (WHO, 2020). In South Africa, the National Institute for Communicable Diseases estimated declines of 48% and 33% in testing and positive specimens, respectively (National Institute for Communicable Diseases, 2020).

A study on reproductive health, conducted in the USA among women of child-bearing age, revealed that 33% decided to either cancel or postpone their visits to healthcare facilities because of the COVID-19 pandemic (Lindberg, van der Visser, Muelle, Kirstein, 2020:4). It was found in South Africa during the hard lockdowns, that institutional maternal mortality rose by an astonishing 30%. A sharp decline in terminations of pregnancy and contraceptive use was recorded, while there had been no change in attendance at antenatal care facilities and facility-based childbirth since 2019 (Ahmed, Rahman, Amole, et al., 2021:2). A similar trend with regard to the decline in antenatal class attendance, contraceptive use and immunisation was observed in other countries, such as Nigeria and Bangladesh, during the implementation of the hard lockdowns (Ahmed et al., 2021:3).

The outbreak of the COVID-19 pandemic has highlighted the interdependence between politics and administration, as well as other spheres, in a country to safeguard life. Drawing upon their pandemic, and career experience, some authors have reflected on a strategic approach any government around the world could adopt to deal with the COVID-19 pandemic, or similar situations in the future. These include institutional responsibilities; executive leadership; public management opportunities and challenges; approachable bureaucracy; street-level crisis management; access to public health information; lessons learned from the pandemic; and lessons from around the world.

It is worth highlighting that the government has many responsibilities. Public health stands out as more important than all the others. The devastation caused to the

human race, over time, by pandemics and less prominent health issues, is greater than that from all the wars witnessed over human history. Regarding executive leadership in a federal system, better management of pandemics requires a clear leadership response and a dynamic communication team to clear up any misunderstanding. The head of state or the head of the executive is expected to use the shared expertise of his/her advisors to inform the public and provide policy responses. In public management opportunities and challenges, there is a need for the government to work together to address conflicts of competence, capacities, and finances, to provide effective and timely responses to crises. This is an essential step in responses to benefits-affected people where bureaucracy may represent a serious impediment. For instance, in the USA, an estimated 80 thousand clusters or sub-groupings, spanning the federal, state and local governments, were responsible for providing responses to the COVID-19 pandemic (Holzer & Newbold, 2020:452). Bureaucracy needs to be regarded as a solution, rather than a problem. The management of bureaucracies, such as hospitals and health departments, during the COVID-19 pandemic has been laudable because of their professionalism. This was achieved because the response started with early and decisive action; depended on national unity; utilised effective and comprehensive communications with the public; and adapted to changing circumstances (Holzer & Newbold, 2020:451). Street-level crisis management in the outbreak of a pandemic may result in a crisis that exacerbates vulnerability beyond the effects of the virus, especially for vulnerable groups, such as victims of gender-based violence or racial segregation. Better responses need to take into consideration the complexity of the problem. It was stated that “we needed, not only to fight the pandemic, but also those racial policies that magnify its impact on Blacks, Native Americans, and other such groups” (Holzer & Newbold, 2020:452). Concerning access to public health information, making the public aware of the dangers of spreading the virus, its prevalence, and mortality rates, were essential in public health during the pandemic. Lessons of the pandemic include that, while healthcare workers took their time to learn and seek ways of implementing what they had learned, officials were not aware of the magnitude of the situation. For instance, in the USA, a politically motivated ‘worst-case scenario’ resulted in the removal and downgrading of pandemic specialists and their offices shortly before the virus emerged in late 2019 (Holzer & Newbold, 2020:453).

Lessons are learned globally, and effective responses are provided when organisations learn from others. This contrasts with the majority of public organisations which only learn from within their country, without exchanges with other national governments outside their borders. The implementation of these strategies is essential for any government around the world to attain health equity.

2.13 TOWARDS IMPLEMENTATION OF HEALTH EQUITY

In 1978 at Alma-Ata, a global health strategy was launched by the World Health Assembly of the World Health Organization (WHO) with the goal of Health for All (HFA) by the year 2000 (WHO, 1981). Health equity is an implicit priority in Health for All and was particularly prominent in WHO's HFA strategy for Europe. Equity within healthcare reflects an interest in reducing inequalities in health opportunities associated with membership of disadvantaged groups, such as the poor; disenfranchised racial, ethnic, and religious groups; women, and rural populations. Thus, striving for health equity means addressing health inequities that are rooted in social disadvantage and marginalisation (Braveman, 2003:182). Therefore, achieving health equity involves addressing and eliminating health disparities that are consistently linked to underlying social disadvantages or marginalisation (Braveman, 2003:182). There have been appeals for effective strategies to enhance equity in low- and middle-income countries (LMICs) from development agencies, civil society organisations and governments, emphasising the significant gap in access to health services (Chopra, Sharkey, et al., 2012:7).

Equality in the provision of eye health services does not necessarily create equitable access to the service. It is, therefore, important to prioritise eye care service provision that is proportional to the need. For example, women are often much more likely than men to have age-related cataracts. Factors such as older age and low socioeconomic status are believed to be responsible for differences in cataract rates between males and females (Lou, Ye, Xu, et al., 2018:118). Worldwide, women constitute 55% of individuals with visual impairments and encounter distinct obstacles in accessing eye care services, invariably resulting in lower utilisation rates. Against this backdrop, between 1990 and 2020, the proportion of people living with blindness increased by 51% and those with moderate and severe vision

impairment, by almost 92% (Bourne, Steimetz, et al., 2021). This trend is likely to increase eye problems in females, as compared to their male counterparts.

The 2030 Sustainable Development Goals (SDGs) have prominently urged governments and NGOs to recognise and rectify disparities on a global and national scale. In South Africa, various initiatives and programmes have been implemented to enhance the effectiveness, safety and quality of public health services, ensuring inclusive access for all users (Lawn & Kinney, 2009; Maphumulo & Bhengu, 2019:1). Several commendable goals have been identified for improving the quality-of-service delivery in healthcare settings. Regrettably, recent findings indicate that public health institutions continue to fall short of meeting essential care standards and patient expectations (Maphumulo et al., 2019:1). In terms of eye care services, notable disparities exist in health status and access to healthcare across the nine provinces in South Africa (Lawn & Kinney, 2009:2; Majid & Subban, 2021:477).

A study by Sithole (2013) indicated that, in parts of South Africa, only an estimated 30% of rural populations had access to eye healthcare, in contrast to the estimated 60% in urban areas with access to eye healthcare. This is exacerbated by the fact that the majority of South Africa's poor communities reside in rural areas. The shortage of an eye health workforce in the rural areas further increases challenges. Of the 325 ophthalmologists in South Africa, only about 70 worked in the public sector, serving 80% of the population (Naidoo, Jaggernath, et al., 2015:3). These disparities in geographic location lend themselves to the unequal distribution of human resource capacities and personnel, and they do not advance equity in South Africa in a justifiable and rational manner. This gap, presented in the scholarly literature, necessitated this study and the need for more empirical research into how this anomaly might possibly be addressed in the future. This aspect is further addressed in Chapter Seven as part of the key recommendations arising from the study that has been undertaken.

The Brien Holden Vision Institute (BHVI), in its analysis of the 2013 HPCSA register for optometrists, found that about 97% of the 3408 practitioners were operating in the private sector in the urban areas of the various provinces in South Africa (Brien Holden Vision Institute, 2006). This presents an alarming barrier for most rural

residents with eye health and vision challenges who cannot access eye care as a result of poverty (Sithole, 2017:169). The impoverished population should, therefore, benefit from an eye health plan that promotes easy accessibility in terms of costs and availability. All these practices and recruitment processes do not promote equity in terms of access and use of healthcare services, in particular eye health.

Programmes structured to achieve universal health access, should dictate that access to health services be available to all people, with reduced risk of impoverishment and financial ruin. The effectiveness of programmes to improve healthcare access, following equitable and universal principles, requires the effective implementation of this principle. However, it requires a strong and capable health financing system that strictly manages the costs to end users, based on their ability to pay for these services (Asante, Price, Hayen, et al., 2016:2). Measures to promote financial protection through UHC have been identified as a major component in global efforts to fight poverty, and this is reflected in the United Nations SDGs (Asante et al., 2016), to which South Africa is a signatory. Aligned with this commitment, the government seeks to implement this principle in the fight against poverty and poor access to healthcare.

Despite the government's implementation of the National Health Policy (NHP) to promote equity in the health sector, this study reveals that the majority of citizens have limited access to services, including screening and basic treatment at primary healthcare clinics. This, again, highlights the need to address this identified gap through the research. Rawlings (2011:9) highlights that ophthalmology and optometry services are expensive and largely exclusionary to people residing beyond urban areas; whereas those residing in urban areas, with access to medical insurance, are more likely to afford these services. Despite various efforts to alleviate the issue, the state of eye health in South Africa remains a cause for concern (Jaggernath, Overland, et al., 2014:1856); especially as none of the existing programmes have prioritised equity, which is the antithesis to the clarion call in, and strategic focus of, the SDGs of 2030.

In recognition of the influence of poverty on health equity, the South African government has launched the War on Poverty Campaign (WOPC). This campaign

aims to deliver services and assistance to the impoverished population by creating a database of households within the specified target group. The WOPC highlights that, despite nearly two decades since the end of apartheid, there has been no improvement in income equality. With ethnicity playing a significant role in disparity, this widely impacts the eye healthcare services in the country (Naidoo, Gichuhi, Basanez, et al., 2014:111), giving further credence to the research.

Several studies have revealed that there is inequity in the health sector financing and distribution in many developing countries (WHO, 2000). In their studies of five developing countries, Baker and van der Gaag (1993:8) reported that there are disparities in healthcare services distribution between rural and urban areas, and townships and low-density residential areas. In support of this, Le Booysen (2010:659) argues that health inequality in SA continues to discriminate against the poor. Le Booysen (2010) further argues that residents in rural communities generally rely more on the government than the private sector, as compared to urban dwellers. It follows, then, to highlight the eye health situation in the South African context.

With regards to the above literature, it is imperative for the government to prioritise eye healthcare in both rural and urban populations, like any other condition, such as HIV/AIDS. It is highly recommended to increase educational and training institutes, as this increases research and awareness in the public domain. The current trends in eye health needs are indicative that both the private and public sectors need to unify their functions and actions to avoid facing future disparities in the healthcare system. The 'blame game' cannot bring a solution to the effects of corruption and poor management of finances currently faced in the health sector. It should, instead, be that all parties, including human resources, play their role to strive and bring about excellence in service delivery to the public. It is also important to note that quality services have their roots in well-trained staff and the positive attitude of health workers to patients and colleagues to satisfy the needs of the public. Newly trained staff must be encouraged to work in rural areas, and those who were in rural areas must be encouraged to move to urban settings after a number of years, rather than working in one setting until retirement. There is also a great need for community involvement in such initiatives, so that community members can increase awareness through participation and involvement to tackle the barriers to eye care. Cultural

beliefs can be discussed through community involvement, and negotiated in better ways to bring positive results to both parties, bearing in mind the socio-economic status of the people, and that poverty is a force that can prevent people from achieving certain goals.

The preceding discussion lends itself to the Batho Pele Principles insofar as public health service delivery is concerned, and a contextualisation of the relevant principles is highlighted in the discussion that follows.

2.13.1 Batho Pele Principles *vis-à-vis* public health service delivery

'Batho Pele', a Sesotho adage which means 'People First' was adopted in 1997 as the guiding principle for the transformation of the public service at all levels. It was an attempt to improve the fragmented public service inherited from the apartheid regime, and to meet the challenges of development faced by the Republic of South Africa. Within public eye health service delivery, and particularly associated with its disproportionate availability, there are limitations in the application and benefit of these principles by the health sector and for patients requiring healthcare. Consultation, closely tied to health promotion strategies that enable community engagement, does not exist in South Africa (Sithole, 2015:2). Furthermore, the failure of the South African government to adhere to its National Health Plan (Majid & Subban, 2021:474), and coupled with governance limitations, such as the absence of a national directorate for eye health services (Sithole, 2015:1; Majid & Subban, 2021), and no updated national strategic plan since its draft version in 2019 (National Department of Health, 2019), with its consequent ramifications, the fulfilment of Batho Pele principles within the eye health service delivery framework has not been possible. This has impacted the availability of services and the quality of care.

Barriers to access services, coupled with the disproportionate availability of services, limit how patients can interact with the health system to voice their needs and provide feedback. Poor tracking and documentation of patients, resulting from a defective administrative system within eye health, and the absence of patient surveys for eye health services, feeds into a negative information feedback cycle. Whilst the Batho Pele Principles exist as a benchmark for efficient and effective

service delivery, the absence of a sound administrative system within eye health service delivery has emerged as a common limitation in the research, thus hindering the level of efficiency and effectiveness of interventions such as PPPs to address the backlogs. The Principles of Batho Pele serve as a significant benchmark for enhanced service delivery, as presented in Table 2.1.

Table 2.1: The Eight Principles of Batho Pele

1	Consultation	Citizens should be consulted about the level and quality of the public services they receive and, wherever possible, should be given a choice about the services that are offered (regular consultation would address avoidable blindness).
2	Service standards	Citizens should be told what level and quality of public services they will receive so that they are aware of what to expect (non-negotiable with eye health care).
3	Access	All citizens should have equal access to the services to which they are entitled (equity in eye health care).
4	Courtesy	Citizens should be treated with courtesy and consideration (as per the Patient's Right Charter).
5	Information	Citizens should be given full, accurate information about the public services they are entitled to receive (assistance in real time for health service delivery).
6	Openness and transparency	Citizens should be told how national and provincial departments are run, how much they cost, and who is in charge (avenues for enhanced health service delivery).
7	Redress	If the promised standard of service is not delivered, citizens should be offered an apology, a full explanation, and a speedy and effective remedy; and when complaints are made, citizens should receive a sympathetic, positive response (treat patients with fairness, care and empathy).
8	Value-for-money	Public services should be provided economically and efficiently in order to give citizens the best possible value-for-money (cost-effective service to people with the greatest need).

Source: RSA, Department of Public Service and Administration (1997)

Batho Pele is an initiative taken by the government that urges public servants to stay positive, be eager to help, do their best in service delivery, and be committed to improving service delivery. Through the Batho Pele guiding principle, emphasis is

placed on the transformation of public service delivery by putting people first and holding public servants accountable for the delivery of services (RSA, Department of Public Service and Administration, 1997:8; Mkhabela, 2003:15; Foster,2005:245; In other words, the Batho Pele approach intends to gradually improve the standards of service, particularly in destitute communities that have no access to basic services (RSA, Department of Public Service and Administration, 1997).

In the health sector, primary healthcare is part of the first care that patients receive. It is worth highlighting that this type of healthcare is, to some extent, efficient, since patients do not need to travel from one healthcare facility to another to access various healthcare services (Reagon, Irlam, Levin, 2004:339). There are some aspects of primary healthcare that form an integral part of the Batho Pele principles. These include access, affordability, and acceptability. With no discrimination based on age, population group, ethnicity, or social status, healthcare services should be accessible to all people in terms of geographic distance, finance, and function (Abrahams, 2021:73). This aspect of the Batho Pele principles contrasts with the reality on the ground, since a substantial proportion of South Africans (75%) do not have access to eye care, since it is mostly offered in urban areas (Akuffo, Sewpaul, Dukhi et al., 2020:7). The result is that there are disparities in eye care utilisation among South Africans. From the affordability perspective, in South Africa access to healthcare is a constitutional right that cannot be denied to anyone. Section 27 of the RSA Constitution, 1996 explicitly states that every individual possesses the right to access healthcare services, including reproductive healthcare services, and that denial of emergency medical treatment is impermissible. (RSA Constitution, 1996). Affordability should not be seen solely from the fee payment perspective, but it needs to be inclusive. Abrahams (2021:57) argues that all additional costs, such as taxi/bus fares, as well as loss of income related to the visit to healthcare facilities, should be taken into consideration while speaking about affordability. Hence, the long distances between healthcare facilities and the homes of patients makes it less affordable, particularly for rural residents (Akuffo, et al., 2020:2). Regarding acceptability, a substantial number of factors are taken into consideration. These are culture; the kind of services offered; the distance to healthcare facilities; taxi/bus fares; and attitude to healthcare professionals and care (Dennill, King, Swanepoel,

1999). As far as eye care is concerned, its acceptability remains questionable because of the accessibility costs (Akuffo et al., 2020). Rural residents are compelled to travel long distances, or come to urban areas to receive eye care. The nonexistence of eye care facilities in rural areas is perceived as poor public service delivery as well as a denial of constitutional rights. This contrasts with the good public administration practice that all civil servants are supposed to strive for.

2.14 CONCLUSION

Public administration plays an important role in the governance of any country, since it is entrusted with crucial tasks, such as directing, co-ordinating, planning, and organising for the common good and general welfare of communities. The evolution that had occurred in the perception of public administration has impacted the development and implementation of policies. The aim is to adopt the concept that best suits the interests of the people, and benefits their well-being. Public administration does not work in silos but in collaboration with the government. Although public administration and government work within two distinct spheres – political and administrative – conflicts of interest often arise. Actors in the political sphere misuse powers and seek to control the administrative sphere because of their vested interests. These conflicts of competence have far-reaching effects on other societal spheres, and impact negatively on public service delivery. The delivery of service is one of the societal spheres affected most adversely as a result of poor policy implementation, lack of oversight and overall resource constraints.

In South Africa, health is a fundamental right that is enshrined in the RSA Constitution, 1996. It is necessary to provide healthcare equitably. This seems to be achievable by adopting the attributes of caring and putting people first, as required by the Batho Pele guiding principles. In other words, selflessness is favoured, since it is perceived as a better way of improving service delivery, particularly eye healthcare, as emphasised in the context of this research. The adoption of the principle of Batho Pele in eye care is synonymous with providing equal opportunities for all, regardless of their background and socio-economic status.

The theories have allowed for an opportunity to probe the scholarly literature on the challenges to eye health services delivery, and how these can provide a solution, if adopted in the development and implementation of M&E at eye health service delivery sites. The study highlights that policy decisions that affect eye health care and the structure of governance including the role of practitioners managing same requires urgent attention.

A critical deduction drawn is that effective governance in public administration is paramount for ensuring equitable healthcare provision, particularly in contexts like South Africa where healthcare is a fundamental right. However, challenges arise due to conflicts between political and administrative spheres, hindering service delivery. Embracing principles like Batho Pele can enhance service quality and equity. The utilisation of theoretical frameworks provides valuable insights into addressing challenges in healthcare delivery, emphasising the urgency of addressing policy decisions and governance structures to optimise service management and delivery.

Chapter Three presents the challenges in, and opportunities for, eye-health services improvement and addresses the key objectives raised in Chapter One.

CHAPTER THREE:

EYE HEALTH SERVICES ACROSS SOUTH AFRICA'S PUBLIC AND PRIVATE SECTORS

3.1 INTRODUCTION

The eye care sector is one of the healthcare areas mostly underfunded in many African countries (Bechange, Jolley, Virendrakumar et al. 2020:3). Eye conditions, including blindness, are proving to be a challenge to treat and manage, especially at primary healthcare level (Oduntan, Mashige, Hansraj, et al., 2015:2). The health system in South Africa is a highly polarised sector. It has been indicated that 82.6% of the population access healthcare services from the public hospitals, while the remaining 17.4% of the population get their medical treatment through private healthcare. There is an almost 50:50 parity of expenditure in the public and private spheres, and this has resulted in a huge mismatch in the provision of quality healthcare (Carzis, Wainstain, et al. 2019:1910; Hadebe, 2022). Similarly, eye care in South Africa is mainly provided at a PHC level, which primarily serves the majority of South Africans (Buthelezi & van Staden, 2020:2). According to Watson, Broemeling and Wong (2009:34), it is vital to have a framework for healthcare management and distribution in order to create and generate information to support healthcare policy, management and practice that are relevant to people who need them the most.

Furthermore, according to the 2016 national household survey, users of private healthcare are more likely to be satisfied with the health services and facilities, as compared to those using public healthcare facilities (Nkonki, Bhengu, et al., 2014:86; StatsSA, 2016:3). In the fiscal year spanning 2017 to 2018, it was anticipated that the South African government would allocate R187.5 billion (€11.6 billion) – constituting 12% of its overall budget – to health services. The National Department of Health (NDOH) was expected to incur a substantial total expenditure of R606 billion (€37.6 billion) over the Medium-Term Expenditure Framework (MTEF), an annual rolling three-year expenditure plan. Despite these considerable projections, the public health sector has persisted in being inadequately funded (Erasmus, Ranchod, Abraham, Carvounes & Dreyer, 2016:11). Many of the challenges

encountered by the South African public healthcare sector are intricately rooted in its past. Presently, the country continues to contend with insufficient resources, including qualified medical staff (Zihindula, Ross, Gumede & MacGregor, 2019:14), and adequate infrastructure and equipment (Erasmus et al., 2016), while catering for a growing and ageing population, and a high burden of disease. The high cost of access to, and use of, healthcare services remain the biggest challenge, and is of immense concern, which is driving this study.

3.2 GLOBAL PERSPECTIVES ON EYE HEALTHCARE

Blindness, defined by the WHO (2018:1) as vision of less than 20/400 in the better eye, is a rising global health challenge. Globally, in 2017, there was an overwhelming number of 48.2 million individuals who were blind, with an additional 39.6 million experiencing severe vision impairment. A further 279 million had moderate vision impairment, and 969 million individuals had near-vision impairment (Hassan, Ahmed, Li, Noor & Hassan, 2019:20). The majority of those individuals affected (87%) reside in low- and middle-income countries (LMICs) (WHO, 2013:2). Various eye disorders contribute to visual impairment, including cataracts, glaucoma, trachoma, and refractive errors (Binagwaho, Scott, Rosewall, Mackenzie, Rehnborg, Hannema & Dushime, 2015:19). Approximately 80% of impairments can be prevented or treated (New IAPB, 2012) if addressed earlier, rather than later. Scientific evidence indicates that, as populations age and face increased risks such as diabetes, the incidence of avoidable blindness in the Sub-Saharan region is expected to escalate substantially. Although there is a recognition of the need for an efficient initiative to enhance public health service delivery by expanding and strengthening the workforce, as outlined in the WHO Workforce 2030, Africa is still grappling with its human resource for eye health (HReH) targets (Graham, 2017: 5).

Africa accounts for 15% of the global blind population, with 8.3% experiencing low vision and 9.2% facing visual impairment due to uncorrected refractive errors, contributing to 42% of the overall visual impairment. It is, therefore, deemed to be a significant public health problem (Loughman, Moodley, Holden & Naidoo, 2014:2). The condition of eye care in Africa starkly contrasts with the global situation. Multiple factors contribute to this, including eye diseases linked to poverty that result in

preventable blindness, a deficiency in educational programs and funding, inadequate healthcare services, and a scarcity of eye care professionals (Naidoo, 2007:15). It is significant that Sub-Saharan Africa, alone, has an estimated 3,934,000 visually impaired individuals, constituting 37% of the 11,042,000 cases in the region. (Steinmetz, Bourne, Briant, Flaxman, Taylor, Jonas, Abdoli, Abrha, Abualhasan, Abu-Gharbieh & Adal, 2021:1).

Approximately 18–25% of the Sub-Saharan Africa population is estimated to be affected by eye diseases, as reported by the World Health Organization in 2019 (WHO, 2019:3). This encompasses conditions like blindness (impacting 0.6%–1% of the population), moderate-to-severe visual impairment (3.6%-4%), presbyopia (7%–8%), and ‘all other ocular morbidities,’ a comprehensive term covering significant eye conditions that may or may not lead to sight loss (8%–10%) (Graham, 2017:85). Nevertheless, the WHO suggests that nearly 80% of visual impairments in South Africa can be prevented or treated (Loughman et al., 2014). Prior studies have warned that the aging population and the absence of national plans addressing the impact of visual impairment on productivity and quality of life are likely to exacerbate the burden of eye disease in numerous African countries (Patel, Munoz, Burke, Kayongoya, Mchiwa, Schwarzwald & West, 2006:732; Wong, Zheng, Jonas, Flaxman, Keeffe, Leasher, Naidoo, Pesudovs, Price, White & Resnikoff, 2014:6; Wang, Congdon, Bourne, Li, Cao, Zhao, Yusuf, Dong, Zhou & Wang, 2018: 22).

Blindness rates in affluent countries typically fall below 0.5%, in stark contrast to the 1–2% incidence of blindness in impoverished countries. Various factors contribute to this disparity, including the persistence of diseases like corneal trachoma, exophthalmia and onchocerciasis (river blindness) in less affluent regions. Additionally, untreated or undertreated corneal infections, HIV-related Cytomegalovirus (CMV) retinitis, and limited access to ophthalmic services, further widen the gap. These factors explain why individuals in economically disadvantaged areas experience higher rates of blindness and visual impairment compared to wealthier populations in the developed world (Sommer, Taylor, Ravilla, West, Lietman, Keenan & Council of the American Ophthalmological Society, 2014:16). Regarding regional disparities, the prevalence of distance vision impairment in low- and middle-income countries (LMICs) is estimated to be four times higher than in

high-income regions (Sommer et al., 2014:17). Unaddressed near vision impairments have led to rates exceeding 80% in western, eastern, and central Sub-Saharan Africa; while comparable rates in affluent regions of North America, Australasia, Western Europe and the Asia-Pacific region are reported to be less than 10% (Fricke, Tahhan, Resnikoff, Papas, Burnett, Ho & Naidoo, 2018:14).

A recent survey by Statistics South Africa (2018) estimated that 9% of the total population relies on spectacles for corrective purposes. The same survey revealed that 10.3% of the population experiences visual disabilities, making it the highest prevalence among all surveyed forms of disability (Statistics South Africa, 2016). The unequal distribution of people across the country, which affects their access to health services, driven by urban-rural disparities, continues to pose a challenge. Barriers to accessing and delivering services, especially influenced by the availability of healthcare providers, represent a limitation to care. The scarcity of service providers in the country, exacerbated by their concentrated presence in urban areas, creates difficulties in achieving targets for eye health service delivery, especially when the majority of the population in need of services resides in rural settings. This emphasises that prioritising public health service delivery is a distinct imperative at both provincial and national level in the country, if government is committed to improving public services in this regard.

Moreover, there is a lack of comprehensive documentation on the disparities between the availability of service providers and the services offered in state facilities, compared to those in private settings, which act as barriers to the uptake of services. In 2017, the HPCSA registered nearly 3697 professionals, with only 262 of them employed in state facilities, which were not uniformly distributed nationwide. The remaining optometrists practised in the private sector. Over the same period, state facilities accounted for 113 ophthalmologists (Maake & Moodley, 2018:2). Despite the expected ratio of providers to the population in 2017 being four ophthalmologists, and ten optometrists, per million (Graham, 2017:87), South Africa, with a ratio of 1:15052 in respect of optometrists, continues to grapple with the challenge of ensuring equitable access to eye health services (Maake & Moodley, 2017:2). This is a major cause for concern, affecting the state of public health services, and warranting this research as an attempt to address some of the gaps

and present possible solutions. The significant gap in the availability of service providers between the public and private eye health sectors in South Africa is severe, demanding comprehensive evidence-based solutions to enhance the efficiency and effectiveness of access to screening, diagnosis, and referral to advanced care.

3.3 HEALTH SYSTEMS IN SOUTH AFRICA

Although the ‘new’ health system, sponsored by the democratically elected government in South Africa, is rooted in primary healthcare principles, the health of many Black and marginalised segments of the population unfortunately continues to be severely compromised. This reflects the pervasive influence of poverty and various social and educational factors that adversely affect the health and wellbeing of communities (Brauns & Stanton, 2016:29). In addition, while the health sector has undergone significant transformation, there is a sense that little has truly changed; old patterns of segregation and inequality persist, with historical hierarchies extending into the present.

Most clinics and hospitals are mainly concentrated in urban area and people residing in rural areas have to travel long distances to access public healthcare facilities on time. This situation is observed in the South African context, and calls to public administrators and the leadership to fix the infrastructure appropriately, with capacity to address the “existing supply shortage and manage increasing demand” (Ministry of Foreign Affairs, 2017:6). As one of the best ways to address the above challenge, the South African government opted to design and legislate on the NHI, in an attempt to respond to this issue of infrastructure in both the private and public healthcare facilities.

Since the end of the apartheid government, the public health infrastructure has been undergoing a systematic, albeit gradual, transformation, driven largely by the objectives outlined in the NDP 2030. In contrast, the private sector has experienced a lack of new regulations for approximately a decade, leading to unchanged market dynamics (Ministry of Foreign Affairs, 2017:3). This stagnation primarily stems from government’s concentration on designing and legislating the NHI. With the NHI

officially gazetted and the release of the Competition Commission's findings pending, expectations for change have soared, carrying potential implications for the structure and state of both public and private healthcare facilities. Subsequent sections delve into pivotal trends and regulatory initiatives in this context.

The NHI is intended to provide quality healthcare to all South Africans, without consideration of their financial status. There is an emphasis on accessing quality healthcare in public hospitals. The NHI encompasses extensive operational reforms, aiming to enhance service delivery by implementing improvements and expanding facilities (Ministry of Foreign Affairs, 2017:21); ensuring equal access to healthcare in both rural and urban areas; effectively addressing the considerable burden of disease in the country (Zihindula, 2020:7), and ensuring that spending on maintenance of healthcare facilities should be more balanced.

The National Infrastructure Plan, unveiled in 2012, was designed to tackle the previously mentioned infrastructure challenges encountered by the public sector. This plan consists of 18 Strategic Integrated Projects (SIPs), that address the nation's infrastructure requirements, spanning energy; transportation; education; healthcare; and information, communication and technology (ICT) connectivity. The SIP 12 specifically concentrates on the extensive renovation of public health facilities, involving hospital refurbishment; rejuvenation of nursing colleges; and improvements in six major academic hospitals, in anticipation of the NHI system (Ministry of Foreign Affairs, 2017:18). The unanswered question remains, concerning the financing of the NHI and the monitoring of resource use in this regard.

The current government had planned to establish an equal distribution of resources in both the public and private health sectors (Heywood, 2014:8), and this has resulted in delays in implementing the NHI policy. Maphumulo and Bhengu (2019:5) indicated that the public administration practices need to improve, insofar as infrastructure in rural areas is concerned, mostly because those are the areas where some healthcare facilities do not have piped water or other basic necessities for seamless health service delivery. It can be seen that the public health is failing to provide consistent quality of healthcare as it is overburdened (Heywood, 2014:6),

and this continues to remain one of the main challenges facing the healthcare system in the country.

3.4 CHALLENGES TO THE HEALTHCARE SYSTEM IN SOUTH AFRICA

The challenges to the healthcare system in South Africa have been documented by several previous researchers and scholars (Ager, Lembani, Mohammed, Ashir, Abdulwahab & de Pinho, 2015; Benatar, 2013; Dunjwa, 2016; Gray & Vawda, 2018; Lannon, 2018; Malakoane, et al., 2020; Ntsoane et al., 2018). Healthcare delivery is poor in most of Sub-Saharan African countries, because the health systems suffer from a lack of basic and essential human resources; and South Africa is not the exception.

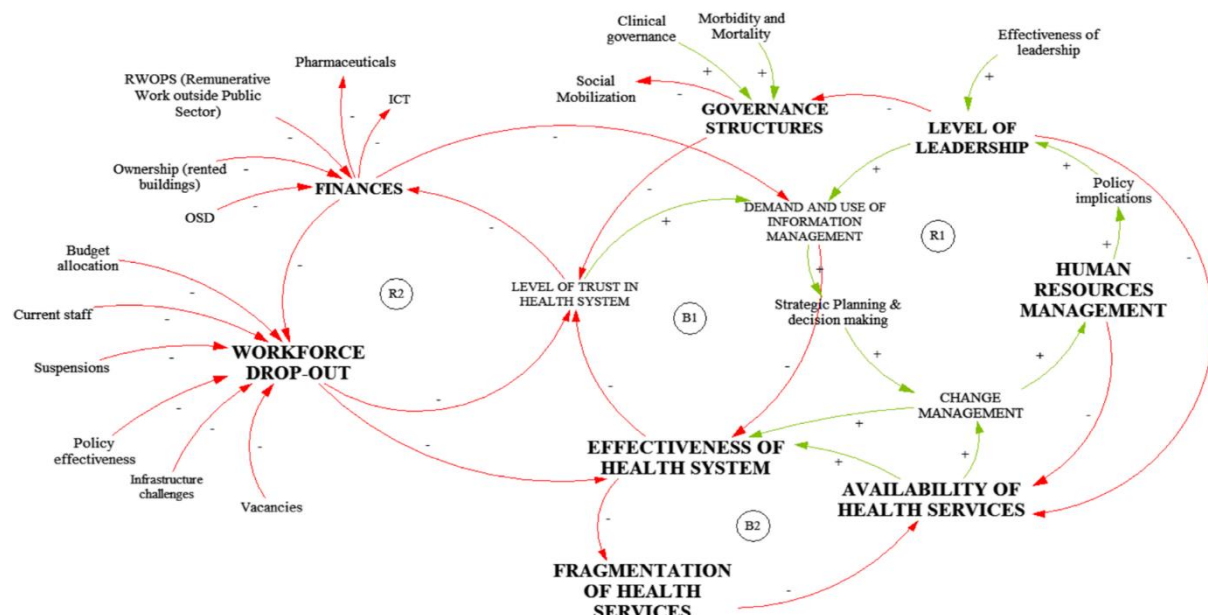
Barron and Padarath (2017:4) contended that the health challenges in South Africa are exacerbated by an uneven distribution of healthcare professional between the private and public sectors, along with an imbalanced allocation of public sector health professionals among provinces. For example, some studies state that medical practitioners in public hospitals are known to provide inadequate services, which ostensibly result in mental and physical exhaustion of the patients, and are later perceived as wasted time (Tana, 2013:37; Kama, 2017). The poor delivery of healthcare is mostly reported from public hospitals, due to the quality of the infrastructure; an unacceptable environment for the patients; a shortage of medical practitioners, medicines and equipment; long waiting times; and poor management (Young, 2016:20). It has been noted by Manyisa and van Aswegen (2017:35) that the shortage of administrative equipment and the lack of skilled health professionals has a higher impact on the delivery of healthcare services.

The National Health Amendment Bill suggested that all clinics should operate 24/7, but the proposal has not been put forward for consideration by the public administrators, due to practical limitations (Gray & Vawda, 2018:4). The study by Maphumulo and Bhengu (2019) found that many measures that have been put in place to modify the delivery and quality of healthcare did not reach the level of the delivery of healthcare services targeted. Achieving a lasting, quality improvement in healthcare is a serious challenge. It can thus be said that the South African

government has been challenged to ensure the implementation of ‘national core standards’ that, it was hoped, would deliver the preferred healthcare results (Maphumulo & Bhengu, 2019:1). These national core standards failed due to the unequal distribution of resources (between the private and public sectors); a leadership and management crisis; the higher rates of disease burden; the HCPs pull-and-push factors; and the slow progress in terms of restructuring the healthcare system (Maphumulo & Bhengu, 2019:2).

Additional challenges are illustrated in the diagram that follows, derived from a recent study carried out in the Free State province of South Africa by Malakoane et al. (2020:4). The study involved a situation appraisal to explore the viewpoints of healthcare managers, frontline service providers, and community stakeholders, regarding the health system challenges associated with inadequate public healthcare service delivery, with the aim of informing efforts to strengthen the health system. (See Figure 3.1).

Figure 3.1: Causal loop of public health system challenges affecting service delivery



Source: Lannon (2018); Ager et al. (2015); Lembani et al., 2015)

Figure 3.1 sheds light on the effect of the components of the six building-block framework on the health system. The diagram has two “reinforcing loops, R1 and

R2, and two balancing loops, B1 and B2” (Malakoane et al., 2020:8). With R1, an improvement in leadership leads patients to require and use more health information. As a result, an ongoing effort for planning and decision needs to be maintained in order to improve performance and meet the demand in terms of required services. Balancing loop, B1, shows that the effectiveness of the health system is required for meeting growth in the demand for services. Meeting the demand for services positively affects the community, and results in continual patronage and use of all healthcare services on offer. This results in an increase in the proportion of patients with high expectations who need the health system to meet their expected demands. When the health system fails to meet their expectations, the demand for services declines. The balancing loop, B2, demonstrates the interplay between a decline in the effectiveness of the health system and inadequate healthcare service provision. This has a direct impact on the integration of services both vertically and horizontally at the facility level, consequently influencing the quality and efficiency of service delivery (Malakoane et al., 2020:7). Consequently, there is a need to institute management changes to enhance health services.

The findings from the study conducted by Malakoane et al. (2020:8) indicate that the public health system was delivering sub-standard care and unsatisfactory health outcomes due to deficient leadership and service fragmentation at the implementation level. This aligns with observations made from other studies conducted in South Africa (Muhwava, Murphy, Zarowsky & Levitt, 2018; Benatar, 2013; Balabanova, McKee, Mills, Walt & Haines, 2010). Additional research carried out in the Gauteng province (Abaerei, Ncayiyana & Levin, 2017) revealed that around 75% of participants chosen at random reported discontinuing their use of public healthcare services, citing a perceived decline in service quality as the primary reason.

Corruption in the health sector has often been mentioned in South Africa, due to the lack of finances in the health sector, and other challenges associated with audits and a lack of fiduciary responsibilities or poor oversight measures. Results from the Auditor-General’s reports indicated a downward trajectory in audit outcomes, displaying significant differences among nine provinces. Of particular concern, is that key informants suggested that corruption adversely impacts on patient care and the

morale of healthcare workers. The majority of media reports on corruption (63%) were associated with the public health sector, with provincial health departments nationwide implicated in 45% of cases (Auditor-General's Report, 2019). While the characteristics and complexities of the public health sector may heighten its susceptibility to corruption, it is essential to recognise that the public-private distinction oversimplifies the situation, as corruption often involves actors from both sectors.

Despite the absence of universally accepted indicators for gauging corruption on a global scale, Rispel, de Jager and Fonn (2016:3) implied that corruption poses a significant challenge within the South African healthcare sector, among other areas. The occurrence of corruption is influenced by factors such as unfavourable agent selection, a lack of effective mechanisms for corruption detection, and a failure to impose sanctions on those engaged in corrupt activities, popularising the concept of 'consequence management', which includes predicting, identifying, managing and minimising, the adverse social, economic and environmental outcomes resulting from an event. Rispel et al. (2016:3) argue that appropriate legislation is a necessity; but unfortunately, not a sufficient intervention to reduce corruption. They proposed that mechanisms to reduce corruption should also include the political will to implement consequence management (Rispel et al., 2016:4). Significantly, establishing a well-functioning bureaucracy and ensuring that public servants possess the appropriate skills, competencies, ethics and values, with their interests aligned with health system objectives, are essential measures in combating corruption. Brinkerhoff and Bossert, (2014:7), indicate financial management practices in the government health sector are not transparent, permitting corruption and resulting in the unreliable delivery of critical health outcomes.

The difficulties in delivering eye care services in South Africa can be attributed to a lack of personnel; medication that is either unaffordable or unavailable; inadequate programme evaluation; and insufficient coverage for Vitamin A supplementation, vision assessments, the provision of spectacles, cataract surgery, and the screening for eye complications in patients with diabetes (Lilian et al., 2018). This is supported by Ntsoane et al. (2018), who affirm that the success of the health systems' strengthening (HSS) intervention in South Africa rests on improving the organisation

of eye care and the availability of essential resources. This is, however, limited by the health system challenges which continue to allow inequitable access to, and use of, healthcare services in South Africa, specifically with regards to the eye health services.

3.5 THE EYE HEALTH LANDSCAPE IN SOUTH AFRICA

In South Africa, limited data is available on the prevalence of visual impairment and blindness. There is a paucity of literature on the current state of eye health care in South Africa, and this is seen as a definite gap, making this study a very relevant one in the context of public service delivery priority. Available data indicates that, in South Africa, eye care is offered at a PHC level (Oduntan, 2001:2), with referrals to higher-level institutions as necessary. It is important to highlight that South Africa lacks a specialised directorate for eye health care, and the absence of an integrated eye health promotion policy leads to insufficient eye care services. (Oduntan, 2001). Furthermore, although the content in four national guidelines is related to eye health promotion, awareness campaigns are less likely to be prioritised for dissemination. It is worth pointing out that the eye health policy document is not only fragmented, but also not integrated with others (Sithole, 2022:7). As a result, without fear of being contradicted, it can be said that eye health care services will continue to be overlooked in the health system of South Africa.

According to a study conducted in rural South Africa by Mabaso et al. (2014:9), cataracts and uncorrected refractive errors (URE) were recognised as the primary causes of visual impairment (VI) and blindness among diabetic black South Africans aged 40 years and older. Another study by Naidoo, Sweeny, Jaggernath and Holden (2013:2) also identified refractive errors and cataracts as the predominant causes of VI among patients seeking care at the district level. In the rural areas of the KwaZulu-Natal (KZN) province, cataracts were identified as one of the major causes of blindness (Naidoo et al., 2013:5-9) and have been designated as a national health priority for the past decade (Lecuona & Cook, 2011). However, it seems that the country faces challenges in addressing the prevalence of cataracts, a common occurrence in many adults, both male and female. This highlights the poor

knowledge of cataracts and the lack of awareness campaigns that would minimise the risk of permanent blindness.

In 2018, Maake and Moodley (2018:2) indicated that the cataract surgical ratio (CSR) in South Africa stood at 1226 cataract operations per million population per year, lower than the initially targeted value of 2000, and the subsequently adjusted value of 1500. This number, it can be argued, is an exaggeration of the CSR, if data is examined at individual district level. An inappropriate use of surgeons' time on performing other non-surgical work is cited as one of the reasons for not achieving the targeted CSR (Maake and Moodley, 2018:2). Key to the problem is the lack of M&E reports to indicate the progress with putting enabling measures in place, and the actions needed to respond adequately to the demand for cataract services in public health facilities.

Visual impairment negatively impacts on the quality of life of the affected individuals, as well as their economic productivity. Many adults experiencing severe visual impairment and blindness might face obstacles in actively engaging in the mainstream economy, placing an additional burden on the government to address their needs. Similarly, visually impaired children may encounter exclusion from the education system, given that many developing countries lack sufficient facilities to accommodate them.

It is, therefore, essential to establish programmes aimed at eliminating unnecessary instances of preventable blindness (Sithole, 2013:92; DoH, 2002). Diabetic retinopathy (DR) is recognised as one of the six major causes of blindness in Sub-Saharan Africa. It has a prevalence estimated 8.5% in the adult population aged 20-79 years worldwide, and affects 25 million adults in Africa, and an estimated 2.6 million adults in South Africa. In South Africa, the predominance of DR across the country positions KwaZulu-Natal at the top of the list with 40.3%, ahead of the Western Cape (32.3%) and Gauteng (22.8%). In its initial stage, DR may be asymptomatic, but advanced lesions lead to irreversible vision loss if poorly managed (Abdool, Naidoo & Visser, 2017:1); and South Africa cannot escape this reality, especially in its rural areas. At present, there is an absence of eye health policies specifically addressing the ocular complications of diabetes mellitus (DM);

diabetic retinopathy (DR) is not prioritised, despite being recognised as one of the six primary causes of blindness in Sub-Saharan Africa (Naidoo et al., 2014:11).

For paediatric groups in South Africa, the prevalence of childhood blindness correlates with under-five mortality rates and is estimated to be 0.47 per 1000 children (DoH, 2002). In 1996, a survey conducted by the DOH on avoidable causes of childhood blindness among students in schools for the blind revealed that corneal scarring was a significant factor leading to blindness in rural African children (DOH, 2002). This corneal scarring could be a result of a combination of factors, such as vitamin A deficiency; measles; secondary bacterial infections; the use of harmful traditional medicines; or ophthalmia neonatorum. While in the most impoverished regions of Africa and Asia, corneal scarring contributes to 25–50% of blindness in children, in developed countries, corneal disease accounts for less than 2% (Gilbert & Foster, 2001:1025). The survey further indicated that 10.3% of the population has a sight disability (Statistics South Africa 2016:2).

3.5.1 Eye health services in the public health sector

There are also challenges with eye health services in public health facilities. A myriad of challenges, systemic, structural and policy-related, were identified in the literature, and they all affect the NDOH negatively. For example, one challenges affecting the delivery of healthcare is the poor keeping of records, which creates unnecessary delays for the patients (Kama, 2017: 80). In the report of the legislation, it was highlighted that South African citizens lack adequate access to after-hour healthcare in both urban and rural healthcare facilities.

Oduntan (2007:163) indicates that, while the majority of public hospitals in South Africa deliver ophthalmology services, the provision of optometric services is limited to a select few. Optometry services in the country heavily rely on NGOs and the private sector. As a result, a significant portion of the population, especially those residing in remote rural areas, encounters difficulties in accessing these services that are primarily concentrated in urban areas. Despite NGOs making optical correction accessible to many individuals, there is a suggestion that this might not represent the most efficient use of resources. The establishment of sustainable government

systems is considered crucial to making a substantial impact on the global demand for refractive error correction and the management of other ocular conditions.

Regrettably, there is a scarcity of published information shedding light on the utilisation of optometrists within the health sectors in South Africa and across the African continent. The public health approach is considered a viable strategy for the direct provision of clinical services, fostering the development of local health service capacities in a sustainable manner (Kruk, Gage, Arsenault, et al. 2018:e1197). The WHO has recommended that eye care delivery be integrated into the general health services at all levels. Capacitation strategies to enable the suggested integration would require a baseline analysis of the willingness and support from key stakeholders, which would include the government, private practitioners, NGOs and the community. It would, additionally, need to consider the ownership of the project and the costs for consumables.

The report from the Active Citizens Movement (ACM) cataract capacitation programme found that, while the state is in the privileged position of procuring medical and surgical consumables at relatively inexpensive rates, as compared to their private counterparts, the state is significantly challenged with the provision of spectacle frames, the different types of spectacle lenses and low vision devices, as well as contact lenses. The private sector and NGOs, on the other hand, have better access to the equipment and human resources required for high-volume service delivery.

As recently as 2019, in KwaZulu-Natal, the state relied on a contract with the BHVI for the supply of spectacles and low vision aids at state facilities. The non-renewal of the contract has led to more than six months of further limited eye health services being offered at facilities who employ optometrists, due to the unavailability of spectacles. In addition, the ACM report indicated that capacitation programmes for cataract surgeries in KwaZulu-Natal have been shown to have more structure within the province, through the provincial office of the manager for non-communicable disease. Meetings are held in the province to analyse the success and failure of projects, and the MoU held by interested parties creates a more reliable evaluation method and a foundation for accountability. Organisations in partnership with the

provincial Department of Health for cataract capacitation programmes include IIROSA, the Al-Imdaad Foundation, Right to Sight and the Active Citizens Movement. While the nature of agreements may vary between organisations, the commonalities of the challenges faced by the organisations are similar and lean toward the poor organisational and management strategies for patients in need of care; funding; and availability of human resources and essential equipment. Monitoring and evaluation of these projects, as well as reports, are poorly accessible in the public domain.

3.5.2 Human resource challenges and disparities in the public sector

In South Africa, challenges closely mirror those previously outlined, particularly the restricted accessibility of health services in rural areas. This stems from significant imbalances between urban and rural healthcare centres, resulting in various imbalances between urban and rural areas. These include a scarcity of healthcare personnel in rural areas, as highlighted by Zihindula, Ross, Gumede and McGregor (2019:15). Additionally, there is a lack of the social infrastructure necessary for eye health, limited opportunities for professional development, and unfavourable prospects for health workers to engage in lucrative part-time private practice (Oduntan et al., 2015:6).

Similarly, research conducted by Thivhafuni (2011:42) identified inadequate availability, accessibility, and affordability of optometric eye care services in the Mutale Municipality of the Vhembe District, Limpopo Province, South Africa. This issue is prevalent in numerous rural areas, attributed to the predominant private ownership of optometric services across the country, rendering them financially prohibitive for a significant portion of citizens, particularly those residing in rural settings (Mashige & Oduntan, 2011:24). It is well established that eye care facilities tend to be better developed in cities and towns than the rural areas, and these latter tend to have a higher prevalence of blindness than urban societies (WHO, 1998:1). Data from various provinces in South Africa demonstrates that in 2010, merely 10% of optometrists in the private sector in KwaZulu-Natal were situated in predominantly rural areas. Moreover, the Health Professions Council of South Africa (HPCSA) indicated in 2007 that there were over 109 positions available in the public sector

across the nine provinces of South Africa, with at least half of them remaining vacant (Majid & Subban, 2021; Ramson, 2014).

The Limpopo and KwaZulu-Natal provinces currently have designated eye care services as one of the healthcare focus areas. However, the adoption of similar priorities in other provinces has been relatively slow. To make primary eye health services more readily available, efforts have been made to increase posts and budgets allocated for optometrists' salaries in the public health sector. Nevertheless, significant obstacles persist in financing eye care provision (Mashige et al., 2015:5).

The fact of the matter is that South Africa is grappling with a severe shortage of human resources specifically allocated to eye health, creating an inadequate workforce to effectively attend to the substantial number of individuals affected by ocular conditions, as was revealed in and through this research undertaken. This scarcity extends beyond a mere insufficiency of eye health personnel; it includes pronounced disparities in their geographic distribution and the associated funding, thereby resulting in unequal access to services across regions within the country (Graham, 2017:87; Sithole, 2015:1).

Thus, as previously outlined, the healthcare provision during the apartheid era exhibited racial bias. Well-resourced hospitals were constructed in Afrikaner strongholds like Pretoria, Stellenbosch, and Bellville, contrasting sharply with the underfunded, underequipped, and understaffed facilities in rural areas (Sithole & Oduntan, 2010:20). Regrettably, there has been little transformation to correct the prevailing circumstances. The realisation of universal eye health coverage necessitates a robust, well-organised, and efficient system for improving public eye care services. South Africans should have unhindered access to eye health care and should receive appropriate treatment from qualified professionals, as advocated by the IAPB (IAPB Strategic Plan, 2014-2023). This strategic plan aligns well with the National Health Plan (NHP) crafted by the ANC post-1994, recognising the imbalances and dysfunctions in the healthcare system, including the delivery of eye health services during the apartheid years. The NHP underscored the equal importance of all healthcare professionals and promoted teamwork as the foundation of the new public healthcare system. Additionally, it included community

participation, respect for human rights, and accountability to users of the healthcare facilities (African National Congress et al., 1994). Despite these intentions, there has been a deviation from the NHP with dire healthcare outcomes, especially for those in rural areas.

3.5.3 Systemic challenges within public eye health services

The eye care sector stands out as the most affected by the unequal distribution of personnel and services, across various African countries (Oduntan et al., 2015); and this is cause for concern for government and policy-makers responsible for service delivery in the country. Many contributing factors have been recognised for this imbalance, including the disproportionate distribution of the population between urban and rural areas. The majority of the population reside in rural areas where they experience suboptimal health attributed to restricted access to health and social services (Oduntan et al., 2015).

The unequal distribution of people in SA aligns with the deficiency in trained staff across all tiers of the healthcare system. As per the IAPB, a significant proportion of ophthalmologists (67%) and optometrists (66.3%) tend to cluster in capital cities. This concentration falls below the 50% threshold deemed necessary to adequately cater to the ophthalmic needs of the population (IAPB, 2014). Furthermore, people residing in rural areas are typically of lower socio-economic status, and experience impediments to accessing eye care services due to the three important factors of unavailability, inaccessibility and unaffordability of services (Ntsoane, Oduntan & Mpolokeng, 2012:2). Furthermore, even in settings where these services exist, numerous barriers hinder the uptake of available services, such as limited awareness of service availability, financial constraints, and cultural beliefs. The utilisation of available eye care services is imperative to mitigate the burden of visual impairment, worldwide (Ntsoane et al., 2012:2).

In addition, Africa faces other challenges regarding the number and availability of eye care personnel, infrastructure, and training schools to empower the eye health sector. For instance, the African region boasts a population exceeding one billion, yet it possesses only seven countries hosting institutions that provide optometry

training. Regrettably, these nations have significantly fewer schools of optometry per capita compared to more developed counterparts (Borrel, Dabideen, Mekonen, & Overland, 2013:1-4; Oduntan, 2015). Thus, Africa critically needs more schools of optometry to help address the huge gap in public eye health service delivery.

Majid and Subban (2021) contend that, despite acknowledged challenges linked to the number of training schools for eye care professionals in Africa, concerted efforts have been made by NGOs such as the Brien Holden Institute (Brien Holden Vision Institutes, 2014) and collaborative academic initiatives between training institutions in South Africa and the USA. These efforts aim to elevate the training standards of optometrists who serve as primary eye care providers for vision and eye health (Naidoo, 2014b). Despite the existence of multiple optometry institutes in Africa, the optometrists-to-population ratio remains consistently low across all African countries, including South Africa (Oduntan et al., 2014:363).

In terms of healthcare infrastructure, there is a lack of resources to address the existing gap for paediatric ophthalmic centres. Although the WHO recommends a minimum of one child eye health tertiary facility (CEHTF) per ten million population to adequately cater to children's eye care needs, the Sub-Saharan Africa region has only 26 centres distributed across 11 of the 54 countries. Consequently, in southern Africa, with 13 countries and an estimated population of 151 million, there are only four child eye health treatment facilities (Borrel et al., 2013:5).

South Africa, as a developing state, struggles with a lack of managerial capacity within the public service. Therefore, there is a crucial national emphasis on prioritising talent management and cultivating a cadre of skilled and proficient public servants (Subban & Vyas-Doorgapersad, 2014:9). It is the role of the government to ensure that qualified and well-resourced eye healthcare professionals are nurtured, developed and motivated. The synergistic link between public sector management and the substance of public administration can be linked to alleviating significant skills shortages within the public service, and particularly in the health sector. In response to the demand for, and supply of, competent managers, training becomes a matter for serious consideration (Subban & Vyas-Doorgapersad, 2014:9).

Strategies for expanding the optometric workforce involve the establishment of optometry schools in countries lacking tertiary training opportunities (Oduntan, 2015). Additionally, it requires a parallel effort to incorporate training and collaboration strategies with national departments of health to address the lack of robust and well-organised structures to enable competent management of the eye health service. Ultimately, this would impact the quality of services delivered and, through a structured plan, with supporting budgets, could redress the inequitable access to eye care services for people within rural areas.

3.5.4 Barriers to provision of eye care services in South Africa

In addition to health policy-related impediments in South Africa, various other barriers have been identified. These include insufficient human resources; financial constraints; service accessibility; limited public awareness regarding service availability; apprehension regarding surgical outcomes; and cultural as well as social barriers. The provision of eye care services to marginalised communities should extend beyond addressing eye and vision requirements and should encompass preventive measures such as health education and promotion (Sacharowitz, 2005:14). Some of the challenges in this regard can be traced back to the healthcare system implemented during the apartheid era in South Africa. The public health system during this period perpetuated racial segregation through the enactment of discriminatory legislation. Healthcare services were racially stratified with a disproportionate allocation of resources favouring the White minority over the majority (Sithole, 2015:1). Sacharowitz (2005:14) highlighted that a significant barrier to the delivery of eye care services in South Africa, particularly in rural areas, is the historical absence of guidelines for employing optometrists in government hospitals and clinics within previous health policies.

Oduntan et al. (2001) reported that, even in instances where eye care services were available in rural settings, there was a need for educational and promotional programmes for eye care. Their investigation outlined that eye care services within rural communities are frequently underutilised, a phenomenon attributed to economic hardships; transportation challenges; limited literacy levels; insufficient awareness; and traditional beliefs (Oduntan et al., 2001). The consequences of blindness and

visual impairment extend beyond individual health, potentially leading to educational deficiencies, unemployment, and imposing additional burdens on both families and healthcare systems (Oduntan et al., 2001). Overcoming these multifaceted barriers is imperative for the provision of high-quality eye care, with particular reference to the public sector in South Africa. The fight against poverty is the government's priority, but the rate remains high and disproportional in the community. For example, a national plan that promotes the rural population, guided by equity, envisioning the promotion of eye health and education, and well implemented, could offer hope for improving eye health care in South Africa.

3.5.5 Innovative approaches in the delivery of eye care

According to Kocur (2019:716), the adoption of a health systems approach, as outlined in the World Health Report (WHO) titled 'Health Systems: Improving Performance' (2000), marked a significant advancement in the global initiatives of healthcare policy-makers and decision-makers working towards achieving universal health coverage. This approach targeted the enhancement of six areas within health systems, including eye health, prompting collaboration between the public and private health sectors to address eye health care in South Africa and other African nations. Nevertheless, as revealed in this research, it appears to remain a relatively lower-priority concern.

In the same study, Kocur (2019:716) contends that there has been an increasing commitment from governments and international partners since the late 1990s to prevent avoidable vision impairment. This commitment is evident through the establishment of the Vision 2020 Global Initiative and the inclusion of eye health in the global public health agenda of World Health Assemblies and WHO Member States. This dedication to preventing avoidable vision impairment has been translated into various resolutions by the World Health Assembly, including the most recent one adopted in 2013, endorsing the Universal Eye Health: a Global Action Plan 2014–2019 (Keel and Cieza, 2022:3). However, despite these efforts, eye care has not received adequate attention from policy-makers in many parts of the world, and most regions lack substantial support for these services (Burton, Ramke, Marques, et al., 2021:541).

The global action plan's comprehensiveness became a pivotal point, providing an opportunity for refining eye care service provision applicable to all countries and communities (Khanna, Marmamula, Rao, 2017:63). This strategy aims to establish a comprehensive range of healthcare services, encompassing the prevention of eye diseases and associated risk factors, extending to the delivery of low-vision services and rehabilitation. If fully embraced in South Africa, this plan could accelerate actions aligned with the vision stated in the eye health action plan, envisioning a world where unnecessary visual impairment is eliminated.

Additionally, the recently developed WHO Eye Care Service Assessment Tool (ECSAT) presents a structured approach to assess current eye care services at a national level, identifying gaps and needs. By integrating findings from ECSAT and evidence from population-based surveys like the Rapid Assessment of Avoidable Blindness (RAAB) studies, which reflect the prevalence and causes of vision impairment, countries can formulate evidence-based eye health plans, identifying achievable, focused priorities (McCormick, 2022a:4). Thus, there is a crucial need to monitor and evaluate policy implementation actions taken to provide eye care at the district and provincial levels in South Africa. This presents an essential opportunity for eye health planning teams and other stakeholders to conduct a much-needed baseline investigation of the state of eye health services, identifying needs and preparing a strategic plan to achieve the broader goals of eye health service delivery through an organised and structured system.

3.6 Monitoring and evaluation of eye care services in South Africa

In the post-apartheid era, there has been an acceptance of the need for M&E within the governmental framework. This serves as the foundation for engagement with international bodies, essential for co-operative endeavours (Friedman, 2011:4). The purpose of M&E is to support democratic engagement through the enhancement of transparency and accountability, by providing evidence for planning; and, in general, supporting the development of the state.

Routine M&E of eye care services has been lacking, as indicated by certain eye care managers who have not employed any M&E methodologies (Sukati, Moodley,

Mashige, 2018:167). Moreover, some studies noted a complete absence of eye health care data collection at PHC level (Ntsoane et al., 2012). The dearth of eye health care data collection in South Africa presents a critical challenge that hinders effective monitoring, and consequently the improvement of eye health services in the country. Similar challenges regarding data scarcity have also been observed in other African settings (Iwegbuna & Iwegbuna, 2018:3), underscoring the need to establish robust systems for monitoring and evaluating eye care services in alignment with the World Health Organization's global action plan for universal eye health (Robin, Nirmalayan, Ramasamy, Rengappa, Katz & Tielsch, 2004).

The global action plan for universal eye health spanning 2014–2019 is grounded in a HSS approach, emphasising the incorporation of eye care across all healthcare system tiers, including PHC. Nevertheless, the efficacy of HSS concerning primary eye care remains uncertain, prompting calls for additional evaluations to address research gaps in eye care (Robin, Nirmalan, Krishnadas, et al., 2004). Maake's study in 2014 notes that the eThekweni district is geographically surrounded by three districts employing optometrists. A preliminary district review indicates that the eThekweni District hosts 13 hospitals, iLembe District has four hospitals, Ugu District has five hospitals, and uMgungundlovu District has nine hospitals. Importantly, not all hospitals provide optometric services. Consequently, optometrists are occasionally required to extend outreach services to institutions lacking such services. The services offered by optometrists in these districts are contingent and restricted by available resource capacity. These outreach programs lack a systematically defined plan informed by identified needs, relying on the capacity of limited resources and lacking a needs-informed plan. Maake (2014) further emphasises the insufficient studies evaluating the services provided by optometrists to the public since the introduction of optometry posts at the district level.

The reporting system in place for primary eye care services also needs to be evaluated for its relevance and reliability to inform further planning processes. Using indicators of the number of spectacles dispensed, and cataract surgery referrals, as the priority focus areas necessary to report on the Vision 2020 commitment are likely to be insufficient for planning at an institutional, district and provincial level for the

procurement of consumables, resource allocation, and other supporting interventions, to ensure equitable access to eye health care.

3.6.1 Monitoring and evaluation to enhance governance in the eye care sector

Implementing M&E is not a new concept within governance. The focus of conventional M&E systems is centred on the monitoring of the foundational phases, which includes the planning, budget and implementing systems. A shift to performance-based evaluation relies on the conventional method, with an added focus on the medium- and long-term impact resultant on the outputs. Monitoring and evaluation are different: monitoring measures the progress of the steps undertaken to achieve the final goal; whereas evaluation is an observation of the outcomes and their long-term impact on the beneficiaries or recipients of the programme. Performance-based M&E is the periodic measurement of the short-, medium-, and long-term outcomes, and the impact of the programme at its various stages. An evaluation provides explanations for what has caused specific changes at a given point in time. In the absence of an evaluation, monitoring is only able to provide input about what had changed at the time of measurement, and would not offer reasons for why this change has occurred (Kusak & Rist, 2001:15).

M&E programmes can be tailored for specific indicators, target audiences, sectors, and settings, and can be conducted independently at each level, or for multiple levels at one time. The ideal system should allow for observation and reporting of individual levels and collective levels with a dual flow of information to benefit forthcoming levels with corrective measures to be implemented lower down. There should also be a steady flow of feedback across sectors and between stakeholders, where the content is audience-specific, such that it allows for participants and beneficiaries to engage with the process meaningfully. Irrespective of the individual requirements of the individual levels, each level is interdependent and, as such, a performance-based model needs to take care in ensuring that there is alignment and co-ordination across the various levels (UNESCO, 2016).

Experts in the field have summarised the construction of a performance-based model in different numbers of steps. The success of the process is not dependent on

the number of steps in its creation, but rather the core focus areas and thematic separation of levels to ensure that comprehensive measurements can be conducted at each level, and meaningful rapport can be produced. Kusak and Rist (2001:18) opted for a 10-step approach for developing countries to allow for the clear differentiation of levels. The authors note that the advantage of multiple steps allows for the maximal reduction in ambiguity within and between levels. Whilst there are 10 distinct steps, this does not limit concurrent activity at different levels. The steps have been contextualised to this research and are linked to the key questions and objectives that are raised in the study.

3.6.2 Monitoring and evaluation for performance-based governance

The illustration of a ten-step process to develop a performance-based M&E system is provided in Table 3.1, below.

Table 3.1: A ten-step process

<p>1. Conduct a readiness assessment</p> <p>Identify the constructs of the PPHF, role and capacities of stakeholders, terms of reference to govern engagement, ownership of cataract relief project, challenges encountered by and between stakeholders.</p>	<p>Determine the willingness and capacity of government and identified stakeholders to construct a performance-based M&E programme. Focus on the presence or absence of key stakeholders in government, barriers to building the system, ownership, and resistance to the system.</p>
<p>2. Agreeing on performance outcomes to monitor and evaluate</p> <p>Identify common goals and objectives of the DoH and stakeholders, resource allocation and planned activities by all stakeholders in the cataract surgery relief programme, alignment of goals with</p>	<p>A key requirement is to develop strategic outcomes and goals which drive resource allocation and stakeholder activities. Should be aligned with the strategic priorities of the country.</p>

provincial and national indicators for cataract surgery.	
3. Develop key indicators to monitor outcomes Examine if key indicators were identified at the onset of planning for cataract relief intervention. Were the indicators useful in identifying if objectives were reached, and in enabling early interventions when challenges were encountered? Was there any conflict in proposed indicators by stakeholders?	The core activity in the M&E process is to develop indicators to measure outcomes. Consideration needs to be given to political and methodological issues attached to creating credible and appropriate indicators.
4. Gather baseline data on indicators What information regarding the need for cataract surgery was used as a motivation to implement relief project by the PPHF? Which stakeholders made this information available? Was there any measurement of initial indicators?	Describe and measure initial conditions related to the goals. It is the first measurement of indicators.
5. Set realistic targets and plan for improvement Were the goals to alleviate cataract surgery backlog aligned with timeframes? Were these goals structured to achieve intermediate and long-term goals? Were resources apportioned accordingly? Do goals factor in sustainability?	Establish interim targets (how much of a goal needs to be achieved), time frames to achieve goals, resource allocation needed to reach the goal. Measurement of the performance of these indicators can be direct or indirect, quantitative, or qualitative.
6. Build an M&E system Is there a detailed guideline to track cataract	Establish guidelines for: <ul style="list-style-type: none"> • Data collection

<p>intervention programme aligned with agreed goals by the forum? Does the guideline track collection of information, implementation of interventions aligned with timelines, manage and track costs, and document challenges arising with management, ownership, and credibility? Does the guideline enable transparent, factual, and credible reporting at any specific time?</p>	<ul style="list-style-type: none"> • Analysis • Reporting guidelines • Role clarity • Quality control strategies • Timelines and costs • Transparency of information and analyses • Challenges of ownership, management, maintenance, and credibility
<p>7. Analyse and report findings</p> <p>How often were results and feedback provided to the forum, who was tasked to produce this information, how was it presented, what were outcomes of the presentations?</p>	<p>A crucial step in the process is to determine what findings are reported and to whom they are reported, the format used and the frequency of reporting.</p>
<p>8. Collect and provide evaluative information</p> <p>How did the information collected and reported shape the way forward to the next steps? How did the reporting system and activities undertaken influence the process, outcome, and impact of forum interventions to address the cataract surgery backlog?</p>	<p>This involves the analysis of the programme theory and evaluations made throughout the process. It also includes:</p> <ul style="list-style-type: none"> • Evaluability assessments • Process evaluations • Outcome and impact evaluations • Evaluation syntheses
<p>9. Use findings</p> <p>Have findings been distributed timeously to various stakeholders? How has it worked to shape the approach to the cataract backlog from</p>	<p>The importance of the information created extends beyond reports, but is linked to the timeous distribution of information to all stakeholders to</p>

stakeholders in governance? Did sharing of findings, or lack thereof, influence stakeholder responses, commitments, and resource allocations? Was civil society included in the process of distributing information regarding cataract backlogs?	inform their decision-making processes. It includes all stakeholders, including civil society partners. The purpose of the information is to enhance transparency and accountability and to strengthen the process for resource allocation.
10. Sustain the M&E system Has there been continuity and sustainability in the reporting? Are stakeholders held accountable, and is there capacity for the forum to continue with cataract intervention programme aligned to goals?	This is dependent on the demand, structure, reliability and transparency of information, accountability of stakeholders and capacity.

Source: Kusak and Rist (2001:18)

3.7 Exploring best practices and policy Initiatives in South African eye health service delivery

South Africa has endorsed the Vision 2020: Right to Sight initiative, a worldwide program urging national governments to pledge to specific targets in eye health services. The initiative strives to avert avoidable blindness and improve the eye health of all individuals in a fair and unbiased manner. Numerous nations, South Africa included, have affirmed the declaration and instituted national committees focused on preventing blindness (Faal & Gilbert, 2007:62). Collaboration within this framework has led to notable results. Many achievements have had significant results. However, in Sub-Saharan Africa, several challenges persist in addressing the substantial number of people experiencing blindness, despite governmental commitments (Odusote, 2007:61). The commitments made by governments, in alignment with the Vision 2020 initiative, are intended to advance eye care services globally, and include the following key aspects:

- increased political commitment.

- increased commitment from eye health professionals.
- increased commitment and support from national and international NGOs.
- increased involvement of, and partnership with, the corporate sector.

(Majid & Subban, 2021)

Many developing countries, including South Africa, have incorporated health promotion into their PHC systems to enhance the efficiency of healthcare service delivery (Sithole, 2017: 2). The promotion of eye health aligns with the Ottawa Charter for Health Promotion and is acknowledged as a crucial component of VISION 2020. Over the last two decades, it has played a substantial role in global health promotion, stemming from the inaugural International Conference on Health Promotion held in Canada in 1986 (Prozesky, Porter, Odusote, Morris, Francombe, Stevens, Gilbert, Astbury, Faal, Khan & Thulasiraj, 2007:57).

There are four national directives regulating different facets of eye care within the framework of part of health promotion. One such directive pertains to the prevention of blindness in South Africa, concentrating on the prevention of avoidable blindness as an integral component of VISION 2020 (Sithole & Oduntan, 2010:4). The guideline also includes an advocacy strategy geared towards improving eye care service provision. With an emphasis on the identification of influential stakeholders, especially policy-makers, community leaders, and healthcare professionals, this policy underscores the important role of stakeholders in influencing change (Thulasiraj, 2007:6). Thus, advocacy programmes are posited as a viable avenue for addressing the challenges in the eye health service domain in South Africa.

The green paper, published on 12 August 2011, advocated for the adoption of the NHI as a vehicle to achieve equitable health service delivery for all people. Subsequent deliberations and strategic planning directed at realising the objective of the NHI instils hope that health service provision, with an emphasis on primary eye health services, and a departure from hospi-centric models, would give precedence to eye health service delivery. This approach aims to identify and correct challenges that have until now impeded service delivery (National Department of Health, 2011). The effective implementation of the NHI is dependent on its successful bridging of the divide between the private and public health sectors, facilitated by strategies that

foster PPPs. Additionally, it necessitates a rights-based perspective to ensure equitable accommodation of those with the most pressing needs, with the entire process defined by transparency and fairness. These essential aspects will influence the way eye care services are dispensed in the South African public health sector (Sithole, 2015:2).

Some prior interventions to bridge gaps in eye health service delivery involved initiatives by The International Centre for Eye-care Education (ICEE), particularly through its 'giving sight' program. This endeavour aimed to empower ophthalmic nurses in KwaZulu-Natal to provide primary eye care services in rural communities, emphasising eye health promotion (Sithole & Oduntan, 2010:20). Despite aligning with VISION 2020 goals to eliminate avoidable blindness, the project's sustainability was compromised, resulting in its absorption and impacting the achievement of its primary objectives. There exists a reporting gap regarding the organisation's effectiveness before absorption, prompting questions about potential barriers arising from an incongruent relationship with stakeholders. The persistence of NGOs and corporate social service initiatives in eye health collaboration with the government raises limited published information about their impact at both organisational and governmental levels. The operational frameworks and engagement models facilitating such collaborations lack adequate documentation.

South Africa instituted the National Prevention of Blindness Programme to assist both the local prevention of blindness initiatives and those in the Southern African Development Community countries. The program sought to coordinate efforts in preventing blindness within South Africa, advocate for the rights of blind individuals, and decrease the prevalence of blindness in the country from 0.75% to 0.50% by 2005. However, it remains uncertain whether these objectives were accomplished (South African National Department of Health, 2002:4). The effective execution of programmes designed to prevent avoidable blindness necessitates a strengthened public administrative response to ensure meaningful reporting on projects undertaken (Sacharowitz, 2005:13). As of 2021, reporting on efforts to prevent blindness in the country remains an ongoing challenge. Despite available literature referencing the policy and its objectives, little is known regarding the extent of changes since its inception, the challenges encountered, and the successful

mitigation of implemented strategies. Moreover, data on the prevention of blindness at district, provincial, and even national, level are not readily accessible. The disconnect between the private and public sectors in reporting further exacerbates the gap, impacting the reliability and validity of information available.

The above policies lack sufficient detail regarding the strategic placement of primary eye care providers, such as optometrists, within the public healthcare infrastructure in South Africa. A notable exception to this is the Limpopo DoH, which has been filling optometry posts in public sector hospitals since 1991, with more than 30 optometrists in various hospitals in the province currently, an achievement in public eye health service which is unparalleled by any other province (DOH, 2013:8). The adoption of this model has alleviated the prevalence of eye health challenges among the province's population. Initiatives from organisations like ICEE amongst others, have sought to emulate this success by promoting the efficient administration of primary eye care service roles, tailored specifically for optometrists within the public health system (Sacharowitz, 2005:14).

Regarding the human resources for eye health, KwaZulu-Natal has recently enhanced its optometry services within the public sector. Consequently, the KwaZulu-Natal DoH has established positions in several public health facilities across the province. The reality is that, although most district and regional hospitals now benefit from the presence of two optometrists who predominantly facilitate refraction services, evidence suggests there is a high turnover of staff, rendering the workforce unstable (Ramkisson, 2014:3). Observations in the literature over the last decade show that, while there are sustained opportunities for optometrists within the state sector, these opportunities are not the same between urban and rural areas, and differ considerably across provinces; where some provinces have shown accelerated efforts to make opportunities available, while others have not yet begun (Maake & Moodley, 2018; Ramson, 2016).

3.8 Role of public administration in improving eye health services

The fundamental goal of public administration is to advance management and policies so that the government can function. The role of the government in the

second decade of democracy in South Africa was to construct and unify the progressive state. The essence of national success requires that the quality of the citizens' lives should be improved through enhanced public service delivery. Furthermore, it demands the establishment of suitable sites to increase the participation of citizens in wealth management to strengthen the voices of marginalised communities (Maserumule & Mashigo, 2010:8).

The government faces dual challenges in enhancing service delivery and fostering an environment conducive to the impartial involvement of citizens in *the “mainstream of the economy”* (Mkhize, 2019:83), particularly within the health sector. Public administration and economics play vital roles in aiding the government's efforts to enhance, fortify, and reform governance systems and administrative institutions. Simultaneously, they augment the government's policymaking capacity and overall productivity. Public administrators are inclined to formulate solutions for societal challenges and establish normative rules guiding decision-makers toward optimal choices.

It has been stated that behind the scenes administrative leaders exert far greater influence on governmental affairs than political office bearers, and the importance of the disposition of implementers becomes evident (Marume, Mutongi, Madziyire, 2016:91). There was a call for a new management system regarding the involvement of the government in tasks where it is not needed. The emergence of the latter stemmed from critiques asserting that traditional public administration was insufficient for contemporary requirements and necessitated replacement (Ibrahim, 2012:1). Criticisms were based on the extensive government approach, leading to resource overconsumption; pervasive bureaucracy; elevated inflation rates; the lack of a distinct separation between policy and administration; the absence of rational decision-making, and a disregard for citizen satisfaction.

The multitude of challenges has adversely impacted the execution of the mandate by the National Department of Health (NDoH). Inefficiency, corruption, lack of accountability, and inflexibility permeate all levels of government departments due to these issues. It is noteworthy that recently independent nations, such as South Africa, aimed to reform their Weberian-style public administration systems by

drawing insights from the best practices of civil service systems in countries like Australia, Canada, New Zealand, Singapore, and the United Kingdom (Maphunye, 2011). Some of the most severe criticisms of traditional public administration have centred on policies prioritising the dominance of politicians over administrators, a common observation in many Sub-Saharan African countries (Uwizeyimana & Maphunye, 2014:93).

The commitment to correct inequitable systems and prioritise the rights of its people's social and economic rights (access to basic services such as health, housing, education and sanitation), as listed in the constitution of the Republic of South Africa (Mayosi & Benatar, 2014:7), by the government, resulted in a diversity of development plans, as were articulated in the Reconstruction and Development Programme (RDP), revised in 1993; the Growth, Employment and Redistribution Strategy (GEAR) in 1996; and the Accelerated and Shared Growth Initiative (ASGISA) in 2006. These development plans, with enormous economic implications for the nation, were expected to address socio-economic challenges – mainly poverty, joblessness, and the uneven delivery of resources, faced by the state.

Since assuming power in 1994, the newly established South African government has implemented a series of charters, policies, strategies and plans aimed at fortifying the performance of the public health system performance and improving the delivery of health services (van Rensburg & Engelbrecht, 2012:3). Additionally, both the national and provincial governments have progressively embraced the WHO building blocks approach to assess the performance of the public health system (SA NDOH, 2013:12). Despite the wide array of plans, strategies, regulatory measures, and policy interventions, coupled with a commitment to quality healthcare, and a significant annual expenditure, deficiencies persist in the public health system. These shortcomings pose an ongoing threat to the health and lives of those dependent on it, leading to diminished confidence among users (Malakoane et al., 2020:3). Key to this failure is the poor linkage between public administration and the national Department of Health. This study calls for a renewed integration of both services, and this is believed to be a process through which the corruption in the NDOH could be minimised, as the emphasis on public administration and service delivery becomes fully immersed in the delivery agenda for public health services.

3.9 Public-private partnerships in eye care service delivery in South Africa

A PPP constitutes a prearranged agreement involving government departments and various stakeholders, essential for enhancing the delivery of pertinent social services to communities. Stakeholders within this partnership encompass state entities, NGOs, NPOs, the private sector and community representatives. The RSA Constitution, 1996 promotes the principle of cooperative governance in Chapter 3, Section 41(1)(i), stipulating that *“all spheres of government should cooperate with one another in good faith by fostering open and mutual relations, supporting one another through consulting one another on matters of common interest, and aligning their actions and legislation while adhering to legislated procedures.”* Thus, these partnerships between government departments, civil society and the private sector seek to improve the quality of service delivery, and these partnerships should be encouraged to be operational in the health sector. Where any PPP becomes operational, there are protocols for M&E systems, as outlined by the Department for Planning, Monitoring and Evaluation (DPME), which need to be in place to regularly track the progress and evaluate the success of the collaborative work conducted. It is important to note that, while PPPs exist to capacitate service delivery, the intention to prioritise some projects above others, and the preference for specific communities as beneficiaries for the resulting services, remains at the discretion of individuals. This suggests a level of bias, and without strict monitoring can create opportunities for exploitation, maladministration and corruption (Abrahams, 2015:7).

3.10 The role of public-private partnerships in health and eye care

Many countries have enjoyed the positive impacts of PPPs in public health service delivery, including eye health care. According to Iwegbuna and Iwegbuna (2018:1), the existence of PPPs has increased access to health services in local hospitals or clinics in some parts of Africa. In India, the Aravind Institute implements the ‘Aravind Eye Healthcare Model’, which aims to eliminate needless blindness by providing free cataract services to poor patients (Aravind, 2021). Since its establishment, Aravind has helped more than 68 million outpatients, and performed approximately 8 million eye-related surgeries (Aravind, 2021). Further afield, in the USA, the Orbis Institute provides eye care and ophthalmic outreach programmes in developing countries

where there are high prevalences of blindness (Orbis, 2021). Similarly, the BHVI, an Australian based NGO, develops relevant technologies to improve ophthalmic services to the needy (BHVI, 2021). In Ghana, for example, a comprehensive range of health services, encompassing general health, eye health, and rehabilitation services, are offered locally, catering to substantial numbers of patients, daily. Hospitals have expanded their outreach programmes beyond the confines of facilities, conducting programmes in schools throughout the academic term. These initiatives include immunisation, health education, and routine check-ups for dental and eye services. Some services, such as Antiretroviral Treatment (ART), are provided at no charge, with medical access and family planning services, among others, also offered free of charge. South Africa has fared well to provide similar services to its people post-1994. Challenges with consistency and the equitable distribution of services continue to require urgent attention.

Kula and Fryatt (2013:561) observe that South Africa has long recognised the significance of fostering interaction between the public and private sectors as a policy objective, as outlined in the National Health Act of 2003. The Health Charter for the Public and Private Sectors (Reynolds, London, Sanders, 2005:742) was established to facilitate consensus between these sectors, focusing on prioritised issues, strategies for their resolution, and the private sector's role in effecting comprehensive health system transformation. Numerous reviews have been conducted on public-private interactions in the health sector, exploring the role of the private sector in South Africa, the public-private mix in the country, and PPPs (Wadee, Gilson, Blaauw, Erasmus, et al., 2004:4).

Furthermore, the National Treasury maintains a dedicated PPP unit and offers guidance for initiatives of this nature (National Treasury, 2004:3). Their database systematically documents PPPs within the health sector (National Treasury, 2012:1). Instances of public-private collaborations in South Africa include formal contracts for managing specific aspects of public hospitals in the Free State (Shuping & Kabane, 2007:11); the contracting of district surgeons in the Western Cape and Eastern Cape (McIntyre, Kruger, Valentine, Van Zyl & Jacobs, 1997:73; Sinanovic & Palmer, 2000:3); and collaborations with employer-based service providers for the delivery of tuberculosis (TB) care and other services (Sinanovic & Kumaranayake, 2006b:10).

However, there is a paucity of published literature on the factors contributing to the success of such interactions and the benefits these partnerships confer on the delivery of eye health services in South Africa, making this study a timely one. This is significant, considering the prospective opportunities emerging from the NHI framework (National Department of Health, 2011:13). Given the substantial effort and inherent risks associated with effective interaction, which frequently results in failure (Reich, 2000:618), a meticulous examination of the conditions conducive to success may enhance the likelihood of success in future initiatives.

It is notable that, not only in South Africa, do PPPs tend to neglect the eye health service in rural areas. This has been attributed to poor infrastructure, lack of funds, and a lack of knowledge about service provision, *inter alia* (Nishtar, 2007:936). A study conducted in India revealed that eye care is unavailable because of a limited number of skilled personnel, who are concentrated in urban areas (Sabherwal, Javed, Sood, 2022; Senjam, 2017). Evidence has revealed a gap and broad inequality between rural-based and urban-based public health facilities. Ntsoane et al. (2012:2) highlight that numerous factors can function as obstacles to the utilisation of eye care services in remote regions. These encompass inadequate awareness of the services available, notwithstanding media reports indicating significant budget allocations by provincial governments in South Africa for healthcare services, including eye care, aimed at assisting citizens, particularly those unable to afford private services. It seems that people are not aware of these services being provided in their neighbourhoods, and conclude that eye health care in remote areas is neglected. With little or no literature to support the above in South Africa, the researcher considers the aims and goals put forward by the PPPs in the health sector in South Africa, which apparently neglect eye care.

The amalgamation of public and private sectors in the healthcare system is clearly a time-conscious move and service delivery is being experienced at a faster rate than ever before, as asserted by Asasira and Ahimbisibwe (2019:4) regarding their observations evidenced by several studies. As examples, a study by MeTA (2014:9), posits that long waiting times are the biggest possible cause of service dissatisfaction. Tateke, Woldie, and Ololo (2012:2) highlights that the waiting time at a private hospital is less than the time spent in a public hospital. The time spent at a

private facility could thus be enough for patients to consult with the medical staff. This notion is supported by Sajid and Baig (2007:546), who agrees that spending long hours waiting in a public hospital for a physical examination is associated with a higher-level of dissatisfaction. The PPPs have been proven to provide a change in service delivery as staff numbers are increased. Bowling, Rowe, Lambert, et al. (2012:68) suggest that low levels of staffing have an impact on the quality of healthcare and its delivery, and thus PPPs provide a 'cushion' for public hospitals in most countries. A heavy reliance on the public hospitals to deliver on healthcare issues, such as blood test results or spectacles, requires a lengthy wait, due to understaffed laboratories and hospitals, coupled with serious backlogs in many departments. Well-structured PPPs, therefore, could alleviate many challenges and improve the effectiveness of service delivery, through providing capacitation to the public health sector.

3.11 A public-private forum as a tool to achieve eye health needs

The diverse nature and forms of PPPs over the years have made it difficult for uniform M&E criteria to be implemented to track the progress and sustainability of such systems. The collaborative approach, which requires private partners to adopt, support and implement solutions aligned with public policy, allows for some reference framework to measure outcomes against the intended objectives. However, the process from conception to implementation requires a deeper understanding of the greater administrative themes for successful implementation. This includes a context-specific definition for the PPP, risk management, drivers for the adoption of a PPP model, and performance evaluation (Wang, Xiong, Wu & Zhu, 2018:19).

Creating a definition for a specific PPP requires deliberations over the type of partnership, the intended time frame for the partnership and, importantly, the link to, and need for, public finances within the partnership. As such, the assessment of the PFMA and guiding documents from National Treasury relating to PPPs need to be well understood. Furthermore, the planning process needs to be detailed, which would require a considerable cash investment, and more, from all relevant stakeholders. Recording and management of such information are central to

accountability and transparency in engagements. Ethical considerations and identifying common goals are also central to this process.

The design and building phases, when well-planned, allow for the creation and development of M&E criteria from within the process, rather than external to it. These are attached to the desired impacts, outcomes, outputs, activities, and inputs of M&E. Clarification about the roles of the stakeholders and their intentions and vested interests is necessary to distinguish a PPP from privatisation and outsourcing. It also influences the governance approach, which focuses on joint co-production, co-ordination and consensus about the specific needs of the project and the intentional solutions to be implemented (SA National Treasury, 2017:4).

Risk identification, allocation and management are dependent on the scope of the project, the expertise of those at managerial level, and on financial perspectives, including the positioning of the project within local and national markets. The risks attached to PPPs are much higher than other in collaboration strategies. Monitoring the risks and evaluating them from an administrative position, as an ongoing part of the project, could allow for the quick implementation of interventions for unforeseen occurrences during the lifespan of the PPP. The roles of each stakeholder and the risk-sharing amongst them influence, to an extent, their commitment to the partnership and their willingness to drive the process (Sarvari, Valipour, Yahya, et al., 2019:2).

The adoption of PPP models is largely driven by the opportunity to enhance service delivery with a lowered risk and reduced need for public sector borrowing. It also allows for development and innovation opportunities through inclusive policies to drive equity. A challenge in this process is the political interest in such projects and a politically autonomous approach to involvement in the PPP approach. This has an impact on the process of accountability for stakeholders, where accountability models in partnerships like these are complex. Issues associated with accountability between actors and agents within partnerships in the South African context include corruption; poor or absent transparency and public consultation; challenges with public accounting and a failure to ensure value-for-money, including non-compliance

with fiduciary responsibilities; poor equitable risk allocation; and ineffective contracts and performance management (Fombad, 2013:14).

Growing demands on public services, with a corresponding shrinking of the economy in South Africa in 2020, required that innovative and collaborative strategies between the public and private sectors continue to thrive. In the current political climate of the country, however, there is a growing focus on the need for accountability in collaborative partnerships between the state and other sectors. This is secondary to the evident misappropriation and mismanagement of public funds presented in various Auditor-General reports from the years 2014 to 2020. The Zondo Commission of Inquiry, established in 2018 to investigate financial crimes at a national level, executed through collaborative partnerships with poor management and accountability, provides much-needed motivation for the necessary strengthened approaches to ensure the reliable and controlled approach to public-private solutions for service delivery. There is need for effective M&E systems, built into the design of public-private models, to monitor and evaluate both engagements between stakeholders, as well as the impact on service delivery resulting from the inputs and activities.

3.12 Monitoring and evaluation of public-private partnerships in the eye health sector

The diverse forms of public-private partnerships over the years have made it difficult for uniform M&E criteria to be implemented in tracking the progress and sustainability of such systems. The collaborative approach, which requires private partners to adopt, support and implement solutions aligned with public policy, allows for some reference framework to measure outcomes against the intended objectives. The process, from conception to implementation, requires a context-specific definition of the public-private partnership; attention to risk management; drivers for the adoption of a PPP model; and performance evaluation, overall. The practical implication is the relevance of M&E as a central element for public-private partnerships, as is evident in this study. This should be built into the conceptual phase of all engagements and should be an ongoing and continual process. Monitoring and evaluation create the capacity for transparent reporting and

enhances opportunities for accountability by all stakeholders. Through timeous and adequate interventions, attempts to improve the quality of services delivered for the benefit of the public is sought.

There is little or no evidence of eye care service delivery in most remote areas in South Africa from the literature reviewed, and the researcher is convinced that the rural population is almost totally neglected, despite the existence of PPPs which are meant to ease the pressure on public service delivery in hospitals. In the private sector, the shift from hospi-centric care to preventive, as evidenced in the amendments to the Medical Schemes Act, and in the review of the prescribed minimum benefits by the Council of Medical Schemes in South Africa, is an indication of preparatory steps already underway to shape a health sector which can, meaningfully, connect the worlds of people dependent on public and private healthcare. The challenge, here, rests with the integration between sectors which currently exist in isolation to each other, where barriers to integration include policy, political will and profitability, amongst others. One can state that PPPs offer a link between two opposed models of service delivery aimed to provide the same service, to the same people, differentiated only by their economic privilege.

3.13 CONCLUSION

Overcoming impediments to service delivery necessitates a renewed and comprehensive strategy to realise the objectives outlined in the government's national and provincial plans. The paucity of evidence in the literature on eye care in South Africa suggests that this service is neglected at a district level, coupled by other challenges as highlighted in the study. There are, however, few models for the successful delivery of primary eye care services, which currently limits the ability of eye-care professionals and planners to agree upon effective models for the delivery at the primary level. A growing need exists to address the urban-rural inequalities in access to healthcare services in South Africa, as these continue to persist, and seemingly discriminate the poorer communities in rural areas. The inequity ranges from resource allocation in urban and rural areas, to the widening gap between rich and poor, which is exacerbated by access to the social determinants of health, and existing social ills inherited from the apartheid government. Achieving the national

goal of universal health coverage through the NHI would require a thorough understanding of the limitations in the current public health system, together with an overview of the available service providers and stakeholders, in civil society and the private sector, who could provide short- to medium-term solutions which could be tested for long-term implementation. The significant gap which emerges throughout the available literature, which is not unique to eye health services, is that, where attempts are being made to address underserved areas with health services through different models, the documenting, M&E of this remains a primary challenge. The role of an effective administrative system is largely ignored, which inevitably reduces the quality and impact of the work which is done. The demand for primary eye health services in South Africa, linked to higher numbers of people who are avoidably blind, will continue to be unmet, due to the growing population and the widening gap in economic privilege between sectors of the population, as well as a disproportionate allocation of service providers. The first step in resolving the challenge of eye health service delivery is for the departments of health at all provincial levels to quantify the status of eye health services within districts; to convene stakeholder engagements intended to provide information; to develop a commitment and willingness to provide support; and lastly, to map a way forward in such a manner that M&E is built into every level. A public-private health forum is, therefore, deemed an appropriate example of a baseline system, which can be used to achieve this tangible outcome.

A critical deduction emerging from this chapter is that addressing impediments to service delivery in South Africa's healthcare system, particularly in eye health services, requires a comprehensive strategy aligned with national and provincial plans.

CHAPTER FOUR: RESEARCH DESIGN AND METHODOLOGY

4.1 INTRODUCTION

Various methods and procedures were employed to obtain relevant data for, and knowledge about, the issue under investigation. This chapter has provided substantial details of the whole process, from the study design to the outcome. The methodological aspects covered include the introduction; research setting; research design; philosophical orientation of the study; qualitative research; population and target population; sampling strategy; sample size and participant selection; sampling adequacy; interviews; interview design; data collection; case study; data analysis; thematic analysis; ethical considerations; data saturation; reliability and validity; pilot study; and the significance of the study. This study ends with a concise conclusion.

4.2 RESEARCH SETTING

The uMgungundlovu District in KZN was the location for the study. It is one of the biggest districts in the province, with seven (n=7) sub-districts. It is an economic hub for trade from smaller areas in the KZN Midlands and forms part of the Johannesburg – Durban corridor (SALGA & SACN, 2016). This district has a population of 1 052 730 people, of whom 84.3% are uninsured. People aged 15–64 account for approximately 62.8% of the population. Elderly patients, aged 65 and older, comprise 4.1% of the population. To service this population, there are two district hospitals, one being a regional hospital and the other a tertiary hospital. Other hospitals include generalised facilities for psychiatric and TB care. There are an additional 46 clinics, 17 mobile clinic units, and one state-supported clinic. Unfortunately, the distribution of services across the district is neither uniform nor consistent (uMgungundlovu Health District, 2019; Yes Media, 2019).

Surgical eye health services for the treatment of cataracts are only offered at three sites, all of which are concentrated in the Pietermaritzburg area. There are a limited number of eye health staff employed in the district. They include ophthalmologists;

medical officers and registrars; ophthalmic nurses; and optometrists. Their roles are defined by their scope of practice, and services offered range from screening, refraction, therapy and rehabilitation; to therapeutic and surgical management. While screening and some level of management for eye health conditions are conducted by nurses and general practitioners in different departments, and at primary health facilities, the consistency and accuracy of early cataract detection and visual impairment diagnosis, and the access to, and availability of, ophthalmic equipment by these cadres is not well documented, giving impetus for this timely research study. Record keeping for patients awaiting cataract surgery at the different facilities is not uniform, and this is likely to impact the efficiency and effectiveness of interventions put in place to address the considerable backlog, which seriously impedes the efficacy of public health service delivery in this district. The current situation warrants this study to address some of the serious shortcomings and deficiencies in this area of service delivery, in an attempt to remedy the disastrous *status quo*.

Many well-established private health facilities in the district and province have national and/or provincial footprints for capacitation activities to support the Department of Health in eye health and other services. These include the Midlands Medical Centre; the International Islamic Relief Organisation; Mediclinic; Right to Sight; Penny Appeal South Africa; the Daymed Hospital; the Al Imdaad Foundation; the Islamic Medical Association of South Africa; and Brien Holden Vision International. While a limited number of participants have contributed to the intervention, the aim would be to engage more role players in the province acting within the eye health service space to provide data and information, which is rich in quality, and to make meaningful contributions to the intended outcomes of the research study.

4.3 RESEARCH DESIGN

Research design is described as “a plan for collecting and analysing evidence that helps to answer the questions posed” (Jaakkola, 2020:19). Research methodology focuses on the combined use of both processes and tools required to conduct research and obtain data (Babbie & Mouton, 2006). It is the overall plan used to link

the conceptual research problems with empirical research. This is to say, research design ensures that the data required, and methods used for data collection and analysis, help answer research questions. Robson (2002:82) indicates that research can be exploratory, descriptive and explanatory in design. The choice of design depends on the research area, since each design is based on a different end-purpose.

Boru (2018:2) posits that, when there is not enough known about an event or phenomenon, and the problem is not clearly understood, then exploratory research is perceived as adequate for the investigation (Saunders, Lewis, Thornhill, 2007). Exploratory research deals with either new problems, or those around which little research, or no previous research, has been conducted (Brown, 2006). Although, the research questions do not aim to lead to final and conclusive answers, exploratory research helps provide some insights into the issue under investigation. Furthermore, exploratory research falls short of explaining why an event takes place (Punch, 2005:26). Exploratory research remains a basis for more conclusive research, and it even influences steps, such as research design, sampling methodology, and the method of data collection (Singh, 2007).

A descriptive design aims at depicting a situation, events, or people, or highlighting how things occur in the natural environment, or how they are related to each other (Blumberg, Cooper, Schindler, 2005). A descriptive study seeks to answer the research questions by asking 'what' kinds of questions, while explanatory studies deal with 'why' and 'how' questions (Crowe, Creswell, Robertson, et al., 2011). Explanatory research aims to identify the causes, and provides underpinning motives that can be refuted. It is conducted out to identify and highlight the existence of relationships between different features of the event or phenomenon under investigation. Hence, when there is substantial descriptive information, other designs, such as explanatory or exploratory, need to be considered as options to achieve better research outcomes.

4.4 PHILOSOPHICAL ORIENTATION AND PARADIGM OF THE STUDY

The approaches of researchers are contingent on their worldviews, comprising their beliefs and philosophical assumptions concerning the nature of the world and how it can be comprehended (Guba & Lincoln, 1994:105). These perceptions of the world are referred to as research paradigms, and they influence the design, and how research projects are conducted (Wahyuni, 2012:69; Creswell, 2013). A paradigm consists of a set of theories, ideas, and assumptions that make up part of one's worldview and approach, used to interact with other people or things. A paradigm is a lens that a researcher employs to view the world, assess the research methodology, and decide on the methods that need to be employed to collect and analyse data (Kivunja & Kuyini, 2017:26). There are four philosophical elements associated with research paradigms: axiology, ontology, epistemology, and methodology (Creswell, 2013:33). It is incumbent on a researcher to choose adequate philosophical elements before proceeding with designing the research. Ontology deals with the study of being. It focuses on how the researcher views reality and how people engage in the world (Kivunja & Kuyini, 2017:27; Wahyuni, 2012:70). Its assumptions are based on the researcher's perception of what is true, and his/her acceptance of what is true. These assumptions guide a researcher during his/her research, its importance, as well as its methodological approach to answer research questions (Creswell, 2013:33). It leads to asking questions such as 'What is real in the natural or social world?', 'how to know what is known?', and 'how to understand or conceptualise things'. Biomedical ontological, social constructivist ontological, and critical realist ontological, stances are most commonly adopted in healthcare (Wahyuni, 2012:70).

Axiology looks at the understanding of values and their role in the research of the researcher. These philosophical elements focus on values, and issues of right and wrong, and assess the level of development as well as types of perception biases (Guba & Lincoln, 1994:115). This sheds light on the role and importance of research process, considers the values assigned to research by researchers, and helps the researcher in their attempt to acquire more knowledge (Creswell, 2013:20). The researcher takes into consideration what needs to be done to uphold and respect the rights of each participant; the type of ethical principles to be followed during the

research; the type of cultural and intercultural features to be considered during the research; how research can be conducted respectfully; and how risks can be reduced during research. Researchers may consider employing axiological stances such as patient-centredness, evidence-based practice, health equity, and cultural humility (Scotland, 2012:13; Guba & Lincoln, 1994:110).

Epistemology is one of the branches of philosophy that specialises in the study of knowledge and belief. It provides descriptions of how knowledge about reality is obtained, understood, and used (Creswell, Hanson, et al., 2007). It is instrumental in increasing the level of confidence that researchers may have in their data. It influences the approach of researchers to identify and find answers during research (Kivunja & Kuyini, 2017:27). Researchers using epistemology may ask questions related to understanding knowledge; how to obtain it and its limits; its trustworthiness; the need to conduct further investigations; and the extent to which knowledge is accepted in a given discipline. Epistemological stances such as positivism, interpretivism, critical theory, and pragmatism are used by researchers in their studies (Wahyuni, 2012:71; Creswell et al., 2007).

Methodology is a strategy or action initiated with the aim of guiding the researcher to choose and use methods related to a particular research paradigm (Crotty, 1998; Wahyuni, 2012:72). The methodology includes sub-themes such as study design, methods, and procedures, used to find answers. Some examples are data analysis, an interview guide, data analysis, and the study participants. Based on the methodology, questions to be asked by researchers should revolve around issues such as “how to find out more about this reality, and the type of approaches or methodology used to acquire the data, enabling research questions to be answered” (Kivunja & Kuyini, 2017:28). There are two main types of methodology: qualitative and quantitative research. Depending on the case, a combination of quantitative and qualitative, referred to as ‘mixed methods’ may be used. Quantitative, qualitative and mixed methods are examples of methodological approaches used by researchers (Wahyuni, 2012:72; Bunniss & Kelly, 2010:361; Creswell et al., 2007; Scotland, 2012:10).

Case studies can be undertaken through diverse methodologies. Depending on the researcher's epistemological stance, the approach to case studies may involve critical inquiry, where assumptions are scrutinised, interpretivism, aiming to comprehend shared social meanings on an individual level, or positivism, aligning with natural sciences' criteria and emphasising considerations of generalisability (Crowe et al., 2011:4). This study relies on a positivist, epistemological stance.

4.4.1 Qualitative research

Several definitions of qualitative research are provided in various studies. It is described as a type of research that investigates and sheds further light on real-world problems (Tenny, Brannan and Brannan, 2022). Derived from its methodology for data collection and analysis, qualitative research is understood as an interpretative approach that revolves around exploring the meanings individuals assign to their experiences in the social world and their sense-making processes within that context. (Pope & Mays, 2020:2). According to Leavy (2023:9), qualitative research is perceived as *“an approach to explore; to robustly investigate and learn about the social phenomenon, or to build a depth of understanding about some dimension of social life”*.

Qualitative research helps collect data related to the perceptions, experiences, and behaviour of the study participants. It is designed to answer the 'how' and 'why' questions rather than 'how many' or 'how much' (Tenny et al., 2022). “It is contextualised and interpretive, emphasising the process or patterns of development rather than the product or outcome of the research” (Nassaji, 2020:427). In terms of structure, it can be conducted as a stand-alone study, relying solely on qualitative data, or it could be combined with quantitative data as part of mixed-methods research (Tenny et al., 2022).

Qualitative researchers are united in the quest to “gain insight into the meaning (*verstehen*) that the subject gives to his/her life world to understand human behaviour from an insider's point of view (emic)” (Auriacombe 2007 in Auriacombe and Schurink, 2012:145). One of the main ongoing issues in qualitative research is the ethical dilemma faced by researchers concerning the question of how the 'other'

or subjects should best be represented to provide the most truthful picture of their reality” (Auriacombe, 2012:147). How qualitative research methods and methodology are understood is closely linked to the ways in which qualitative researchers conceptualise themselves and the research they are doing (Auriacombe, 2012:148).

Several reasons are put forward to justify the use of qualitative methods. Firstly, some research questions cannot be addressed with quantitative methods only (Busetto, Wick, Gumbinger, 2020:1). For instance, a study conducted in Australia sought to identify the reasons why patients from Aboriginal communities came in late, or did not seek healthcare services offered by tertiary healthcare institutions at all. The administering of qualitative interviews to healthcare workers and patients highlighted the absence of a bus service connecting the residential areas of these communities to the hospital, as the main barrier (Kelly, Dwyer, Willis, Pekarsky, 2014:110). Using a quantitative methodology would have highlighted the number of patients and failed to discover the right reasons behind the pattern. Secondly, there are research problems that require qualitative methods if they are to be approached correctly. These include *“addressing questions beyond “what works”, towards “what works for whom when, how and why”*, and focusing on intervention improvement rather than accreditation” (Busetto et al., 2020:2). Finally, qualitative research works as a complement to quantitative research methods. For example, qualitative research can help shed light on the frustration inherent in the medical expenses of patients or caregivers, while quantitative tools may be instrumental in estimating the costs and benefits of treatment in terms of side effects or survival rates (Busetto et al., 2020). In this study, the study participants consist of people involved in the governance and co-ordination of the forum and public health eye services.

The units of observation, or material, used for this study were the primary and secondary texts in the public domain. The textual material consulted consisted, *inter alia*, of the following documents: regulatory documents, such as the RSA Constitution, 1996, relevant legislation, regulations, and policy documents; national eye health policy and the strategic framework 2018 – 2022; the provincial strategy for the prevention of blindness; KwaZulu-Natal’s eye health service plan; the district health plan; Section 27 of the RSA Constitution, 1996; Vision 2020 and WHO

prevention-of-blindness guidelines; and guidelines and framework documents from the Department of Performance Management and Evaluation.

Concerning the uMgungundlovu District in KwaZulu-Natal, the investigation results serve as the foundation for the primary generalisation in this research. This is attributed to its capacity to facilitate in-depth exploration and provide insights into the research phenomenon characterised by specific features, including a focus on an individual unit, detailed and intensive study, examination within a contextual framework, and the utilisation of multiple data-collection methods (Ritchie, Lewis, Nicholls, et al., 2013:66).

4.4.2 Population and target population

The clear distinction between the concepts of 'population' and 'target population' is important in any study and needs to be addressed. According to Martinez-Mesa (2014: 609), a population is a group of people living in any geographical region (metropolitan area, province, state, country, continent, etc.), or in some institution (prisons, schools, hospitals, etc.); that is, people that share at least one characteristic. As per Alvi (2016:10), a target population encompasses all members who meet the specified criteria for a research investigation. This author makes it clear that the target population refers to a part of the population in whose characteristics the researcher is interested. It is worth highlighting that a target population needs to be unique enough to avoid causing bias in the study, by including participants who may misrepresent the population of interest (Casteel & Bridier, 2021:344). Furthermore, the target population needs to represent a full portion of the population of interest, while satisfying the need for members of the target population to be described within the boundaries of the population of interest (Casteel & Bridier, 2021).

The inclusion criteria for this study were all participants of the eye health forum; the district health manager; the provincial co-ordinator for eye health services; and the head of ophthalmology in the district; as well as all registered organisations known to the Provincial Department of Health, acting in the space to provide support to cataract surgery services since 2014. The exclusion criteria were civil society

groupings providing cataract services who are not known to the district, and were not acting in the space within the defined period of 2015–2019. Former staff of the DoH, private hospitals, and civil society organisations, may have been part of the forum due to their employment at the time.

4.4.3 Sampling strategy, sample size and participant selection

Qualitative researchers employ sampling techniques for the selection of study participants. A sample is defined as a relatively smaller group of individuals chosen from a population for investigative purposes (Alvi, 2016:11). The author highlights that the impossibility for researchers to access every single case of the large population in an investigation leads them to select a smaller group of people to carry out (and make) the assessment. A sample of a large population is extracted through a process referred to as sampling. Qualitative research has two main types of sampling, which are convenience and purposive sampling (Clark, Foster, Bryman and Sloan, 2021:177).

Convenience sampling is a sampling strategy used by researchers to access people who are convenient, and willing to take part in the study (Gray, 2018). The difference between this strategy and purposive sampling lies in the fact that it has nothing to do with the conceptual frameworks or theoretical characteristics of the sample (Etikan, Musa, Alkassim 2016:4). Convenience sampling is favoured when the researcher struggles to find people who may meet some specified criteria, such as age, gender, or socioeconomic status. This may be common in research requiring particular data such as ethnography. Researchers are required to use key informants who may provide useful information on the issue under investigation and in the research setting. Researchers typically make decisions based on factors such as availability, specialised knowledge of the setting, and willingness to fulfil the designated role. (Hesse-Biber 2017:56).

Purposive sampling is the deliberate selection of particular people, events, or locations, since they can provide some piece of information that might not be available elsewhere (Etikan et al., 2016:2). Similarly, Clark et al. (2021:377) describe it as a type of non-probability sampling that entails the strategic selection of

information-rich units or cases (those expected to offer significant and pertinent information) directly aligning with the research objectives. In qualitative research, purposive sampling tends to be used more than convenience sampling. This sampling strategy is associated with both advantages and disadvantages.

The first advantage is that it is designed to accommodate several research methods, making it easy to employ various tactics and reach the intended outcome (Thomas, 2022:4). Likewise, Tracy (2020:82) emphasises the adaptability of this approach, highlighting that proficient qualitative researchers, at a minimum, practice purposeful sampling. This involves deliberately selecting data that aligns with the project's research questions, goals, and objectives. Secondly, it is not possible to extrapolate data from a single sample. Although the research outcomes cannot be extrapolated, *“the various purposive sampling procedures let researchers establish broader inferences predicated on their sampling”* (Thomas, 2022:5). Thirdly, the sampling strategy allows researchers to have access to, and choose, a substantial number of non-probability sampling possibilities at the start of each step. Fourth, it allows researchers to save both money and time during the data collection stage. Fifth, it offers the possibility of achieving the highest level of variance by using certain strategies during sampling. Sixth, purposive sampling leads participants to adopt attitudes and behaviour that might influence the investigation, either positively or negatively. Seventh, the utilisation of entire sampling occurs when only a limited number of individuals or units demonstrate the sought-after characteristics (Thomas, 2022:5). Finally, it allows researchers to obtain as much information as possible on any investigated subject. Moreover, purposive sampling offers the researcher a comprehensive understanding of the study phenomenon (Patton, 2015:463), although it does not make room for generalisation. Some disadvantages inherent in purposive sampling are highlighted. Purposive sampling makes use of several inference techniques, during data collection, which become obsolete once they have been updated. The strategy is not only challenging to demonstrate a representative sample, but also is highly subject to researcher bias (Thomas, 2022:5).

Table 4.1: Research population categories

Data Source	Population groups	Population size	Data Collection Category	Sample-size proportionally represented	Selection criteria/ sampling strategy
Governance	District Health Managers Provincial NCDs Co-ordinator District Co-ordinator ACM Chairman	04	Qualitative In-depth interviews	04	Non-random sampling
Public health eye service delivery	District Eye Care Co-ordinators District Optometrists Hospital Staff Head of Ophthalmology	07	Qualitative individual interviews	07	Convenience sampling
Forum participants	Hospital board members Manager Private Hospitals	09	Qualitative In-depth interviews	09	Non-random sampling
	Manager State Hospitals CEOs Public Hospitals	06	Qualitative in-depth interviews	06	Purposive sampling
Civil society organisations	CSOs Contributors to Eye Health and Forum	05	Qualitative in-depth interviews	05	Non-random sampling

	Members; CSOs at District Level	01		01	
TOTAL				32	

Table 4.1, above, presents the categories of sampled participants. The researcher had mixed experiences in the fieldwork undertaken for the study. This is documented in the discussion that follows:

- Some participants were not available and this delayed the process and timeline for collecting data from them. This was especially applicable for those to whom the convenience sampling was applied. Most of them were healthcare professionals employed by the National Department of Health, especially on the front line, and this was understandable during the pandemic.
- Some hospital managers had resigned during the time of the research, and this made it difficult to reach them for their participation, which became challenging for the researcher.
- Notwithstanding these challenges, the researcher continued with data collection as planned.

4.4.4 Sampling adequacy

Sample adequacy in qualitative research pertains to the appropriateness of both the composition and size of the sample, playing a crucial role in assessing the quality and reliability of qualitative research (Vasileiou, 2018:2).

Given the nature of qualitative research, sample sizes are typically small to facilitate in-depth, case-oriented analysis, a fundamental aspect of this research approach (Fusch, 2015:1410). Furthermore, qualitative samples are purposively selected, based on their ability to provide information rich in texture, and relevant to the investigated phenomenon. Luborsky and Rubenstein (1995:110) posit that purposive sampling, in contrast to probability sampling used in quantitative research, focuses on selecting cases that offer substantial information. Van Rijnsoever (2017:2) supports the efficiency of purposive sampling over random sampling in qualitative

studies, highlighting the potential for information-rich data to be collected from a closed group of participants. This is supported by Patton (1990:184), who argues that there are no rules for sample size in a qualitative study; rather the guidelines for judging the adequacy of sample size should be based on flexible thinking, experience and tacit knowledge.

Despite the modest sample size that came out of the study, the responses gathered demonstrated a significant level of saturation, aligning seamlessly with existing literature and reviewed source documents. The collected data not only exhibited a coherence reflecting established theories, but also illuminated nuanced insights, thereby underscoring the robustness of the research methodology. This convergence between empirical findings and the existing body of knowledge substantiates the validity and reliability of the study, emphasising the richness and depth of the data acquired within the constraints of the limited sample size.

4.4.5 Interviews

A qualitative research interview revolves around asking questions of the study participants. However, it is different compared to other types of interviews. Pope and Mays (2020:43) regard as “a form of social interaction in which the interviewer must be able to listen to, and encourage, the accounts of others so that they feel safe to tell their story or share their views”. The interaction consists of the interviewer guiding the interviewees to speak about their experience and to tell their stories, while probing and digging deep to acquire more information on some aspects of their accounts. In an interview, researchers seek to place themselves in the study participants’ shoes, and to make sense of the phenomenon under investigation (Pope & Mays, 2020; Brinkmann & Kvale, 2018).

In research, there are three types of interviews. These include structured, semi-structured, and in-depth interviews (Pope & Mays, 2020:43). Structured interviews are made up of closed questions asked to the study participants. This type of question is answered by a ‘yes’ or ‘no’. These questions are mostly used in surveys and do not aim to generate qualitative data (Elhami & Khoshnevisan, 2022:1-2; Pope & Mays, 2020). With semi-structured interviews, although the researcher has an

interview guide, he will be flexible, will probe, and will attempt to urge the study participants to provide further information on the issues they raise (Pope & Mays, 2020: 44). During in-depth interviews, the utilisation of a minimal number of open-ended questions is intentional. This approach is chosen because the research emphasis is placed on comprehending “the experiences, thoughts, and perceptions of the participant,” affording them greater control over the interview agenda and typically providing more time for them to express and reflect (Pope & Mays, 2020:44).

Semi-structured interviews were administered to the participants during the fieldwork. An interview guide was prepared to assist the researcher with the semi-structured interviews. This was primarily so that the interviews would be less time-consuming. It also helped to ensure that the interviewer and interviewee focused on matters which are central to the study without deviating from the topic during the discussions. The interviews were conducted at the interviewees’ workplaces, and others were done telephonically, subject to all the necessary COVID-19 protocols in place at the time of the fieldwork being undertaken. The interviews were tape-recorded, following permission by the respondents, as per the informed consent protocols that were explained to them at the time of the interviews taking place.

Before collecting data, permission was sought from the District Health Department and the Research Ethics Department. An introductory email was sent to all the participants who were identified for the interviews, to provide them with a summary of the study, the application for permission to conduct the study, and a request to meet on a pre-arranged date. The researcher, accordingly, initiated the interview process and conducted the interviews.

Consent to participate was obtained from the participants. This was done as part of an introductory explanation relating to the study, which clarified the aim of the study and what it sought to achieve. Participants were made to understand that there were no implications for participating in the study. They were under no pressure to participate and their participation was the result of a free decision, made without any coercion.

The selection of participants was limited to people participating in the public-private health forum to address eye health challenges in the uMgungundlovu District. People who met the inclusion criteria were free to participate. This study excluded vulnerable populations, including children; patients at eye health facilities; sedated or comatose patients; psychotic patients; prisoners; and participants who were unable to speak for themselves.

4.4.6 Interview design

Semi-structured interviews have a style that can be adapted to collect various types of information. The guidelines for this form of interview are developed in most textbooks (Brett & Wheeler, 2021; Morris, 2018; King et al., 2019). The interview guide for semi-structured interviews contains some pre-formed questions that are intended to be administered to all participants. Crucially, the interviewer is encouraged to delve into emergent themes rather than solely concentrating on concepts and ideas predetermined before the interview (Brett & Wheeler, 2021:22). While interviewing, the researcher has some ideas about what type of information he would like to get from the participants. The use of an interview guide is intended to guide the direction of the discussion. The interviewer can also “rephrase a question, skip a question, formulate new questions, follow up on emerging leads, and probe for more detail from” a participant (Brett & Wheeler, 2021:22). The interviewer is expected to engage and encourage, but he/she should avoid talking about personal experiences. The researcher administered semi-structured interviews during the fieldwork of this study.

4.4.7 Data collection

There are two distinct categories of data collection methods: primary data collection methods and secondary data collection methods. First-hand information is made up of data not published yet. It is not manipulated by any individual (Taherdoost, 2021:12). This is to say that data collection is not a one-size-fits-all approach. Researchers employ various approaches to collect primary data for their studies. The use of primary data helps the researcher to improve the results, allowing him/her to add further data if necessary. It is essential to note that challenges arise during

primary data collection, specifically in defining various terms related to the process. These challenges encompass aspects such as the rationale behind data collection, determining what to collect, establishing the timing for data collection, and selecting the appropriate method for data collection (Taherdoost, 2021:12). Also, primary data collection is an expensive process. Sources such as experiments, interviews, interview guides, and questionnaires can be used to collect primary data (Kabir, 2016; Taherdoost, 2021a).

Secondary data refers to data obtained from published sources, or data used by someone else in other research. The information in the literature review, an essential part of any research with information from past investigations, is always gathered from secondary data. It can be instrumental in assisting the researcher to design and set a standard for comparing his/her primary results. However, researchers need to reassess the validity and reliability of the information collected and gain genuine results (Taherdoost, 2021:12). Books, records, internet articles, blogs, and published research articles are different sources of secondary data (Qazzafi, 2019:131). Although secondary data sources may run into issues inherent in validity, compared to primary data sources, their importance in research cannot be overlooked, since primary data sources are sometimes difficult to obtain. In general, compared to primary data, secondary data tends to be less expensive, and easier to obtain, and the researcher is not responsible for its quality (Longe, 2021). Besides these advantages, secondary data has disadvantages. Firstly, it tends to be unreliable and inaccurate. Secondly, it does not apply to all situations. For instance, it can be affected by environmental factors and may require updating (Taherdoost, 2021:14).

For the purpose of this study, interviews were used as primary data sources, while secondary data sources were reports; minutes of meetings; presentations; and other academic scholarly literature relating to public health service delivery monitoring, and evaluation. Other sources of secondary information were included, namely, policy documents; official recording documents; legislation; scholarly literature in the form of journal articles; books; and other information, including government publications, that are in the public domain that relate to the focus area of the research. Academic literature was also used to demonstrate the level of knowledge, as well as the

relevance and understanding of scholarly works to support and corroborate the data collected.

4.4.8 Case study

Case studies are one qualitative methodology used in qualitative research. Currently, case studies represent a substantial proportion of journal articles and books in several fundamental sciences such as education, medicine, and psychology (Starman, 2013:29). A case study is characterised as an empirical investigation that explores a current phenomenon within its authentic context, particularly when the distinctions between the subject of study and its surroundings are unclear. It addresses situations that are technically unique, involving numerous variables of interest compared to available data points. In such scenarios, outcomes depend on multiple sources of evidence, requiring a triangulated approach to data coverage. Additionally, the methodology benefits from the preliminary establishment of theoretical propositions to direct both data collection and analysis. (Dul & Hak, 2008:4).

Although the concept of the case study can be defined in various ways, the emphasis is placed “on the need to explore an event or phenomenon in depth and in its natural context” (Crowe et al., 2011:2). Sometimes referred to as a ‘naturalistic’ design, a case study contrasts with randomised controlled trials which are perceived as an ‘experimental’ design in which the researcher attempts to have control over some variables of interest through their manipulation.

There are various types of case studies. Their differences lie mostly in terms of the type of research conducted. Yin (2003) speaks about three distinct types: descriptive, explanatory and exploratory. Stake (1995:43) breaks them down into three types as follows: intrinsic, instrumental, and collective. Zainal (2007:3) identifies two types: evaluative and interpretive case studies; while Dul and Hak (2008:45) categorise them as single case studies and comparative case studies. An exploratory case study can be used to help understand and explain the impact of new policy initiatives or service development (Yin, 2009:139). The explanatory case study approach helps capture more explanatory information, answering ‘how’, ‘what’,

and 'why' questions. This can be related to how policy implementation is received on the ground. Case studies can be instrumental in helping fill the existing gap, or identifying the reasons leading to prioritising one implementation strategy over another (Pearson, Steven, Howe, et al., 2010:5). An intrinsic case study is conducted to investigate a unique phenomenon (Stake, 1995:3). The researcher describes the uniqueness of the phenomenon and differentiates it from others. An instrumental case study, based on a particular case, is believed to be better than the others. The researcher uses it to gain more insights into an event or phenomenon. The collective case study entails examining multiple cases concurrently or sequentially to cultivate a more comprehensive understanding of a specific phenomenon (Crowe et al., 2011:2). All things considered, while using case study research, it seems more plausible to consider two types: a single case study and multiple case studies. In this research context, a case study approach was adopted (Crowe et al., 2011:2).

Sibbald, Paccioco, Fournie, Van Asseldonk, Scurr (2021:1) highlight the increasing popularity of case study methodologies within health service research. Case studies as a methodology in this area have garnered criticism in the past, but emerging trends show that it is well-suited to health service research, due to its ability to examine complex relationships, contexts and systems, as they happen in an ever-changing world. What is important to note here is that, whilst much of the research in public health is dependent on the isolation and testing of key variables within controlled settings, it neglects the very complexity of systems that operate to make health services possible (Paxton & Frost, 2018:2).

Within a South African health service delivery context, where service delivery is determined by the ability to deliver services through infrastructure, skilled personnel and a functional budget, the uptake of services is an equal consideration (Fusheini, Eyles, Goudge, 2016:1288). The disparate health service across urban and rural sectors impacts on both the uptake and delivery of services, and is underscored by non-medical determinants, as well as technical and managerial functionality. Slipicevic and Masic (2012:107) identify four areas of significance that govern managerial skills. These are interpersonal; information management; analytic skills, and action skills, underscored by the fading boundary between clinical and management staff. The interdependence between clinically-skilled people and those

tasked with administrative functions for the non-medical component of health service delivery cannot be measured quantitatively.

Within the context of this study, the relationships between public, private and civil society stakeholders to address a public health service is examined. The complexities underpinning the components of health service delivery, in relation to evidence-based solutions that could emerge through PPPs, require a flexible research design that allows for contextual nuances, and one that could provide thorough information about the challenges and opportunities that exist. A case study methodology meets this requirement for the research that was undertaken.

4.4.9 Data analysis

The procedure for the interpretation of results was guided by the 'framework method', as documented by Gale, Heath, Cameron, Rashid and Redwood, (2013:4). For this process, the recordings of the interviews were transcribed verbatim into a Microsoft word document. The researcher studied the recordings for the qualitative responses. Transcripts were analysed, and codes were applied to important lines to highlight their relevance and for interpretation. The data was then generalised by category, to ensure that the themes were aligned with the key questions and objectives raised in the study. In doing this, the researcher maintained balancing the authenticity of the input received, with the generalised data. Interpretation of data was guided by recording ideas and trends.

Thematically, similar and dissimilar aspects inform the qualitative findings, and the connectivity between themes and trends lends insight into causal factors, through inductive reasoning. Framework analysis of the qualitative data was conducted, which allowed for the appropriate results, according to the study's objectives, as raised initially in the first chapter of the thesis, and reiterated in this chapter, setting out the methodological approach and scientific design for the research.

4.5 THEMATIC ANALYSIS

Thematic analysis is characterised as an analysis of data centred on identification, description, explanation, substantiation and linkages of themes (Kampira, 2021:5). It

is also described by Maguire and Delahunt (2020:3352) as “the process of identifying patterns or themes within qualitative data.” Braun and Clarke (2006:78) recommend this method due to its versatility for various types of analysis. An additional advantage is that thematic analysis is not restricted to any particular theoretical or epistemological perspective (Maguire & Delahunt, 2017:3352). In essence, thematic analysis aims to identify significant themes in collected data to address research questions. The analysis distinguishes between two levels of themes: semantic and latent. Semantic themes, according to Braun and Clarke (2006:84), represent surface-level meanings of the data, with no search for hidden elements beyond participants’ explicit statements. In contrast, from a latent perspective, thematic analysis delves into the underlying ideas, assumptions, conceptualisations, and ideologies that shape or inform the semantic content of the data (Braun & Clarke, 2006:84).

Maguire and Delahunt (2017:3354) recommend this analysis be conducted in a six-phase process. These steps, from one to six are: The first step is to become familiar with the data. It consists of reading and re-reading the transcripts. The second step focuses on generating initial codes as it deals with organising data to make it more meaningful. Coding tends to reduce the amount of data and turn it into sets of meaning. The third step is about searching for themes, and based on their significance, preliminary themes are identified. The fourth step concentrates on reviewing themes, with preliminary themes that were identified in the third step being modified and developed. All data relevant to each theme is gathered at this stage. The fifth step defines themes, with the final refinement done at this stage. This is intended to discern what the essence of each theme is about (Braun & Clarke, 2006:92). The sixth step emphasises the write-up, commonly concluding with a report, often in the form of journal article or dissertation (Maguire & Delahunt, 2017:33512). This study made use of thematic analysis to analyse data, in accordance with the sequential steps.

4.6 PILOT STUDY

Pilot studies, integral to the research process are defined as small-scale or preliminary studies, they serve as pretests for specific research instruments, such as

interview guides or questionnaires (Shakir & Rahman, 2022:1620). This type of study can be carried out in qualitative, quantitative, and mixed-methods research. Conducting a pilot test before embarking on the research study is associated with several benefits, as suggested by some empirical evidence (Christensen et al., 2015; Brink et al., 2016). Firstly, “a pilot study is essential to test the effectiveness of the research tools and the recruitment of subjects (Hassan, Schattner, Mazza, 2006:70). Secondly, it helps provide the research with insights into what to expect in the fieldwork (Shakir & Rahman, 2022:1620). Thirdly, it gives participants an opportunity for familiarise themselves with the research process and the researcher. Fourth, conducting a pilot study in qualitative research is thought to result in improved validity and methodological rigour. Finally, it “assists in identifying and resolving ethical and practical issues that could jeopardise the main study or violate participants’ human rights” (Shakir & Rahman, 2022:1620). In this study, the pilot study for patients was conducted with three participants from the forum and one from each of the represented sectors (including the public and private sectors, and civil society at large).

4.7 RELIABILITY AND VALIDITY

The instruments and data need to be valid and reliable. Validity in the context of qualitative approaches is based on the trustworthiness, utility and dependability of the results in dynamic environments where research is conducted. It is necessary to integrate validity into the process, from the research tools to the data analysis process, so that it creates consistency and strengthens the principles for evaluating the research. Processes to validate instruments include content validity, internal validity, utility criterion and external validity. Reliability was concerned with the soundness, consistency, and replicability of the study.

Qualitative studies are less numerical than quantitative ones. Therefore, there is less emphasis on replicability and a greater focus on the agreement between the data and reality. The dependability and consistency of the information are key requirements for validity. They are dependent upon the researcher’s position, triangulation through methods of data collection, and an audit trail (Zohrabi, 2013:259).

In the context of this study, the validity was measured by asking questions such as 'Does it make sense?'. This was done in interviews, informal conversations and observations, and while reading reports. The usefulness of the information was tested against whether it could provide sufficient information about the effectiveness and appropriateness of the public-private health forum to provide public health eye service delivery solutions. Additionally, the reliability of the study was achieved through clear explanations of the processes undertaken to obtain data, with detailed explanations of how the results were derived.

4.8 DATA SATURATION

The issue of data saturation is an important factor as far as data collection is concerned, especially in qualitative research. Bekele and Ago (2022:48), in their overview of previous research, found that there is growing support for a sample size ranging between 10 and 20 in total, which implies that, for study participants in homogenous populations, it is a substantial number. This is further supported by Hennink and Kaiser (2022:9) who affirm that saturation can be achieved in between 9 and 17 interviews, and in four-to-eight focus group discussions. Saunders, Sim, Kingstone, et al., (2018:1896) indicate that saturation in qualitative research occurs when, during interviewing, the interviewer notices that participants start providing the same responses. Furthermore, InterQ (2023) suggests that saturation is achieved when the researcher is unable to discern new themes, viewpoints, opinions, or patterns. Despite an increase in the number of study participants or in the sample size, there is no further increase in terms of information collected. Although it seems difficult to predict how soon saturation may occur, it is believed that saturation depends on both the specificity of the study and the level of homogeneity. This is to say, for highly homogenous samples, it can occur after five interviews; while for diverse populations, saturation could occur only after interviewing 30 participants or more. In this research, the researcher was comfortable that data saturation was reached after interviewing 12 of participants. The sample size of this study was informed by the number of participants in the public-private eye health forum that contributed to the case study. It is necessary to highlight the difference between the number of people who formed the forum and those who responded. Additional information was supplied to justify why the sample size dropped from the estimated

participants to the number that responded given the collapse of the system that took place during the empirical study. This challenge necessitated the need for such a study to build a sustainable system for eye health care.

4.9 ETHICS CONSIDERATION

Ethics considerations are an important aspect of any primary and empirical research. There always needs to be sensitivity regarding the well-being of respondents (Christensen, Johnson & Turner, 2015). The common principles attached to the ethical framework of this research include, as explained by (Christensen et al., 2015) the following key aspects that were considered:

- Do not harm, and respect the rights of, participants.
- Obtain full consent (and assent in the case of minors), and prioritise the protection of participants' privacy.
- Apply confidentiality to the research contents, to ensure the highest level of anonymity.
- Be transparent and truthful about the aim of the study; and what it seeks to achieve.
- Be honest in all communication related to the study.

Participation was voluntary, and respondents were able to withdraw at any stage of the study. This was communicated to them verbally at the onset of engagements; and they were provided with an information sheet, which indicated the details of the study, including contact details for the researcher and the institution. Permission was sought from the Department of Health to conduct this research with employees of the department, and a gatekeeper's letter was received, granting permission to access the necessary information relating to the study.

The ethics approval was sought at the Humanities and Social Sciences Research Ethics Committee (HSSREC) of the University of KwaZulu-Natal, Durban, South Africa through the provision of an ethics clearance letter and a protocol number granting permission to conduct the data collection.

The right to anonymity was upheld regarding participants' names and their contact details. Where recordings were made of the interviews, these recordings were only used in the transcription phase of the study. The transcribed reports did not include any personal identifying details of the participants.

All literature and information used within this study were duly referenced to generalise the scholarly work of the authors. The researcher applied objectivity in discussions and analyses throughout the research. Feedback on results was given in the form of a summarised report to clinicians and other management-level staff when the study was complete.

This study is a low-risk study with no risk of biological, psychological, or social harm. Respect for the participants was upheld, through exercising confidentiality throughout the study. Once the study is completed, transcripts are stored for a period of five years, in accordance with the university's policy for postgraduate studies. No post-study benefits were declared at the onset, and there were no incentives or remuneration for study participants, in keeping with the requirements of the university policy for postgraduate research.

Due to the outbreak of the Coronavirus in South Africa in March 2020, and the consequent implementation of lockdown rules, accompanied by new social protocols to mitigate the spread of the disease through the Disaster Management Act 57 of 2002 and Disaster Regulations, there was no physical contact with the participants. Interviews were only conducted in a manner aligned with the level of lockdown at the time of receiving ethics clearance, and with the social distancing measures that were applicable, including the use of personal protective equipment, at the time. Had the level of lockdown at the time not permitted activities linked to data collection, the in-depth interviews would have been conducted telephonically.

4.10 LIMITATIONS TO THE STUDY

Limitations to the study included the modest sample size, governed by the high turnover of staff within the public health sector, and the poor record keeping of forum stakeholders. This resulted in no updated contact details for participants. Furthermore, record keeping of forum activities was lacking. This posed a limitation

for incumbent participants, who replaced stakeholders upon their retirement or resignation. However, the findings in this study were not compromised by the modest sample size, in that the findings still yielded results that demonstrated huge gaps in the area of research. These are discussed under sample adequacy in the next chapter, on the interpretation of the findings.

To overcome these challenges, however, effective recording mechanisms to track participant details and commitments, and forum activities, need to be implemented.

4.11 SIGNIFICANCE OF THE STUDY IN PUBLIC HEALTH DELIVERY

Monitoring and evaluation have been generalised in the public sector through the former Office of the Presidency in 2011, with the provision of a generalised government-wide M&E policy document, which has become institutionalised in public institutions in the country. All public institutions are, therefore, required to ensure a more vigorous implementation of M&E procedures to enhance service delivery to communities. Given the gaps that exist in effectively monitoring and evaluating health care service delivery in this local area, and the contemporary focus on PPPs in public administration, the study was intended to examine the efficacy of a PPP in eye care service delivery. It aimed at addressing the unsustainability of interventions, due to the absence of effective administrative resources to deliver more efficient and effective public health services. The social and physical value of the study, as an integrated model (presented as a new contribution to the study), is explored in further discussion in the following chapter. This model could be implemented to enhance the effectiveness of the health services in the uMgungundlovu District through the work of the public-private health forum, deemed as one of the key derivative aspects of Public Administration in improving the welfare of society at large. Improvement in the effectiveness of health services through strengthened administrative interventions creates an opportunity for streamlined operational processes, improved M&E, and ultimately a reduction in the avoidable barriers to the delivery of public health services.

4.12 CONCLUSION

The qualitative design was a good fit to document in-depth issues around eye health service delivery. The methodology, through a case study design, allowed the researcher to inductively gather rich, detailed information that was needed for thematic analysis. This ultimately led to highlighting the current situation with the M&E of eye health service delivery in the district of uMgungundlovu, KwaZulu-Natal, in South Africa. Although the type of research method did not allow for gathering data that could be generalised to include other sub-districts, the information gathered did shed light on the actual situation on the ground, capturing the lived experiences of individuals in this under-researched area of public health delivery, which is, anecdotally, not much different from what is happening in other underserved areas of South Africa. The chapter presented the scientific steps that were followed by the researcher in the data collection, the conducting of interviews, and the analysis of data, in generating a scientific presentation in the thesis. The next chapter deals with the data presentation, with details on fieldwork experiences, and the study participants' behaviour in response to the empirical study.

CHAPTER FIVE:

DATA ANALYSIS AND DISCUSSION

This section discusses the findings from the primary data and the empirical study conducted, in relation to the literature review, and in comparison, with similar studies that have been conducted in different parts of the world. The findings reveal that there is a lack of M&E services provided by PPPs in rural areas, with no significant improvement evident in the delivery of eye care in rural South Africa. The understaffing and lack of equipment in eye service delivery hinders service delivery. These findings among others, are further explored in this chapter.

5.1 INTRODUCTION

There is a dire lack of M&E services provided by public-private partnerships (PPPs) in South Africa, due to inconsistent application across the country, and globally (Mashwama, Thwala, Aigbavboa, 2018:2). Thus, no significant improvement is evident in the delivery of eye care services, particularly in rural South Africa, despite interventions through PPPs. Khoza, Nunu, Ndou, Makgopa, et al. (2020:6) have noted limitations in accessing sight-saving cataract surgery, with multiple causes; notably, a lack of access to skilled staff at primary level and within reach of communities. The disparate structure of the health system in South Africa, coupled with its chronic shortage of skilled staff in the public health sector, has added to the inequitable availability of services. Access to services and geographical coverage poses a significant challenge for numerous communities in South Africa, particularly those in rural areas. While eye care professionals typically establish themselves in major urban areas, rural communities often lack adequate eye care services. This situation creates a major divide between those in urban spaces who have access to public health services, and those rural communities. Thus, there is a need to focus on retention strategies, proven models of eye care service delivery, and mechanisms supporting the uptake of eye care services thorough integrated solutions between the public and private sectors.

5.2 FINDINGS

The data generated from in-depth interviews led to the development of several themes, with a focus on capturing the nuances and responses of participants in the context of eye health care service provision in the Msunduzi District, a sub-district within uMgungundlovu District. The themes, presented below, are adequately nuanced, incorporating pertinent direct quotes from participants while maintaining their anonymity, as stipulated in the research protocol.

Through immersion analysis, eight (n=8) broad themes were identified. This process involves a continuous examination of the data set to foster a close familiarity with the findings in relation to the study. A theme, defined as a main and recurring idea, serves to encapsulate something significant about the data concerning the research question and reflects a level of patterned responses or meaning within the data set (Braun & Clarke, 2006:82).

5.3 EMERGENT THEMES

The study yielded eight (n=8) broad themes and they are listed below in the order in which they are discussed in this section of the study as:

- knowledge and participation in the public-private forum for cataract surgery;
- cataract service delivery overburdened in public hospitals;
- private-partnership: easing cataract service delivery in public hospitals;
- challenges faced in the public-private eye health care service delivery;
- understaffing and equipment provisioning hindrances to cataract service delivery;
- oversight measures taken to ensure service delivery for cataract surgeries;
- lack of reliable patient information systems: a hindrance to eye health care service delivery; and
- eye health care service delivery barriers in clinic referrals to hospitals.

5.4 DEMOGRAPHIC INFORMATION OF PARTICIPANTS

The participants were asked questions regarding their age, gender, job designation and sector. The number of years in their role was deemed valuable to enable the researcher to establish the depth of awareness of the challenges within the general health and eye health service delivery system. The majority of the participants had in excess of five years of experience in their specific roles.

It is important to note that the study was conducted following a considerable time lapse after the suspension of the forum and its activities. Whereas 32 participants were identified from the source document labelled the PPHF Stakeholder List, some only attended the initial meeting, while others attended but did not actively participate in the activity of the forum. Many of the participants who were initially identified as part of the study group left or retired from the forum, and there was no initiative from the Department of Health to address this anomaly. Furthermore, due to the lack of efforts to institutionalise the roles, responsibilities and their contributions to the forum, the study focused on the pertinent responses of the remaining participants. While the overall response rate might suggest a modest engagement at 12 out of 32, the response rate does not adversely affect the study findings in that, the researcher still remains confident that the segmentation of participants revealed a robust and insightful distribution across key sectors, and the information that they provided is still relevant and reflective of the bigger picture of the forum. This aspect was covered in the discussion of data saturation as outlined in the methodology chapter. This material fact is that the study makes a compelling submission that such instances of a poor response rate heightens and reinforces the notion of the need for a well-established and strong forum so that the work of this nature is strengthened for effective health service delivery, which is what the study has been emphasising. This strategic participant allocation response rate helped unlock nuanced perspectives, with feedback that could possibly elicit similar responses, given the common problematic issues faced across the board in this area of research, had there been more participants who did not leave the forum for various personal reasons.

Some of the impediments to participation in the study included, amongst others, the resignation of the then district manager, who presided over the forum in the capacity of chairperson; the demise of the beneficiary hospital's medical manager; and the retirement of the same hospital's chief executive officer, amongst other staff having left due to the poor governance nature of the forum. The lack of adequate recording of the forum's activities was also identified as a limitation to participation. Mosewu and Rakemane (2020:103) describes record keeping as a central component of good governance and necessary for accountability, trust and stability. The culture of poor record keeping within South Africa has led to backlogs; it has affected accountability and impeded governance systems (Mosewu & Rakemane, 2020:104). Table 5.1 below provides an overview of the categories.

Table 5.1: Categories of participants in the public-private health forum uMgungundlovu District

IDs	CATEGORY	AGE & GENDER	SECTOR (PUBLIC /PRIVATE)	ROLE	NO OF YEARS IN THIS ROLE
Participant 1	Public eye health service delivery	48 Female	Public	Ophthalmic nurse	19 years
Participant 2	Civil society organisation	79 Male	Civil society	Chairperson civil society organisation	2 years
Participant 3	Public eye health service delivery	34 Female	Public hospital ophthalmology	Medical officer ophthalmology	6 years
Participant 4	Public eye health service delivery	46 Male	Public	Head of Clinical Unit Ophthalmology	15 years
Participant 5	Public eye health service delivery and forum participant	60 Female	Public	Eye health Co-ordinator	12 years

IDs	CATEGORY	AGE & GENDER	SECTOR (PUBLIC /PRIVATE)	ROLE	NO OF YEARS IN THIS ROLE
Participant 6	Public eye health service delivery	32 Female	Public	Optometrist	6 years
Participant 7	Civil society organisation	67 Male	Private practice	Executive Director private health facility	15-20 years
Participant 8	Public eye health service delivery	47 Female	Public	Technical advisor in service delivery	15 years
Participant 9	Civil society organisation and head of public-private partnerships	56 Male	NGO	Head of department, eye care co-ordinator	6 years
Participant 10	Civil society organisation	45 Male	Private	Chairperson	6 years
Participant 11	Chairperson of hospital board, formal community level representative – political	43 Female	Public	Chairperson	10 years
Participant 12	Public eye Health service delivery	52 Male	Public	Eye care co-ordinator	16 years

5.5 KNOWLEDGE AND PARTICIPATION IN PUBLIC-PRIVATE FORUM FOR CATARACT SURGERY

The findings indicated that some participants were aware of the public-private partnership in uMgungundlovu, whose main focus was to provide cataract surgery, which was initiated due to the backlogs that were being experienced in hospitals. Participants indicated that a lot of old people were in search of cataract services, and without this partnership from the private sector as a public service, they did not know how to address the issue. One participant said:

“There was one in, I think, two to three years ago, three years ago. Yes, initiated by the private sector, and in partnership with hospital X, and we did have a backlog with cataracts, and we didn’t even know then how to move forward because you have these genuinely old people that need to see, and barely can see. So yes, it was a public, private public participation, and it went extremely well”. Participant 11

The introductory engagement with participants included some general questions about their awareness of the forum, their role in the forum and their general views about public-private health forums. The approximately four-year time lapse between the forum’s existence and the commencement of the study was taken into consideration. It allowed for the creation of a specific context within which the remaining questions would be based.

Aboobaker and Courtright (2016:146-147) attribute the South African eye health service challenges related to the cataract surgery backlog to poor commitment from staff; lack of operating theatre time; surgeons performing non-surgical tasks; and nursing staff under-equipped to manage high volumes of cataract surgery. In the study undertaken, participant responses and source documents informing the need for the PPP support these claims.

Some participants from the civil society organisations indicated that they did not know about a partnership between the public and private sector which was working towards the provision of cataract surgery to the elderly in the district. One participant said:

“Not very aware of it because I work for a civil society organisation”. Participant 9

Walwyn and Kolele (2018:3-4) assert that, while there have been efforts to standardise how PPPs operate, there continues to be asymmetry when it comes to the implementation of partnerships for projects. Currently, there is no known process for establishing how partners are identified. The strength of a PPP rests in its flexibility. However, there are no guidelines for how many partners can enter into such a partnership, and or how they are identified (Fombad, 2013). Administratively, there is no known repository at national or provincial level that documents civil society organisations engaging in collaborative services. The establishment of a forum for PPPs to alleviate the cataract surgery backlog in uMgungundlovu was premised on the reality that more than one skill set and resource were needed to achieve common goals. However, no informed process was applied to identify the stakeholders in the forum.

Participants indicated that their participation in the public-private forum helped to fast-track the process of cataract surgery for patients who had been on the waiting list for a considerable time. Participants indicated that the partnership enabled the fast tracking of cataract surgery patients and enabled those who had been looking for these services for a very long time. One participant said:

“Yes, assisted with finding and preparing patients for the cataract surgery after the civil society organisation contacted us about the cataract programme for patients on a backlog”. Participant 1

Law and Wright (2022:2) define a surgical waiting time as the period beginning from the time a clinical decision to treat patients is made, until the time that the surgery is completed. In South Africa, there is a paucity in information regarding the documentation of patients requiring surgical intervention from a public health perspective. Whereas the Department of Health holds a database for surgical

indicators and targets, no uniform database exists within the province and the district where the study was undertaken, for the recording of patients. The preparation of patient records was a manual process, subject to the reliability of the hospital department to store files correctly, and to record the pre-surgical work and information accurately. Information in this regard is of a strategic nature, in order to make value-added decisions for enhancing this critical area of health service delivery. Luthuli and Kalusopa (2017:9) emphasise that, even though previous studies regarding the overarching connection between poor patient record keeping and negative health service delivery may exist, the absence of a records management policy to govern the records management function is still absent. As such, record-keeping strategies differ and are dependent upon the administrative systems and competencies at the public health facility level.

Participants' roles in the programme helped yield positive results for both the public and private sectors. As some were working tirelessly in recruiting patients for the programme, others were working just as tirelessly in putting together a group of doctors who would carry out the much-needed surgery (ies). One said:

“... Private Hospital C provided the staff. I got a group of doctors together and the doctors were the ophthalmologist and a need that is so in total as far as doctors were concerned and think we were about eight doctors, four anaesthetists and four ophthalmologists, that provided our services pro bono over the weekend to do the surgery, and Private Hospital C covered the cost of the salaries for the nursing staff” Participant 7

Tsimanyane, Kotsie, Makgotloe (2023:1235) note that there is no national consensus about theatre utilisation targets in South Africa. In the context of ophthalmology services for cataract extraction, the majority of patients presenting for surgery are elderly. Within health service delivery, the increase in waiting lists due to ongoing cancellations is attributed to, *inter alia*, patients not arriving for surgery; incomplete records; staff challenges; power outages, and unavailability of theatre time. Mazibuko, Nadasen, Govender (2023:2) describe PPPs as a critical strategy for improving health systems and improving the sustainability of health services in the public sector. Basabih, Prasojo, Rahayu (2022:1) agree that PPPs in hospitals reduce waiting times for surgery. However, they have identified communication, and

M&E, as challenges encountered. The preparation of patients to undertake surgery in the context of the study faced layered challenges linked to communication, record keeping and M&E, which are deemed significant aspects of good public administration practices in public sector institutions.

The findings revealed that participants in the study indicated that providing health care is more than a job; but can be regarded as a calling, and one that is seen as passion-driven. Some participants highlighted, in their responses, how dedicated they were to this programme. Seeing it to fruition was their ultimate goal. One participant said:

“Yes, I did. I was a director of Private Hospital C. I took this upon myself with complete co-operation from my fellow directors. They gave me the blessing to take this forward. So, it was a unanimous decision by the directors of the hospital to envisage a cataract programme. We did the costing. We did the homework. We provided all the information to the Department of Health. It was coordinated by the hospital. So, we provided the facility”.
Participant 7

Osei-Kyei, Chan, Yu et al. (2019:2) situate PPPs within social responsibility initiatives, premised upon sustainability. Public-private partnerships do not directly transfer risk and or benefits from one stakeholder to the next, but instead seek to establish sustainable solution-driven outcomes that have extended benefits within the communities they serve. Corporate social responsibility initiatives are good drivers of PPPs for eye health. Reports from Netcare (2017) illustrated that there are some partnerships that exist between the public and private sectors to provide cataract surgery for disadvantaged South Africans, such as *Gift of Sight*, which aims to provide access to vision-restoring procedures for those who cannot afford it. The project has been supported by the Nedbank Foundation with donations of over R400 000 (Netcare, 2017). This was a response from non-governmental bodies upon the realisation that cataract blindness was a major issue affecting the elderly in South Africa. Beyond responsibility and obligation, an added consideration is that of compassion and empathy by healthcare workers, which has been identified as a contributor to both patient satisfaction levels and improved quality of health service delivery (Landers, Pitama, Palmer, Beckert, 2023:3; Ahmad, Ullah, Ryu, et al., 2023:1082). The directors of the participating private hospital, within their scope as

clinicians, accelerated efforts to expedite the project. Some healthcare workers in the private sector were dedicated to the execution of the cataract programme, as they took it upon themselves to put in more work, and were dedicated to seeing the cataract programme executed as satisfactorily as possible. The flexibility of the private sector, as compared to the government sector, in respect of decision-making processes and procurement was recognised by Nutt (2006:293). The ability to make quick, but feasible decisions, is a strength of the private and civil society sectors, which improves efficiency and effectiveness within collaborative engagements, deemed values enshrined in public administration (Baker et al., 2015:131).

The findings indicate that the pairing up of two sectors to provide health-related care is of paramount importance because one sector cannot function without the other. This interdependence of the two sectors (public and private) is well articulated in the participants' responses. Some participants said:

“A lot needs to be done. I think at times, as well, we end up taking one step forward and two steps backwards. You definitely need the private sector involved with the public sector in order to get things done”. Participant 11

“.... And they also contributed towards some of the costs involved in the surgical sundries that were involved. But the most of the funding came from the civil society organisation, which I forget the name of the organisation. Okay, it came from that and also there was another international organisation that contributed funds. So it was Hospital C and it was a private company. And there was another organisation, it's about three or four years. So, my memory is lacking a little bit as far as my concern, but yes, some stakeholders played a vital role in their organisation, providing the funding for this, but creating challenges for us”. Participant 7

Partnerships between the public service and private sector have a positive impact on service delivery, as evidenced by findings of this study, where the fast tracking of cataract surgery backlogs was initiated. The traditional conceptions of public service delivery and management are now outdated and need to be revised to consider the potential of collaborative relationships between multiple stakeholders in the public sector (Ma, Christensen & Zheng, 2023:6; Andrews & Entwistle, 2015:11; Bovaird, 2006:82). It is evident that the collaboration of the two entities brings efficiency, and public service delivery is improved (Savas, 2000:76). Osborne (2002:5) emphasises

that PPPs can yield various potential outcomes, such as reforms in service provision, increased accessibility, and a more responsive government. Trebilcock and Rosenstock (2015:350) contend that PPPs bring efficiency and innovation, bridging the gap which exists between public demand and service delivery. Some studies have indicated that some opportunities arise in scaling up public-private interactions in health in South Africa (Bovaird, 2006:98). The studies have highlighted the necessity for the state to establish effective regulations for supervising quality and standards and offering stewardship and oversight (Cruz & Marques, 2011:4030). The public sector requires sufficient capacity, not only to manage relationships with the private sector, but also to enable innovation and experimentation (Peters & Pierre, 1998:227; Isett & Provan, 2005:161).

5.6 CATARACT SERVICE DELIVERY OVERBURDENED IN PUBLIC HOSPITALS

The findings indicate that the eye service delivery in rural KwaZulu-Natal is overburdened and this leads service delivery for cataract surgery to be delayed. The delay causes backlogs, and involvement of the private sector to work with collaboratively with the public sector is believed to ease this burden. Some participants said:

***“It is in a shambles right now. There are big backlogs and challenges for cataracts and glasses. There are no staff”.
Participant 1***

***“The status at the moment is that there is a lot of backlogs and they need to up their service by providing more camps and look at how operations in hospitals can be done more, and very importantly is to try and get the backlogs off by getting more ophthalmologists and more operations done. That is the biggest problem”.
Participant 9***

“... nothing much has changed from that time. And again, that tends to be correct. But the backlog still sits at around 66 000”. Participant 10

Cataract service delivery in the uMgungundlovu district is offered in a few hospitals in the greater Pietermaritzburg area. Participants argue that this overburdens the system because the hospitals are understaffed, and there is a lack of qualified personnel to oversee the delivery of this service.

One participant said:

“There are three major public health hospitals in the uMgungundlovu District, principally in Pietermaritzburg. The three are Edendale, Northdale and Greys. The majority of the major ophthalmic surgery is undertaken at Greys because it is better staffed, both numerically and the level of qualification and/or experience, and bed availability for post-operative recovery. The pre-operative screening is better at Greys, which accounts for the higher preparation of the patients for surgery”. Participant 2

Some participants indicated that cataract surgery has not been performed for a number of years in some hospitals in the district. This prompts backlogs and participants argued that the service for cataract surgery is poor and needs to be improved. Provincial leadership and clinicians within the participant group said:

“Dismal. No surgery at Northdale for two years. Almost no cataracts at Edendale for two years. Minimal cataract surgery in Greys”. Participant 4

“It is poor and not recognized. It is underdeveloped”. Participant 6

“It’s not up to the optimal standard, but there are standards that they have identified. So basically, it needs to be improved”. Participant 8

The public health sector struggles with chronic shortages of skilled staff. Khoza (2020:5) attributes the cataract burden at facility level to the unavailability of eye health services at a primary health level. Additionally, they recognise the malalignment of service between traditional and other healthcare providers who could increase capacity at the PHC level. Majid, Fraser, Maluleke, et al. (2023:2) explain the role of optometrists within the primary care space in offering screening; detection/diagnosis; triage; rehabilitation, and management of vision and some eye health conditions. The existing human resource capacitation challenges in eye health service delivery were further exacerbated by the cessation of cataract surgery services during COVID-19; and the government’s slow pace and resource constraints has led to an increase in the backlog (Steffen & Mustak, 2022:199). With no foreseeable relief for the skilled workforce through increased posts, coupled with an increased demand on services from a growing, and ageing population, there need to be innovative strategies to meet the health needs of the public. To achieve this,

Karumanchi (2014:74) proposes a capable cataract surgery PPP that incorporates a patient-centred design, and that is underpinned by sufficient human resources, a capable administration system, and intentional M&E for evidence-based responses.

5.7 PUBLIC-PRIVATE PARTNERSHIP FOR CATARACT SURGERY SERVICES IN PUBLIC HOSPITALS

While some participants indicated that the service for cataract has been poor in the district, some indicated that the eye health care in the district was good, following its pairing up with the private sector. Participants indicated that there was a need for staffing to be increased, and at the facilities at the hospitals improved Some said:

“Very good service but very overburdened. Too many patients to see and too few doctors and facility”. Participant 3

“I’d say that the service is good because people are working together in terms of both public and private sectors to do away with the backlog”. Participant 12

“.... Very very important that public private partnerships take place because backlogs can be assisted where there is much capacity challenges in state hospitals and the public camps on weekends can add to getting rid of the backlogs”. Participant 9

Some participants indicated that the pairing up of the public and private sectors has eased things a bit for the public hospital and doctors were working tirelessly to ease the backlog that had accumulated over a number of years. One said:

“It’s functional. It’s very functional. And it has got all the skills categories and the time needed. The team is easing up the backlog with visiting doctors on site” Participant 5

Participants indicated that the poor service delivery for cataract surgery was sadly synonymous with the public sector, and it was argued that the coming in of the private sector would ease a backlog of more than 10 000 individuals who have been on the waiting list to have cataract surgery done. Participants indicated that the shortage of staff prompted negligent eye health care in public hospitals.

One participant said:

“.... It was identified that there was an estimated backlog of 12 000 individuals requiring cataract surgery. The poor state of public eye health service was clearly identified when I sought to obtain a database of the 12000 potential cataract patients so that a screening programme could be commenced to determine a list of patients from which patients could be listed in order of priority, based upon the findings at their screening procedure It was clear that there was a very real need for the PPHF to become efficient and effective if it was to justify its existence. The problems were many and health-trained staff were short in numbers at most levels”. Participant 2

Some participants indicated that the public sector neglected eye health and such negligence probably results in funds not being allocated for this purpose in service delivery in the public sector. Participants argued that the entry of the private sector would mean a greater priority being given to eye health care. One said:

“A public-private partnership for eye health will be very useful because eye health services are very neglected. There is no urgency to address issues. It will help to close the gaps”. Participant 1

“It was a good initiative and, indeed, reduced the extremely burdened system, even if it was by a few percent”. Participant 11

Despite the easing brought by the partnership between the private and public sectors for cataract surgery, some participants were convinced that there was a need to strengthen the relationship between the two sectors. They indicated that some expertise that was lacking in the public sector can easily be accessed from the private sector, and be availed to the general public. One said:

“If that can be strengthened? It just needs to be strengthened. Because if that can be strengthened, it can really work, because there are skills in the private and they are not there in the public; and there are skills in the public that are not there in the private sector. So just need to strengthen the relationship and then need to create awareness, especially to the senior management about the importance of public-private partnership”. Participant 5

“It’s a good initiative. We had cataracts camps done before because of this”. Participant 6

In developing countries, the ability of the national and provincial health departments to make quality healthcare services available depends largely on the organisational and human resource capacity. Vian et al. (2007:1) suggest that skills transfer and skills capacitation is an advantage of public-private partnerships, more so when related to the size and sophistication of the partner organisation. In KwaZulu-Natal, a PPP for cataract surgery services that benchmarks skills transfer was undertaken by the Al Imdaad Foundation (AMS, 2019). The success of the project was underscored by the skills set made available to the rural health departments in three districts in KZN, to conduct high volume surgery within narrow timeframes; a skill yet to be established within the public health sector.

5.8 CHALLENGES FACED IN PUBLIC-PRIVATE EYE HEALTH SERVICE DELIVERY

Participants indicated that the partnership, though good, has led to several challenges in the daily operations of most hospitals in the public sector. Most participants indicated that the partnership is not effective because of administrative barriers within public sector processes, making it difficult for the partnerships to be fruitful. One participant said:

“My views are that private-public partnerships are always negative about the government, instead of working with what the department wants and to assist on the need of the department. The reason it’s not working is because they come with their own plan and want the department to accept, which sometimes it’s not in line with a strategy of the government; and also, the partnership should also be basically agreed by the institution for implementation and not offices. So what they do is make an agreement with offices then expect the service delivery facility to accept which is not always good. It must start by the facility agreeing. Then they prepare understanding and what to do together then, before the agreement is sent so that is where the challenge is”. Participant 8

Some participants indicated that there was a need for the private sector to change in order to meet the requirements of the public sector operations. Participants indicated that the hope that people have for the public sector to change to meet the private sector operational requirements would require a mammoth task. Thus, the

suggestion by some participants was to have the private sector change to suite the operations of the public sector. One participant said:

“Because of my long experience in activism, I know the queues that have a lot of patients and few people to do the work. But it requires a new mindset. As much as you want them to change, you want the public sector to change, sometimes the private sector needs to change, to meet them somewhere; to save a significant we have to work together”. Participant 10

There were indications in most participants’ responses for the need to have these partnerships, as the government is currently over-burdened and has failed to provide adequate resources for all health sectors in public hospitals. In their responses, participants indicated that the partnerships will not only ease the eye health sector, but possibly all sectors in the country. Some said:

“Like I said, again, you do definitely need the partnership. Government cannot do it alone. You can see the state of all our sectors and in all departments as well. There’s a huge challenge. And I believe if the private sector comes involved, there’s much more can be done in the public sector”. Participant 11

“I think it’s part of NHI, so it is a good approach, because we need to work together to deal with the challenges that are affecting the community; not only for uMgungundlovu but also under other district that refer patients to places such as Greys or Edendale”. Participant 12

As far back as 2011, health outcome reports signalled the complete failure of the public healthcare system (CDE, 2011:45), with devastating implications extending beyond the physical well-being of people. Pillay-van Wyk et al. (2016:42) attribute this to inadequate management and a leadership crisis characterised by a lack of vision and the inability to set meaningful goals. A detrimental consequence of the leadership crises, documented by Adejumo and Archibong (2013:2), was the appointment of inexperienced managers in senior positions, with no retention of institutional memory and skills transfer. This cascaded into a lack of performance, and M&E strategies (Siddle, 2011:6). Pillay (2010:33) highlighted that the promotion of public managers within South African public health institutions is underscored by the number of years a person spends within a role, rather than the level of skills and

competencies the person has to perform the job well, thus widening the gap between management and clinical health outcomes. This corroborates Managa's (2012:4) findings that institutional capacity is a key obstacle to quality healthcare service delivery. Within eye health service delivery, policy and programmes for eye health are disconnected between optometry and ophthalmology, despite their interdependence to achieve national eye health targets. Primary eye care services are excluded from the general health policy, whereas ophthalmology services have a designated portfolio, with opportunities for career pathing within the state sector. Within the ambit of decentralised health care, to increase local government capacity to improve resource allocation for neglected groups (Regmi, Naidoo, Pillington & Greer, 2010:407), the lack of prioritisation for skill sets as a pre-requisite for managerial posts, specifically governing specified health services, has proved to be a limitation within PPPs for eye health. The absence of a designated directorate for eye health, and poor understanding about the technical and clinical indications for service delivery mechanisms, has led to time and resource allocation delays. The healthcare service delivery crisis, as aptly summarised by Surender (2014:8), is the outcome of separating policy determinants from policy implementers. The public administration system calls for a normative approach, and offers less flexibility in the decision-making process, compared to the private sector. This 'rigidity', coupled with underequipped health managers, is a challenge to progressive initiatives that could be achieved through PPPs. This finding was evidenced by the responses in the study, for the private sector to adjust to the state sector, with no room to explore common ground.

5.9 UNDERSTAFFING AND EQUIPMENT PROVISIONING HINDRANCES TO CATARACT SERVICE DELIVERY

Participants indicated that there is a lack of trained personnel in eye service delivery in the district's public service. This was argued by most participants to be a reason for the backlogs that most hospitals were experiencing in the district. Some indicated that the fund allocation for machines needed to carry out these surgeries was unfortunately not prioritised in government hospitals:

"No trained ophthalmologist and registrar, high backlog, no theatre time. People can't be seen immediately. No

cataract surgery being done at the moment". Participant 1

"Too few public ophthalmologists and optometrists; too few of the expensive equipment and clinicians needed for the eye service delivery. Need for more funds for the intraocular lenses and theatre time. Cataract is one issue and there is other eye health service that need help too". Participant 3

"Lack of equipment, lack of people. Can actually co-ordinate and manage that [lack of people], but mostly it's lack of equipment, and then lack of staff who are skilled in actually creating awareness and making sure that people attending and are aware of the services which is being provided". Participant 5

"Lack of eye health professionals. Those who are there overwork. Under development". Participant 6

Another challenge faced by the public sector is a lack of administrative staff who help with filing records as part of records management. Some indicated that, since recruiting administrative staff is a problem, there is a need to facilitate electronic databases in public hospitals, where patients' information can be easily stored and accessed. This is argued to be another reason for the backlogs, apart from a shortage of trained personnel to carry out these surgeries. One participant said:

"Inadequate numbers of skilled administrative staff. Lack of a comprehensive database, especially an electronic system. Poor follow-up system in the absence of an effective database". Participant 2

The COVID-19 pandemic in South Africa prompted hospitals in the public sector to shut down some sections for a prolonged period of time. The lack of trained personnel within eye health care, and the under-utilised facilities for eye care, meant the facilities were, instead, turned into COVID-19 wards. This, it is argued, has demonstrated that eye health is not of paramount importance in South Africa. One participant commented:

"Northdale: No elective theatre time for cataracts since COVID. Eye Clinic and wards taken away and converted to COVID wards. Sessional doctor post taken away to employ a COVID doctor. Edendale: Eye wards taken away and converted into COVID wards. Theatre time cut from five days a week to only one day per week. No specialist posts, despite requesting the posts to be unfrozen. Greys: Theatre time down to one day per week which we

reserve for urgent cases only. Outreach: No more AMS transport to Dundee and other places". Participant 4

While some participants blamed the lack of staffing and equipment provision in public hospitals, others were convinced the blame solely lay on the management staff in public hospitals. Participants indicated that mismanagement of funds, lack of equipment servicing, and limited resources, were major problems in most, if not all, public hospitals that perform no cataract surgeries. One participant said:

"One has to go and see the mismanagement in the public sector. I was told that the cataract backlog goes up to 2027. Now, the longer you wait for a patient to have cataracts removed, the more damage is going to be done. And it's unfortunate. I think the backdrop is purely for management. The skills are there; the equipment is there. But at the end of the day, one doesn't know whether the equipment has been looked after in-service. I mean, equipment is only as good as whether it's operational or not. So, I don't think that the issue with the backlog is to do about there not being enough skill available. The skills are there. The problem is – there it is. It's poor, poor management, by the medical managers of the hospitals, where these patients attend". Participant 7

While blame was placed on the mismanagement of funds, some participants indicated the need to train staff, as well as service hospitals with facilities that cater for eye care, as a fundamental imperative. One participant said:

"One is that lack of ophthalmologists; two, at certain hospitals lack of theatres; and three, lack of knowing how to use machines by some ophthalmologists. They need to be educated. Fourthly, staff needs to be trained". Participant 9

Some participants indicated that the budget allocated for eye care in public hospitals was not enough to cater for public service provisioning. Participants blamed a corrupt system that allows funds to be misused or miss-allocated to other health care systems, instead of prioritising primary attention on eye care. One participant said:

"I think one of the major issues is budgets hasn't been enough money. There isn't enough allocated to it. And with the rise of corruption in various departments, I think there's been a lot of wastage. So obviously, they didn't budget well in terms of healthcare. And, as you probably know, the conditions some of the public hospitals. So,

the root cause of the issues is firstly budget, secondary corruption". Participant 10

Participants blamed public service workers who feel entitled to salary raises in order to perform their service delivery functions better. The findings indicate that the private sector healthcare workers are more dedicated to their work than the public service healthcare workers, who possibly receive more pay than their colleagues in the private sector.

"Thirdly, the resources and the skills of the people that are employed. And I'll give you an example. The public sector could do an X amount per day on the surgery, because that's the method they use. The same team from the private sector did almost three times what the public sector, the same amount of people. So, the work ethic, and the commitment to output, is far greater in the private sector. So, I found that the skills are there. But there's sometimes goes low intensity. And it's not it doesn't work. Ideally, the way could work. And many of the workers in fact, for my knowledge, and from the information, I have private sectors, the public sector is actually paid better than nurses, for example, in the private sector. But the public sector workers feel very, firstly very victimised and very entitled. They seem to be sometimes negotiating this productivity and more money. And that seems to be the malaise and, and the cancer in the public sector". Participant 10

The public health facilities, especially those located in rural areas in KwaZulu-Natal, have been experiencing a dire shortage of staff and medical equipment due to many factors, including the mass migration of staff from the public to the private sector for better salaries; and the limited support government gives to its employees, with particular reference to the lack of a retention strategy. All these factors, in addition to challenges listed previously in the primary research, have negative implications for the system as a whole, and for good clinical outcomes for the patients. Another issue hindering eye health services is the non-existence of a reliable patient information programme within the public healthcare system.

Evidence-based responses to challenges are a necessary approach to create sustainable solutions to long-standing problems. Generating evidence requires capable people and processes that are scientifically sound and repeatable. Pule (2014:2) notes that a core function of governance is disciplined management, and

public agents. However, the barrier to achieving this is uncontrolled discretion from people occupying leadership roles. The management approach to development and self-correction is closely linked to M&E strategies, including the significant process of internal auditing.

Ackers (2011:3) attaches the realisation of efficient and economical use of resources; regulation and legislation compliance; and the reduction of risk through early intervention; to the implementation of routine internal audit processes. Mihret and Yismaw (2007:47) suggest that the extent to which an office meets its mandate is linked to the support of management for the audit, and the quality of the audit. Within health service delivery, mechanisms exist to quantify services. Indicators for service delivery have a level of specificity enabling them to identify where services are delivered, and what types of services are delivered. The challenge exists in the quality of services, which is determined by both the number of service providers available, and the lack of availability of upgraded and functional equipment. Young (2016:20) identifies poorly maintained infrastructure and poor-quality healthcare delivery as two prominent shortcomings within the healthcare system. The lack of material and resources has been associated with delayed diagnosis, and increased costs for patients to seek care elsewhere (Mokoena, 2017:67). Manyisa and van Aswegen (2017:36) attributed the challenges affecting health service delivery to administrative malfunctions and poorly skilled staff. Poor record-keeping, coupled with insufficient skills and poor leadership, results in management barriers that directly affect the decision-making processes for the operation of health departments. A contributor to the success of a PPP is its ability to tailor responses to meet the needs presenting. In cataract surgery services in the uMgungundlovu district, the placement of staff is inconsistent with the availability of equipment. An example is the regional level hospital that employs two optometrists on a full-time basis, with no designated space for either of them. They, instead, are both expected to work in a section of the waiting area with no functional and updated equipment; yet the district hospital is several kilometres away, and functions as a primary level site for eye health services, having a district-level optometrist presenting once a week for a limited time. One of the outcomes of the health forum intervention was to capacitate the ophthalmology theatre with a microscope essential for cataract

surgery. A donation in excess of one million Rand was made to fulfil this need, to enhance the sustainability of the project in the long-term. The high turnover of staff, coupled with COVID-19 restrictions on elective surgeries, has dampened the desired effect that could have been achieved. Similarly, hospitals in surrounding areas, who have budgets for ophthalmology and optometry staff, do not have the required equipment to enable operations within the scope of practice. These inconsistencies are directly linked to ineffective strategies to audit and map out the much-needed resources.

5.10 LACK OF A RELIABLE PATIENT INFORMATION SYSTEM AS A HINDRANCE TO EYE HEALTH CARE DELIVERY

Findings suggest that the use of traditional methods to capture patient information in the hospitals has a negative impact on the availability of timely and reliable information. Some participants suggested that these methods were not reliable and, in most cases, there is a lack of follow-ups:

“Waiting list is a book in most places. Sometimes patients are not recorded, but asked to return in a year or two”. Participant 4

“At the outset we [civil society organisation] found the recording of the information of patients recorded in a hard covered exercise book, with no evidence of any follow-up visits recorded with new findings recorded”. Participant 2

“We use an exercise book (A4) and black pen”. Participant 6

Furthermore, the findings indicate that a lack of computerised systems that integrate information from one hospital to the other was a hindrance in the field of cataract surgery. Some participants indicated that the computerisation of the cataract patient system would substantially reduce the waiting list for cataract surgery across the country. One participant said:

“Firstly, I found, just from my experience, I found that the systems where there was not a proper computerised database, a lot of what existed in hospitals were manual, manual documentation, and sometimes even this will get lost. Right, and there was an effort at a particular point in time to digitize all the information. I’m not sure how far

that was, but that has gone now. But to my knowledge, there was not an integrated system and even if there was a computerized system, it wasn't provincially integrated, meaning that if there was an Excel spreadsheet, one would be in Grey's one would be in Edendale and one would be in Northdale. None of them wouldn't know whether there's a backlog whether this capacity etc. So that intercommunication in terms of data capturing was very poor. You need an integrated software where you could actually see live this capacity, not that we need to send patients. This capacity in grades we need to send patients. There was a big backlog of Edendale and operate with that information. Knowledge is king. Information is king rather". Participant 10

Findings suggest that the manner in which the public and private hospitals operate are quite different when it comes to the issue of capturing patient information. Some participants indicated this in their interviews, where they would constantly refer to how differently Hospital X had operated. They indicated that the system in the private sector was far more sophisticated, as they had more available resources. Some participants said:

"... the patient should be seen by the doctor must refer the patient to the eye clinic. Like in X, there is an eye clinic and then in the eye clinic, there should be a nurse who's going to take care of the patient and let the patient know that you are supposed to do. 123. And when you are doing the cataract, this is what is going to be done. So they book the patient. They give them days to come for operation once the patient has been educated and have agreed". Participant 5

"Patients who were recruited from the district hospital had their eye notes kept in a folder, named cataract waiting list, either first eye, or second eye". Participant 3

Participants noted that a waiting list that is not serviced is another barrier to healthcare delivery in South African public hospitals. The findings show that the private sector does not have waiting lists, which indicates an availability of resources to carry out cataract surgery; but it is then overburdened by referrals from the public sector. One participant said:

"... But unfortunately, they get put onto a waiting list for a year or two. The patient is dead, unfortunately, because they've never got down to getting the surgery. So, I think every specialist discipline, in the public sector, there are waiting lists and the private sector there are no waiting

lists. And the private sector. You can quote me on this has the capacity. And I reiterate". Participant 7

Findings indicate that the private sector, with sufficient resources, is able to assist in servicing the backlogs in public hospitals. Participants indicated that the coming together of the private and public sectors would ease the pressure in public hospitals. One participant said:

"The private sector has the capacity to get rid of the backlog in all the surgical disciplines in the public sector. If we are given the opportunity to do it, we have the expertise. We have the knowledge; we have the management skills in getting these backlogs done in a fraction of the time and at a fraction of the costs. So why are they not talking to the private sector? We have extended our hand out as Private Hospital C to the Department of Health. If you get a reply, or an acknowledgement of our request, it's too much. I've had numerous meetings with the Department of Health. This has disillusioned me as far as the process going forward. So unfortunately, I might come up quite critical. But that's reality. Try talking to the Department of Health. It goes on to deaf ears. It goes on to Yes, we'll look at it. Nothing happens. By that time, we losing patients". Participant 7

Findings suggest that there is no uniform system that is used across hospitals to keep a record of all patients on the waiting list for cataract surgery. Some participants indicated that the hospital was responsible for their records; and how they managed their waiting lists was solely dependent on each individual hospital. In other words, there was no formal, unified system for consistency across public health hospitals, as a standard guideline. One participant said:

"Each facility records their own waiting list at a clinic level. They have their own record for their keeping for their own management. So if you are saying how they keep it's in their clinic. If you want to know what is the backlog for Edendale, you go to Edendale eye clinic and you check with them. Otherwise, for us it doesn't matter because you can have a database; but if resources are not speaking to address the backlog, then it does not make any difference. So basically, everybody has a backlog, doctors, dentist, everybody is in a waiting list because of the reporting system. You just don't come now and get assistance now. It's not like headache. If something needs to be looked into and booked you always will have a waiting list. Everybody decides how their waiting list to look like, we cannot put a system. For example, how do you put a system without a doctor to operate. Hospital refers to other hospitals who see their patients with their own waiting list. So, because cataract is not done at all facilities so in one district with seven

facilities only one hospital. So, each and every four of seven they keep their waiting list and refer to this one hospital who also has their own waiting list, which is a challenge because everybody has got their own waiting list. Therefore, we cannot have one central system which will control a waiting list where it is not delivered to all these hospitals". Participant 8

Mathebani (2015:1) asserts that the effective management of records is a key component for efficient and enhanced service delivery in the public and private sectors. This holds true for the medical management of the patient and the administrative function of the facility. Marszalek and DeVilliers (2006:15a) noted that the management of medical records differs between facilities, so that some facilities use electronic systems, whereas others use hybrid recording systems. In addition, there are two types of medical records, facility-held records and patient-held records. Mathebani (2015:2) asserts that medical records have a direct link to healthcare service delivery. The lack of effective management of records in South African healthcare facilities has led to an ongoing situation of lost files (Marutha, Ngoepe, 2011:73).

Record keeping directly impacts patient management (Kama, 2017:80). Any malfunction in the record-keeping system can thus directly compromise the health outcomes of the patient, due to delayed treatment. Furthermore, defective medical record keeping increases the fiscal demands on facilities through repetitive testing and duplication of services. Lastly, a deficient record-keeping system impacts planning, procurement, and evaluation practices (Snider & Rendon, 2012:329). Several limitations linked to record-keeping arose within the context of the study. Communication with patients was compromised. Telephone numbers recorded incorrectly, or files that were not updated with current telephone numbers, hindered patients on waiting lists from participating in the cataract camps. The quantification of consumables was also a time-intensive process, dependent on the manual sorting of files. This could have been alleviated with the use of an electronic database. Lastly, the absence of information detailing the date of diagnosis impacted fairness and inclusivity in the implementation process. Waiting list dates are those relating to the date the patient presented at the hospital, with no consideration for when the patient was initially diagnosed. Barriers to access services, as mentioned in the literature,

include the cost of transportation, and a lack of awareness of such essential services.

5.11 MEASURES FOR SERVICE DELIVERY OF CATARACT SURGERIES

Participants in the study indicated that hospitals had made strides in capturing patient details in a folder assigned for cataract surgery; and some nurses were also responsible for delivering patient updates to the designated patient on time. Findings indicate that patients were also encouraged to routinely follow up with the hospital to find out if any progress had been made in relation to their surgeries. One participant said:

“Patients have their phone numbers noted down in the folder and they are made aware of the cataract waiting list. They are encouraged to call the hospital periodically to either find out the situation of their waiting or to change any details. Patients are called by the ophthalmic nurses whenever there is space available”. Participant 3

To ensure that surgeries for cataracts are performed, planning and negotiating with other hospitals to allocate available space for some patients was a measure noted from participants’ responses. The findings indicate that, for some hospitals, there was a hold on cataract surgery because they did not have space or sufficient resources to assist patients; hence the negotiations with other hospitals for possible space and resources. One participated commented that:

“Planning: Negotiating with Hospital X to reallocate space for the eye clinic and waiting area close to theatre – should start in 2022. Procurement: All procurement on hold until we have the space to do cataract surgery”. Participant 4

While some participants indicated that there were measures to ensure that patients on the waiting list for cataract surgery were served and catered for, some participants indicated that, in the hospitals where they worked, no measures had been put in place because funds allocated for cataract surgeries were very minimal:

“There is none” – referring to the cataract budget. Participant 6

“There is no system because, as you are saying for planning and procurement, remember each facility plans

for its own because if I am not doing cataract I cannot plan for cataract, so it needs to go to where they are planning for cataract. They cannot plan for me because they do not know how many patients I will send. They only plan for their own, basically. But in terms of budgeting, they use backlog to budget, but this does not go according to waiting list. It is equative with share: if you are given R5,00 you work on R5,00 for all conditions requiring surgery, not that you have R5,00 added for cataract. It is for all operations". Participant 8

Findings from the study suggest that the lack of an effective system that captures patient data has negative implications for the provision of cataract surgeries. Participants indicated that the lack of an effective reporting system meant that the process of carrying out surgeries was delayed in some hospitals, leading to a lot of patients being referred to other hospitals which already have a backlog. The situation, therefore, is compounded, as patients are sent from one health facility to another. One participant said:

"As mentioned above, there was no effective reporting system in place. As a consequence, no data was available to enable planning and procurement for the patients who were waiting for a call to see their doctor again as a follow-up visit. The inadequacies of the weak data management are aggravated by the size of the drainage area of the patients being referred to the facilities in Pietermaritzburg. This drainage area extends as far as Newcastle and Dundee and includes Ladysmith and Estcourt and everything else in between". Participant 2

The findings suggest that a report submitted at district, provincial and national level would ease the burden faced by some hospitals for cataract surgery. Participants believed that when this is done by every hospital in the district and province, then resources could be made available to cater for large numbers in the pool for cataract surgery across the country; and in so doing, the burden for this health facility would be substantially eased. One participant said:

"Relating to cataracts, in fact all the eye care, each hospital needs to report to the district. How many cataracts have they done? There is a monthly report that is sent to the district and the district must compile that monthly report and submit it to the province and the province submit that to national". Participant 5

The findings revealed that, without a system that integrates patients' information, it is difficult to put the necessary intervention measures in place that could cater for the backlogs in cataract surgery. Some participants indicated that the manual system used in hospitals is very inefficient, which calls for better, and improved, operational and management systems in hospitals:

“Coming from civil society, I won’t be able to answer that question accurately. Having said that, I’m going to suggest again, repeat that it was a manual system and are subjected to inefficiencies. And I believe that for the government to be successful in planning better, it needs an integrated software, where all the hospitals can see capacity in each hospital and backwards in each hospital. And why like this integrated system sometimes can be able to manage? How many have been done by day? So invariably, you end up looking at efficiencies”. Participant 10

The findings here indicate that, in addressing the issue of cataract surgery, the issue of backlogs on the waiting list was at the forefront in most responses. Participants indicated that the measures taken included advising the hospital board on how to tackle the issue of backlogs; and they also suggested that a concerted effort be made to increase the staffing component to cater for all patients who are on their waiting lists. One said:

“Not too much on that. Like I said, you find that we just play an advisory role as the hospital board. So, when patients go to the hospital, they would then be interviewed by the nurses and the doctors and tests will be done for them to say that they would be able to get a cataract. And when will they be able to do it. Like I said the challenge is between Grey’s and Northdale for beds. Like I said, you normally have one doctor in between both the hospitals. There is a shortage of doctors which plays a major role, and shortage of equipment, and so forth. So that is one of the reasons that we appreciate the public-private sector relationship”. Participant 11

While some participants adopted an advisory role to the hospital's board on how to tackle the issue of backlogs; other participants indicated that some measures taken included visiting various hospitals to discuss the backlogs and resources needed to alleviate the growing crisis situation in those hospitals.

One said:

“We visit different hospitals to discuss about the backlogs on a monthly basis and quarterly basis we discuss regarding the backlog. We get ophthalmologists and nurses who usually will come and present to make us aware of how much backlogs we have at the time”. Participant 12

5.12 EYE HEALTH SERVICE DELIVERY BARRIERS FROM CLINIC REFERRALS TO HOSPITALS

The findings indicate that there is a lack of effective and efficient management in hospitals that offer cataract surgery. Of concern is that participants indicated that management lacks experienced individuals who can report cases on time and update the system as timeously as possible. One participant said:

“The quality of management is a function of the experience of the individuals and the training given in advance of promotion into a position of management. Reporting barriers start with the IT skills of the clerks employed in the system and the expectation of the management team of the accuracy, punctuality of the reporting”. Participant 2

The study indicates that challenges relating to hospital bookings and referrals are currently an impediment to eye health care at clinics to hospitals. Participants indicated that, for one to be attended to at a hospital, one needs to have a referral letter from a clinic. This effectively means that patients cannot be attended to in a hospital without a clinic referral, and an appointment which puts one back on the long waiting list. Some participants commented:

“Inaccessible, due to the fact that hospitals cannot offer services or assistance at the same time. Bookings are required before you can transfer a patient to a hospital”. Participant 1

“Difficult to get access to tertiary level for non-urgent non-immediate sight threatening cases, e.g. cataract. Clinic needs to go through district hospital eye clinic where an appointment given quite far down the line due to too few staff available”. Participant 3

These findings indicate that the issue of patient referrals from one hospital to the other has cost implications for the hospital that is receiving the patient, Participants

indicated that resources are already scarce, and a referral without reimbursement overburdens an already burdened public health system. One said:

“District and regional hospitals can send patients to another hospital to have cataract surgery done, without having to reimburse that hospital. This creates an incentive, where all hospitals try to reduce the services that they supply so that they can save money. This increasing pressure on the few remaining hospitals that still have a cataract service”. Participant 4

Some participants indicated that, when reports are expected at district level, they are not available, and this is reported to be a problem with management and the system that is adopted in public eye health care. The findings revealed that there is a severe lack of optometrists in hospitals, which is considered to be a major setback for most persons requiring immediate medical assistance. One participant said:

“They don’t report some time. When they’re sitting at the district and expect reports to come. There are no reports. Then go to follow them in order to ensure they bring them and then sometimes they will come and say that there was no cataract done. Because we don’t have doctors to do the cataract. With optometrists, it was easier because they were placed at the hospital and only visiting at the hospital but they came back with statistics and they combined the statistics if you have a person directly at the eye clinic but when their reports is from the eye clinic then to district information officer or facility information officer becomes difficult because the reports reporting format, sometimes the eye target relating to the eye program are not there. So, the facility officer doesn’t want to add something into this tool. I can say that the tool is the challenge because the targets for the eye health are not there. And then the facility officer doesn’t want to add anything and I think that they are lacking on the national province because the only target appearing according to my knowledge was the cataract as if you are doing the cataract only when you are doing eye health and yet there are so many things to do”. Participant 5

From participants’ responses, it is clear that eye health care is not prioritised in the healthcare budget, which is a major shortcoming in the public health focus, as is revealed through the empirical research. The findings indicate that there is a lack of resources which forces most hospitals to refer patients to better-resourced facilities, which are already burdened with an overwhelming volume of persons requiring public healthcare.

One participant indicated that:

“... The urgency of eye health service delivery, it always dealt with as last priority. We only get something if something else was attended to after they get left overs of everything. In terms of getting a patient booked to a district hospital or referral”. Participant 6

These findings indicate a shortage of ophthalmologists, and very limited resources and other much-needed consumables, for cataract surgery. Participants indicated that the shortage of these resources, including human resources, was a major barrier to the efficient and effective execution of cataract surgery in some of the public hospitals; hence, the constant referrals that are met with waiting lists that disadvantage patients. This is indicative of a dire shortage and the need to scale up much-needed public health services to be able to assist the local communities. Some participants commented:

“The barrier’s lack of capacity on the referring hospitals. For example I have a patient has a problem with his/her eye and I cannot refer that patient to the hospital due to not have beds available: or there is no theatre available, or no ophthalmologists, or no specialist surgeon there. So those are the barriers that are there in tertiary institutions”. Participant 9

“The major barrier is ophthalmologists as there is a shortage of this. We now need to refer patients from uMzinyathi to uMgungundlovu which is quite a distance”. Participant 12

The South African healthcare system has taken on a tiered approach to enable a more equitable distribution of services, closest to where people live. Aligned with this approach, community and primary level health services offer patients entry-level care with a focus on triage and health management services that shifts away from the previous hospi-centric approach. After screening and diagnosis, referral is the next important step in the management of a patient requiring advanced care. While it is administrative in nature, it is the singular mechanism connecting the patient between all the care systems. Give, Ndima, Steege et al. (2019:2) indicate that an effective referral system from the community level is an essential lifesaving strategy. It also ensures a continuation of care. Systems thinking, an essential component of PPPs, dictates that a part of a system cannot exist in isolation from the overall system. The

interconnectedness of the referral system is, therefore, connected to the efficiency and effectiveness of the healthcare system, with economic impacts on both the healthcare system and the patient. Seyed-Nezhad, Ahmadi, Akbari-Sari (2021:4364) suggest that an effective referral system provides a close link between all levels of care, affording the patient the best quality of care. Barriers and enablers of referral systems influence healthcare functionality and people's perceptions of care. Therefore, addressing barriers within the referral system could potentially improve health at the broader community level. In KwaZulu-Natal, the referral pathway is directly dependent on the reliability of the patient to follow through on referral instructions, to present timeously at the next-level facility, and to preserve records needed to initiate treatment at that level. This is discriminatory to patients who are socio-economically challenged and/or present with any additional barriers to access advanced care. From a health service perspective, the patient-dependent referral system has an impact on budgets, planning, and resource allocation. The absence of a non-standardised, automated pathway also exposes the healthcare system to duplication, resulting in undue delays for others on the same waiting list. Within the context of this study, it was found that patient-centred referral systems led to duplication on waiting lists and incorrect reporting to district and provincial levels.

5.13 DISCUSSION OF FINDINGS

South Africa has made considerable changes to its healthcare system since 1994, to improve quality of life and to redress the inequalities of the apartheid system. The disparate distribution of services, however, clearly continues to be a challenge to equitable health service delivery. These challenges are caused, largely, by a fractured public administrative system within the public health sector, poor resource allocation, and, at times, poor infrastructure. Central to this, are the documentation systems adopted for medical record keeping, as well as referral pathways. The outcomes emerging from the interconnected complexities of the administration system and the health service are long, and can include fatal waiting times to access care, coupled with poor quality healthcare services that influence the extent of patient satisfaction levels; as well as the efficiency and effectiveness of primary health care.

The researcher submits that, for the district and provincial health departments to fulfil their mandate, considerable effort needs to be made to improve the quality and capability of its public management practices and leadership. Fundamental to management is the ability to internally monitor and evaluate systems and processes for ongoing improvement. Internal audits are also necessary for planning and budgeting for infrastructure maintenance, and the allocating of other resources.

The efficiency and effectiveness of, and ethical and economic factors associated with, health service delivery cannot be defined by its administrative processes, alone. Where medical intervention is necessary for improved health outcomes, it is dependent on a capable, standardised, referral pathway and a highly efficient and effective record-keeping system, given that information of such a nature is a strategic resource to save the lives of people.

The shortage of resources, coupled with the increasing demand for health services, is an ongoing challenge. Realising universal health goals is increasingly dependent on collaborative strategies between the public and private health sectors through PPPs.

Effective PPPs are dependent on well-structured operating models, to enable tailor-made responses to address bottlenecks and backlogs in the healthcare service. The ability of a PPP to improve the quantity and quality of services is directly linked to the ability to quantify the increasing demand for services and to have sustainable administrative functions in place to be able to manage the provision of these services.

In the case of cataract surgery, PPPs have existed to provide short-term responses to the backlogs. While some of these interventions included skills transfer, others included interventions to reduce the surgical backlog numbers and provide spectacles. There is a paucity of information about the successes and failures of PPPs for eye health in the South African context. Within the context of this study, PPP intervention for eye health requires multiple stakeholders. Although government remains a priority stakeholder, the role and scope of other stakeholders does not diminish, as is pointed out through this study. A balance is achievable through an

organised structure for engagement, such as a forum as a vehicle to create a structured and sustainable base to work within.

Of significance, the responses from participants regarding the nature of challenges experienced and the impact of public-private interventions to relieve the cataract surgery backlog directly refers to the connection between the 5C protocol and the Logic Model on which this study is theorised. The context within which services are delivered directly impacts on the inputs and activities to achieve the Department of Health's mandate for eye health service delivery. Where capacity is lacking, there is a corresponding hindrance to the outcomes and the desired impact. Addressing these challenges requires commitment, targeted responses to context-specific challenges and an overarching commitment from all stakeholders to improve capacity through structured coalitions.

5.14 CONCLUSION

The chapter presented and discussed the findings of the study, which were derived from the eight themes that emerged from the data collection. A discussion of these findings was presented, and references were made to scholarly literature to support and corroborate some of the key findings that emerged empirically. The results from the research undertaken for the study have led to the design of a model, as the new contribution from this research. It can be presented to the national Department of Health for possible use in solving the human resource issues for health service delivery; in addition to the persistent budgetary challenges facing public health facilities for the rural poor and disadvantaged sectors of society.

CHAPTER SIX:

PROPOSED MODEL FOR PUBLIC EYE HEALTH SERVICE DELIVERY INTERVENTIONS

6.1 INTRODUCTION

Public-private partnerships (PPPs) share a desire to achieve common goals and outcomes, such as public infrastructure development through collaborative efforts. However, PPPs vary widely in intersectoral initiatives, with partners assuming different levels of risk, enjoying diverse benefits, and contributing resources within contractual frameworks (Walwyn & Nkolele, 2018:3). Brinkerhoff and Brinkerhoff (2011) propose a framework based on two dimensions: mutuality (shared control and responsibility) and organisational identity (distinct competencies and advantages). An ideal PPP maintains high mutuality while preserving organisational identities, distinguishing it from conventional contracting, extension of competence, and eventual absorption.

Rodrigues and Carvalho (2023:1) define a PPP as a structured collaboration between public and private partners in planning, constructing, and/or operating infrastructure. It involves the sharing or redistribution of risks, costs, benefits, resources, and responsibilities. Rodrigues and Carvalho (2023:1-2) also suggest that applying the PPP model to healthcare, particularly hospitals, involves a critical assessment which would lead to a clear model for success. Globally, most hospital PPP implementations have favourable outcomes in healthcare unit performance and cost-effectiveness. A 'path-to-success' model for hospitals considers six PPP dimensions: environment; potential benefits; constant measurement; evaluation; management, and enhancing strengths. The PPP model is applied on a case-by-case basis with specific requirements, cumulatively enhancing healthcare service quality. Success involves creating the right conditions; amplifying the benefits; assessing public concerns; carefully considering private contributions; and managing challenges by enhancing both public and private strengths. The goal of managing PPP models is to incorporate decision- and action-making processes across governmental and social sectors.

Following on from the preceding discussion, Caballer-Tarazona, Clamente-Collado, Vivas-Consuello (2016:2) highlight that, while PPPs in health service delivery have been in existence for a long time in both developed and developing countries, with some interest from academics and researchers, the interest has been insufficient to generate well-documented information about the cost and quality of, and satisfaction with, PPPs. In addition, the information about PPPs is individualised and does not reflect the holistic impact on the healthcare system. Concerning the delivery of eye health services in South Africa, there is a lack of literature and limited studies exploring the influence of PPPs on the efficiency and quality of service delivery. Additionally, there is an absence of knowledge regarding best practices for PPPs. The researcher has argued in this thesis that an efficient and comprehensive database is fundamental for the success of PPPs. It forms the foundation upon which effective planning, allocation of resources, and service delivery are built. By establishing a robust database that connects critical sectors, accurate patient information and healthcare needs are readily accessible, significantly reducing the risks of under-planning and under-serving the populations in need. This approach ensures that services are targeted; and efficiency and effectiveness considered, and precisely directed to where they benefit the community and healthcare providers. It is on this basis, that a model has been proposed to bridge this identified gap in this defined area of research in public health.

6.2 CONCEPTUAL MODEL FOR EVIDENCE-BASED PPPs TO INFORM DECISION-MAKING FOR EYE HEALTH SERVICE DELIVERY

Government policies acknowledging PPPs offer a guideline for how such partnerships should contribute to the fulfilment of government mandates. However, it lacks specificity, which has been one of the key concerns throughout this empirical research. This allows for unsolicited partnerships across sectors, which not replicable or transferrable at local and national levels. Added to this, PPPs generally respond to specific challenges within a system. Ambersari, Soehodho, Sumabrata (2021:160-1) suggest that emphasising technological innovation is crucial for delivering public services that address the community's fundamental needs. This involves high-value intellectual property rights, particularly in providing essential infrastructure services. The research conducted in this study sought to examine the

experiences of stakeholders in a PPP addressing the cataract surgery backlog in KwaZulu-Natal, with a view to identifying the administrative and management backlogs impeding quality service delivery. The study found that, while the need for an intervention was understood, and resources were available to achieve this, there was an overall lack of awareness of how the service should be conducted and what it should specifically target. This was linked to the absence of a database to quantify the number of patients, to document their waiting times from diagnosis to discharge, and to highlight the bottlenecks in the system. This directly impacts how decisions are made to resolve the challenge and, in so doing, limits the scope of the response. The results from the stakeholder engagement were used to develop a structured decision-making model premised on the analytical hierarchy process (AHP). This study proposes a conceptual framework for evidence-based decision making as an appropriate PPP structure to address cataract surgery as a specific case study towards the new contribution.

6.3 ANALYTICAL HIERARCHY PROCESS IN PPPs FOR HEALTH SERVICE DELIVERY

The AHP is a decision-making methodology developed by Thomas Saaty in the 1970s. It provides a systematic approach to solving complex problems by breaking them down into a hierarchical structure of criteria and alternatives, allowing for a pairwise comparison of their importance. In health systems planning, the AHP assists in evaluating and prioritising diverse factors such as cost, effectiveness and feasibility (Saaty & Wong, 1983:183).

In the context of PPPs, the AHP adds value by offering a structured framework for decision-making. It helps stakeholders assess and prioritise various aspects of a PPP, such as project viability, risk management and stakeholder interests. The AHP's ability to quantify and compare diverse criteria provides a transparent and logical basis for decision-making in the complex landscape of PPPs, contributing to more informed and objective choices in health systems planning (Ambersari et al., 2021:160-3).

Balt (2015:16-20) demonstrates the AHP's alignment with evidence-based decision-making by providing a structured and systematic approach to evaluating and prioritising different factors in a decision-making process using the following criteria.

6.3.1 Data-driven comparisons

This involves systematic pairwise comparisons of criteria and alternatives. The process requires decision-makers to provide judgments based on data and evidence, ensuring that decisions are grounded in factual information rather than subjective opinions. Liao and Qui (2016:3) indicate that health information systems in healthcare facilities can range between computers and manual methods to collect, store, process and retrieve patient information related to both patient care and hospital activities. To achieve this, the ideal hospital information system should include functions reflecting basic hospital operations; business and finance; communication and networks; division and department management (including the needs of individual departments); medical documentation that includes both standard medical records and records of individual patient care; and medical decision support that includes the collection of various data to support the clinical decisions made for patients. Eye health service delivery is complex and specialised, and involves generating detailed data covering both patient medical information and operational information from the various stages of care (screening, diagnosis, referral, specialised treatment, surgical interventions, discharge). In KZN, bottlenecks in the care pathway differ between and within districts and municipalities. Access to information regarding patient care needs, as well as information highlighting obstructions to the operational flow, would allow for tailor-made approaches to address the demand.

6.3.2 Informed resource allocation in eye health service delivery

The AHP assigns numerical values to preferences, allowing decision-makers to quantify and compare the importance of various criteria. This aspect enhances the objectivity of decision-making, making it easier to incorporate evidence into the process. In eye health service delivery, resource allocation and the lack thereof are attributed to the absence of sufficient information to justify the need for human

resource and infrastructure allocation. Houria, Masmoudi, Hanbali, Ikram, et al. (2017:1-3) assert that the availability of resources is directly related to the availability of, and access to, quality health services. The cost of resources continues to increase alongside the demand for health services, with little or no information available to guide the decision-making process on the best approaches to maintain and provide the required resources. The AHP approach allows for a determination of the criticality of resource requirements. Within eye health, critical resources may vary from specific pieces of equipment to different categories of staff (for example the availability of optometrists at PHC level; working theatre equipment, such as microscopes in theatre to enable cataract surgery; surgical instruments; sufficient theatre and ophthalmic staff (ophthalmic nurses and ophthalmologists). Establishing the critical criteria within the system being observed would allow for targeted interventions that enhance efficiency and the effectiveness of the service being delivered.

6.3.3 Incorporation of stakeholder input

This often involves input from multiple stakeholders, each with their own perspectives and evidence. A collaborative approach ensures that a diverse range of evidence is considered in the decision-making process, promoting a more comprehensive and well-informed outcome, especially in the context of public health services. The current delivery of eye health services is unsatisfactory, both in terms of coverage and quality. There are very few sustainable PPPs implementing known best practice; and although access to specialist care offered within the public sector largely depends on a mixed health system, with initial diagnosis, management, and referral made by the private sector, the government has chosen to expand its PHC programme, which does not necessarily increase its eye health service programme, due to various limitations and barriers. Lepetu (2012:238) notes that participatory planning processes are rigorous because they are instrumental in making reasonable, rational and justifiable decisions in resource planning, which entail deciding between alternative management approaches. The use of the AHP approach for stakeholder engagement has shown benefits, in that it allows for a structured decision-making process which can be documented and repeated; it can be applied to decision-making situations involving competing criteria; and it provides

measures of consistency, even when applied to situations involving subjective judgement (Lepetu, 2012:239). Within public-private forums for health service delivery, stakeholders have diverse and sometimes contradictory backgrounds that inform their approach. As an example, the public health sector is highly regulated, with stricter approaches to decision-making than the private sector, which is less regulated in its decision-making approach, allowing for it to be more flexible. In addition, the complexity of purchasing strategies and the different clinical approaches between the public and private sectors can disrupt organisational and operational functions. Guiding stakeholder input in a controlled and constructive manner, without impeding subjectivity and individual strengths, is necessary.

6.3.4 Transparent decision process

The AHP's structured approach makes the decision-making process transparent. The evidence used in the pairwise comparisons is visible and can be scrutinised, contributing to the accountability and reliability of the decision-making process. Mohammed and Harputlugil (2020:7) highlight that there are seven critical success factors for PPPs, including risk allocation and sharing; stakeholder commitment; transparent procurement; political support; and an available financial market. An interactive decision-making tool allows for stakeholders to identify the best-fit programme to achieve their goals. Achieving a better eye health service, with reduced waiting times, requires subjective and objective evaluation approaches that are useful for checking the consistency of evaluation measures by providing alternatives and reducing bias in the stakeholder decision-making process, and during the implementation of activities. Eye health PPPs require financial transactions and procurement strategies that are attached to political influence, and are open to manipulation. Thus, the need for transparency and accountability in complex PPP structures is central to their success.

6.3.5 Alignment with research findings

Evidence-based decision-making relies on the integration of research findings and empirical evidence. The AHP allows decision-makers to align their choices with existing evidence, ensuring that decisions are consistent with the best available

information. Babu and Ravilla (2018:S15-16) contend that evidence-based decision-making is crucial for enhancing eye health service delivery. This approach involves consciously utilising reliable information for effective management and decision-making. As in medicine, evidence is vital to managers addressing organisational challenges. Strategic or operational decisions, made without appropriate evidence, can be as perilous as treating patients without a medical history or an investigation. In the context of eye health service delivery, employing the right metrics is essential to align with organisational goals and achieve operational excellence. A comprehensive framework for defining metrics includes considerations of purpose; demand; compliance; quality; human resources; finance, and external factors. This framework ensures that decisions are not only based on evidence, but also lead to tangible improvements in patient care, compliance, financial viability, and overall service quality. Practising evidence-based management in eye care necessitates the continual generation, review, and utilisation of accurate and current information at various organisational levels. Additionally, the role of information technology (IT) is pivotal in building efficient information systems that enable real-time access to, and analysis of, data for informed decision-making. Adopting evidence-based management practices in eye care relies on the accessibility and effective use of information, facilitated by IT-enabled systems, leading to improved performance and outcomes.

In the context of health systems planning and priority-setting resource allocation, it can be concluded that the AHP's evidence-based approach enhances the rigour and reliability of decision-making, leading to more effective and well-supported choices in the allocation of resources, risk management, and project prioritisation (Seixas et al., 2021:1-5).

Balt (2015:20) notes that decision-making involves assessing alternatives, based on attributes, and comparing them against values, requiring subjective judgment that is not easily quantifiable. The ability to ensure consistency and make accurate judgments is crucial in this process. Decision-making, once considered an art, has evolved into a science. Saaty (2012), as referenced by Balt (2015), emphasises the importance of predicting outcomes accurately as a significant test of a scientific theory. Saaty suggests that breaking decisions down into structures involving

benefits, costs, opportunities and risks, and then combining these outcomes, allows for a scientifically informed decision-making process. Thus, in this context, the AHP is presented as a framework that scientifically tempers judgments.

The proposed decision-making model for eye health service delivery through PPPs is underscored by adopting these criteria as a tool that could contribute to the design, planning, and implementation of targeted approaches to address the eye health service delivery challenges across local, provincial and national levels. It aims to support evidence-based decision-making in seeking out the best fit approach to enhance service delivery outcomes.

6.4 RATIONALE FOR AN EVIDENCE-BASED FRAMEWORK FOR PPPs IN EYE HEALTH SERVICE DELIVERY

The governance model for public health service delivery in South Africa is founded on a decentralised approach (Plaatjies, 2008:77). As such, each province is vested with autonomy in its decision-making abilities related to the planning, budgeting, procurement and management of health services within their jurisdiction.

While the provinces are expected to align their provincial and district health plans with the priorities established by the National Department of Health, they are afforded the flexibility to contextualise the directives within the needs framework of the areas they serve. This recognition of diverse local needs is a positive step in achieving the overarching goal of a more equitable health system.

A key strength in this approach is the ability to address local health challenges more swiftly, with the apparently lower administrative barriers than would exist with a centralised health governance approach. It also creates a significant platform for the recognition of lived circumstances within communities, which could contribute to their health and quality of life outcomes. The inclusion of the community in the decision-making process should, ideally, contribute to fostering a relationship that is built on a results-oriented approach and accountability.

The decentralised structure is not without challenges (Plaatjies, 2008). The inequitable access to health services and the low quality of healthcare in the public

sector has been raised repeatedly in the last decade, and more especially as the time for the NDP approaches, in 2030. The marked differences in health services between urban and rural areas, and economically sound provinces, has led to alarming health disparities. Furthermore, maladministration, corruption, neglect of infrastructure and fiscal limitations have hindered the effectiveness of the service delivery agenda.

What is significant here, is that the differences in the provincial interpretations of national objectives, and the inconsistency in the various programming approaches to achieve these goals, has led to fragmentation and co-ordination issues. Healthcare standards vary across and within the country. Careful oversight is necessary to avoid exacerbating health disparities, to ensure that the public health system serves all South Africans equitably and effectively. Sustained corruption has resulted in a diversion of funds away from the intended areas (Rispel, Jager, Fonn, 2016:4). This deviation has resulted in dire constraints to improving the public administrative system. It can be said that the resultant impact is an imbalance between the supply and demand of public health services at macro and micro levels of operation (Rheeder, 2021:3).

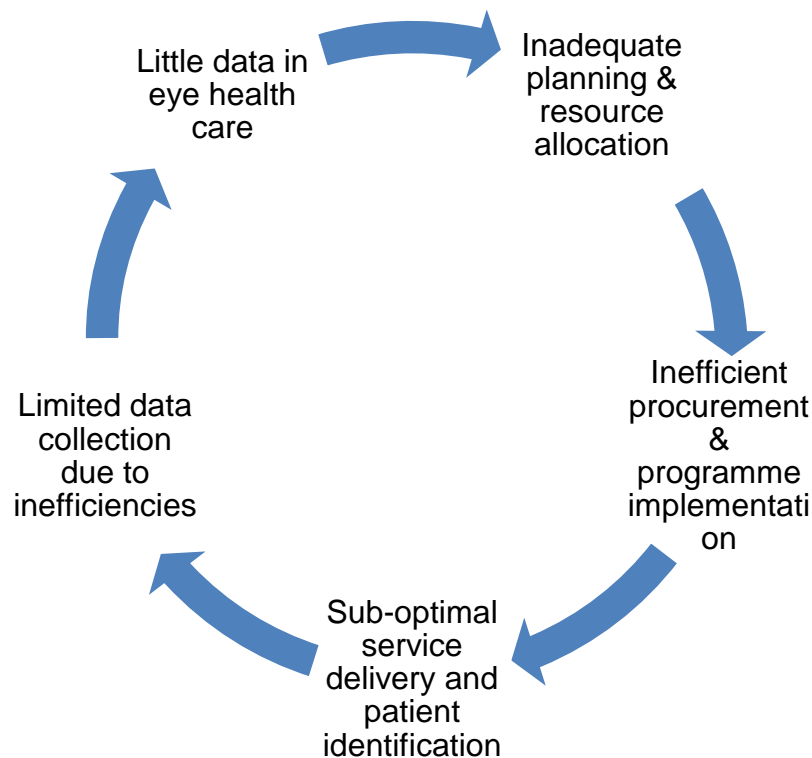
This study considered a public-private health forum as a vehicle for public-private partnerships within the uMgungundlovu district in KwaZulu-Natal. Eye health services are unevenly distributed within districts. Rural communities remain the most vulnerable. The absence of eye care services at a primary health level is a barrier to identification of vision and eye health challenges that contribute to blindness. Cataract surgery is identified at national and provincial levels as a priority eye health service. Whereas this service should be available at district level, it is not always possible. There are different factors contributing to the barriers to cataract surgery. Amongst these, are the lack of availability of sufficient skilled personnel at district, regional and tertiary facilities; a lack of functional and well-equipped clinics and theatres and theatre staff, and an insufficient budget for consumables. While these differ between facilities, the commonality of challenges rests within the administrative system for eye health service delivery. Eye health services in the country currently and predominantly favour the private sector. Optometrists trained in vision and eye health management, and ophthalmologists trained in eye disease management and

surgery, dominate the private urban sector. Access to these services is expensive and largely out of reach for the majority of people. For those able to fund some part of the services privately, there is still a dependence on the state for surgical and tertiary-level care and chronic medication.

Currently, there is no standardised or uniform recording system for patients accessing eye health clinics, from primary care upward, as was pointed out in the study. The poor administration of the referral system is a barrier to the important and necessary areas of planning and procurement at facility and district level. A respondent in the study pointed out that facilities within the same district use different methods to record patients in dire need of surgical care. Where one facility has a notebook with patient information, another asks patients to routinely call in to enquire if they are eligible for surgery. Waiting times have been reported to extend up to 2027, and this creates an untenable situation. Additionally, the absence of a standardised and uniform database inhibits the evaluation of the effectiveness of services. This limitation in tracking patients from diagnosis to discharge impacts the monitoring of services and restricts opportunities to improve on indicators and how reports are structured to district, provincial and national departments. A well-structured database, amidst the challenges faced by the department of health to deliver public eye health services, would enable more capable and tailored public-private collaborations to alleviate the backlogs.

The absence of a structured cluster for optometry, and its connection to either ophthalmology or general medical services at primary level, effectively means that budgeting for the service will always be decided, based upon the negative feedback cycle of information, as shown in Figure 6.1 below.

Figure 6.1: Cyclic recurrence of issues affecting eye health services



Source: Author's perspective

In the cyclic recurrence of issues affecting eye health services, the negative cycle is linked directly to a neglected/non-existent data collection system for primary eye care service delivery within the public health sector and the private sector.

Public-private partnerships have demonstrated the promise as a medium-term solution to address the backlogs in health service delivery. Within the uMgungundlovu district, the forum was able to provide services to patients in need of surgery who had been on the waiting list for longer than three years. It was also able to provide and install a cataract microscope in an operating theatre at a district facility, effectively increasing the cataract surgery output by more than 100%. This was, however, unsustainable in the medium-term as budgeting, procurement and human resource capacity challenges crippled the service once the partnership dissolved. Added to this, was the termination of cataract surgery services during the COVID-19 pandemic, when it was deemed an elective service rather than an essential one.

The benefits of PPPs, therefore, ought to include increased capacity, improved service quality and efficient resource utilisation. The potential of such collaborations within eye health are reflected across several international models. In India, the Aravind Eye Care System is renowned for its improvement of eye health services. It leverages on the private sector's efficiency to provide high-quality eye health services to the underserved population. In India, the LV Prasad Eye Institute has upheld its reputation for excellence in ophthalmology services. Through the integration of cutting-edge technology and research, the accuracy of eye surgeries has improved and the services have been made more widely available (Mehta, Narayanan, Thomas, Khanna & Rao, 2020:3). In the United Kingdom, the Moorfields Eye Hospital entered into a PPP with the National Health Service (NHS) (Mehta et al., 2020). The pooling of funding, skills and specialised resources assists in the management of backlogs and improves the quality of available eye care services.

In South Africa, civil society sector has emerged as the 'third major sector', creating a bridge between public and private sectors. Non-profit organisations (NPOs) and community-based organisations (CBOs) have played pivotal roles in the response to national health crises, such as HIV/AIDS, TB, and the COVID-19 pandemic (Bouey, Han, Liu, Vuckovic, Zhu, Zhou & Su, 2023:5). They have further entrenched themselves within communities by providing various services across all critical areas, impacting on the social determinants of health. Establishing themselves at a community level has strengthened and improved community awareness, links to care opportunities, and alternative service delivery models to meet primary needs. From education to waste management, as well as health services and infrastructure capacity building, this sector has been responsive to the needs of government to deliver on its mandate. A challenge within this sector, which holds true for eye health services as well, is the absence of a repository for data collection and reporting. Whereas some reports are handed to the district departments overseeing the activities of the organisation, cascading information down to the public domain and up to higher levels of governance is somewhat limited (Mathee, de la Rey, Swart, Plagerson & Naiker, 2014; Xulu-Kasaba, Mashige & Naidoo, 2021). Establishing best practices and implementing change to, potentially, avoid repetition of errors through strengthened and sustainable reporting strategies is still lacking. The

reliance of the civil society sector on funding from local and international donors threatens their sustainability.

6.5 BUILDING A DATA-DRIVEN HEALTHCARE FUTURE: ROLE OF PUBLIC-PRIVATE EYE HEALTH

Designing and implementing PPPs is not a linear process. There are several parallel and intersecting pathways to achieve desired outcomes, the very first of which is stakeholder engagement, including community engagement to establish the needs of, and to lobby support from, communities.

Eftimie and Sugden (2019:5) believe that the first step in a PPP is to achieve consensus among stakeholders by defining their expectations and exploring what could be accomplished, and in what time frame. The administration and construction of the forum should be established at this stage, followed by a community mapping and engagement exercise with M&E to provide feedback about the community's position. Mandiriza and Fourie (2023:417) assert that stakeholders within PPPs function at various levels of the value chain. Inadequate management of stakeholders can lead to risks at both the micro level, stemming from partner commitment issues, and the macro level, linked to political opposition. Thus, an alliance of stakeholders is deemed essential for cohesion among stakeholders and to create a conducive environment. This involves adhering to sound governance principles and leveraging expert knowledge for the preparation of PPP documents and execution of complex projects. Stakeholders identified within the eye health service delivery sphere across the public and private sectors include district health management; provincial eye health management; public hospital management; clinicians; civil society organisations; community representatives; nursing staff, and private hospital representatives. While there are pockets of PPPs across the country, there are no known forums for eye health which are addressing collaborative opportunities at national and provincial levels. There are also no guidelines for standardised operations of PPPs for eye health.

Community engagement, identified as the second level of engagement by Eftimie and Sugden (2019:23), has positive outcomes for the forum. A well-resourced

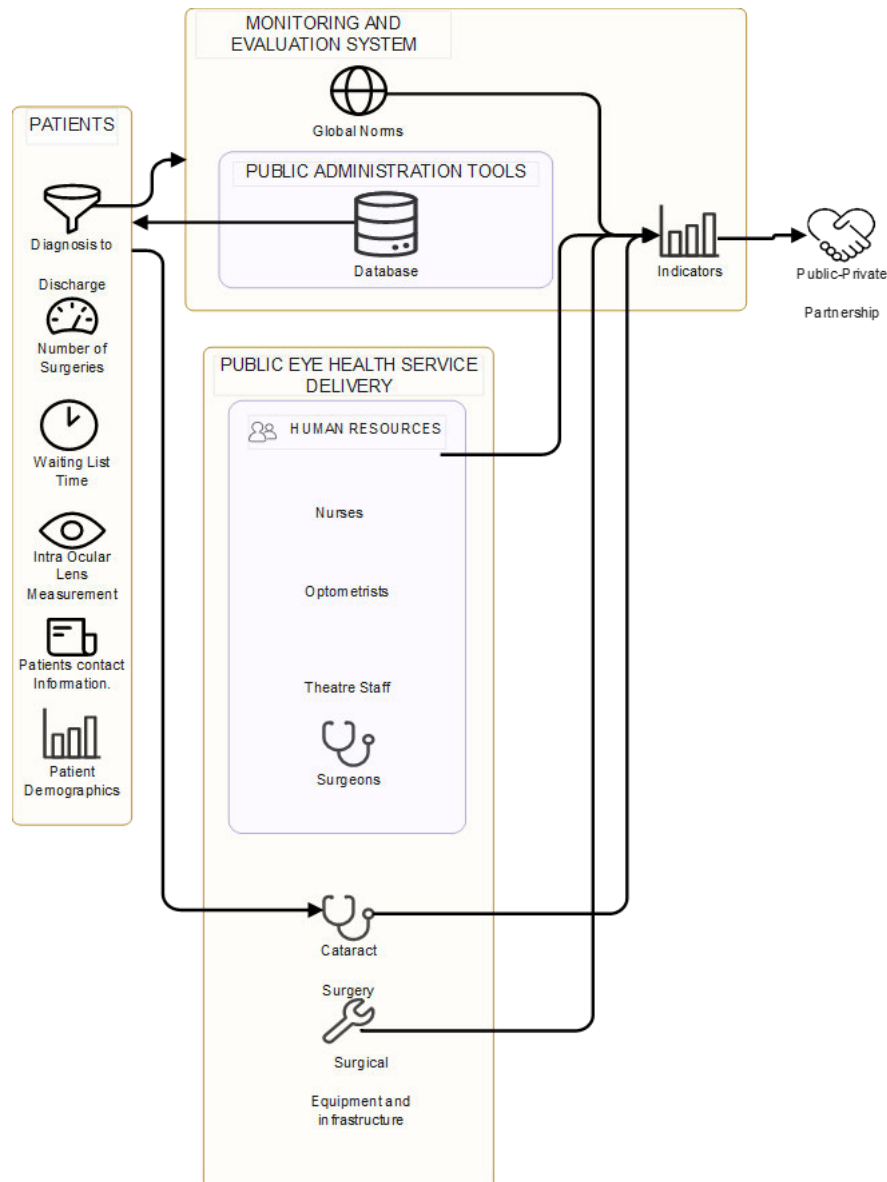
community engagement would allow for the identification of services deemed valuable to communities. It would enlist community support and reduce the risk of delays and disruptions. In addition, it would allow for the design of sustainable projects that are responsive to the needs of the community, and likely to attract the interest of credible partners.

Palinkas, Horwitz, Green, et al. (2015:2-3) align mapping with purposeful sampling designs that rely on qualitative and quantitative methods, so that the qualitative methods achieve an in-depth understanding, while quantitative methods achieve a broader understanding. While South Africa is a signatory to global agreements to prevent blindness, aligned with indicators and global norms, the indicators measuring eye health are poorly accessible and do not reflect the challenges affecting inclusive eye health in the country. In addition, the reported data does not reflect the unequal access to services, with an oversupply of eye health services in the private sector dominating urban areas. Lastly, there is no quantitative measurement of the contribution of the private sector to improving eye health access for surgical and other services for which patients are managed in a mixed health system, seeking primary care privately and more specialised care through the state.

It emerged from the findings of the study that a database is a critical and essential public administration tool, necessary to enable effective planning and implementation of PPPs to address surgical and other eye health backlogs. The database should reflect patient demographics; reliable and updated contact information; clinical information; timelines from diagnosis to discharge; and the services delivered for each patient. This directly influences the allocation of resources for public eye health service delivery, which includes human resources for eye health (ophthalmologists, ophthalmic nurses, theatre staff, optometrists), and the availability and distribution of eye health services (cataract surgery sites, infrastructure for primary and secondary eye health services). The combination of information from the database, and its influence on service delivery, could lead to new and improved indicators of the unique needs of different districts through the identification of bottlenecks within the system. It would be an opportunity for health forums to structure tailored interventions that are sustainable, whilst observing the global norms. The M&E

linked to the database, and the emerging indicators, are central to the approach in the proposed model, as shown in Figure 6.2, below.

Figure 6.2: An evidence-based model for PPPs in eye health service delivery



Source: Author's perspective, (2023)

The model speaks to the link between the public eye health service delivery for cataract surgery services in South Africa, and to the M&E system used to establish backlogs and bottlenecks in the service, to inform the design of public-private partnership (PPP) programmes to alleviate the backlog. The national and provincial departments of health rely extensively on statistical data to inform their budgets for, and resource allocation to, public health facilities, as well as to communities. These

costs include surgical equipment, infrastructure and human resources (surgeons, theatre staff, optometrists, nurses). The data is collected through indicators which, in this thesis and for the purpose of this research, are used to describe what should or could be known about the outcomes of a particular condition in routine clinical or public health practice.

Indicators are also influenced by global norms established through global scientific research. Public administration tools are necessary for M&E systems (Kusak & Rist, 2004:23). One of the key tools is a database. This is a central tool in cataract surgery service delivery because it is needed to quantify the number of patients per facility, the number of surgeries per patient and the specifications of the intra-ocular lens to be ordered. It can be used to establish the length of time each person is on the waiting list, patient demographics for equitable service delivery, and the patient contact information.

According to this proposed model, the database as a tool should also present a macro view of the public eye health system in a district or province to mitigate duplication of services. For example, one patient on multiple waiting lists is an issue that can easily be addressed through a streamlined database. At an individual patient level, using this model would allow the provincial leadership and public health management to track the patient from diagnosis of the cataract to discharge from the system after the surgery has been performed. This would effectively enable the Department of Health to see where the greatest delays occur. Delays can differ across different health facilities, due to several reasons, including a shortage of healthcare professionals (Zihindula, Ross, Gumede & McGregor, 2019); limited clinical equipment; the geographic location of the facilities (rural versus urban); and affordability to, and accommodation of, patients (Zihindula, Meyer-Weitz & Akintola, 2015). However, knowing the reasons for the delay can help inform the type of public-private partnership programme, and the area in which it would focus its efforts. This is one key element of the model which leads to a successful PPP in eye health services at both primary and secondary healthcare services. Equally, strengthening the eye health forums across provinces can serve as an interim solution while working towards implementing the proposed model.

6.6 COMPONENTS OF PROPOSED MODEL

6.6.1 Public-private partnerships

The proposed model in the research study suggests that identifying stakeholders should be the first step in building a successful PPP. Second to this, should be the structure of these stakeholders within the PPP, acknowledging that government is one of the largest beneficiaries of PPPs. Important in a partnership is having enough funding to allow the purchase of consumables and the provision of human resources. For example, some facilities in the KZN province have theatre equipment; but they do not have any theatre nurses (Nkwanyana, Voce, Mngayi, Sartorius & Schneider, 2019:5).

6.6.2 Monitoring and evaluation

Several key areas are presented in the model under this section. The first one, are the indicators used to measure the demand. The second is record keeping for patients, infrastructure, human resources, and the clinical output.

6.6.3 Eye health services

These are services recognised in global targets across primary, secondary and tertiary service levels, and their location in urban and rural settings. It includes the service providers and the infrastructure necessary to enable service provision.

6.6.4 Understanding the demand

According to this proposed model, the data identifies demand and dictates resource allocations. Poor data would mislead resource allocation, and ultimately poor service delivery, leading to negative clinical outcomes for patients. Moreover, public eye health is influenced by demand, and global agreements, and is underpinned by indicators generated from both. In a challenging and complex service delivery system like eye health, PPPs offer tangible relief. However, the effectiveness of the intervention is closely attached to the availability of a database. The current public administration system for health service delivery in South Africa remains a challenge, especially given that the referral pathway cannot be monitored. Capable PPPs

provide a sustainable medium-term solution to generate data that would capacitate government's planning and implementation strategies, aligned with its goals for UHC.

6.7 BRIDGING THE HEALTH SERVICE DELIVERY GAP THROUGH ADMINISTRATIVE SOLUTIONS

It can be said, that the AHP significantly enhances decision-making within PPP forums for health service delivery. The process begins by identifying criteria and alternatives, a step analogous to the initial stages of decision-making in PPP forums where the specific needs of the healthcare sector and the goals of the PPP intervention are determined. The AHP's systematic approach involves quantifying the relative importance of criteria, mirroring the necessity in PPP decision-making to assign weights to factors such as cost-effectiveness, service quality, and long-term sustainability.

Within an AHP, the process advances to comparison and judgment, requiring decision-makers to assess criteria and alternatives, pairwise. This aligns with the complexities of PPP decision-making, which involves comparing alternatives, based on factors like the capabilities of private partners, potential risks, and alignment with public health objectives. The AHP's comparative approach enhances the precision of such judgments, providing a structured foundation for decision-making in PPP forums.

Consistency checks, deemed a crucial step in the AHP, ensure the reliability of judgments made by decision-makers. In the context of PPPs for health service delivery, consistency checks play a vital role in ensuring the alignment of judgments across stakeholders, contributing to the robustness of decisions in this complex domain. Baseline assessments, which are a common requirement in PPPs, can benefit from AHP's ability to prioritise criteria, focusing efforts on the most impactful aspects for health service delivery.

Moreover, an AHP promotes evidence-based decision-making, aligning with the demand for data-driven strategies in the healthcare sector. Its systematic and methodical approach ensures that decisions within PPP forums are grounded in data

and analysis, contributing to the effectiveness and efficiency of interventions. The seamless integration of AHP with the decision-making process and baseline assessments in PPPs for health service delivery underscores its value in providing a structured, evidence-based, foundation for informed decision-making and successful PPP interventions.

6.8 CONTRIBUTION TO THE BODY OF KNOWLEDGE OF PUBLIC ADMINISTRATION VIS-A-VIS PUBLIC HEALTH DELIVERY

The study aims to contribute to the literature on public administration through three contributions: Firstly, the theoretical contribution is an integrative theoretical framework that connects public administration to public health service delivery, in particular, eye health care, for the general welfare of the community at large. Secondly, the study offers an empirical contribution by providing results from qualitative data collected from experts in the field, which influenced the proposed model, designed to improve and increase good clinical outcomes in eye health services. Thirdly, the study has practical relevance in establishing a public-private health forum with key stakeholders, by advocating for a database-driven approach to operational and tactical efficiency in public eye health care, in particular.

6.9 CONCLUSION

This research emphasises the urgent need for a robust public administrative approach to enhance the efficacy, efficiency, ethics and equity of PPPs, particularly within the domain of eye health service delivery in South Africa. The synthesis of findings underscores the complex interplay of stakeholders, judicious funding, and meticulous M&E, as the foundation for successful PPPs. A standout revelation is the pivotal role of data, with the proposed model positioning a sophisticated database as the linchpin to address the clear data gap that hampers equitable service delivery in eye health.

This holistic model, born out of empirical insights, not only contributes to the theoretical framework connecting public administration and health service delivery, but also stands as a practical breakthrough in reshaping the landscape of eye health care. By seamlessly connecting the elements of PPPs, M&E, and eye health

services, the model serves as a transformative blueprint, setting a new standard for excellence in public health administration and contributing significantly to the body of knowledge in eye health service delivery. As the healthcare paradigm evolves, this model represents a unique contribution that has the potential to redefine how eye health services are delivered, and setting a new standard for excellence in public health administration. In essence, the proposed model is a beacon, guiding the way towards a healthcare future where administrative solutions are not merely an option, but an indispensable tool for achieving universal health coverage.

CHAPTER SEVEN:

CONCLUSION AND RECOMMENDATIONS

7.1 INTRODUCTION

Public health service delivery in South Africa faces significant challenges, particularly within a fragmented public administration system. A robust and capable public administration structure is vital for the efficient provision of health services (Malakoane et al., 2020:12). One crucial issue highlighting this challenge is the management of patient records and waiting lists for individuals in need of medical care. The absence of a standardised system and an interconnected database between essential sectors using digital approaches to connect documents, such as the Department of Health with local registries, poses a considerable obstacle in quantifying, budgeting, and planning for healthcare services (Bojović, Bojović, Jovanović, Suh, Sen. 2023:6).

This fragmented approach to record-keeping creates a web of challenges, hindering the effective administration of healthcare. The lack of a coherent database creates difficulties in tracking patient health records, treatment histories, and waiting lists (Mutshatshi, Mothiba, Mamogobo, Mbombi, 2018:4). This absence undermines the efficient access of the required resources, hinders proper budgeting, and obstructs efficient service planning. Without a seamless and integrated database, patient care, including essential surgeries like cataract surgery, becomes significantly more challenging to manage and deliver effectively (Powers, McGree, Grieve, et al., 2023:534).

Cataract surgery, a crucial medical intervention, faces substantial backlogs within the South African healthcare system. These backlogs further exacerbate the plight of individuals awaiting this procedure, contributing to a decline in the quality of life for affected individuals and a strain on the healthcare system's capabilities. It is in addressing such critical backlogs that the role of PPPs becomes particularly pertinent.

Public-private partnerships are essential to alleviate the strain on the public healthcare system (Barnes, 2011:4) and address the backlog in cataract surgeries. These collaborations bring together the expertise and resources of both the public and private sectors, offering a potential solution to the challenges faced by the public health system. However, the success of these partnerships is significantly contingent on the presence of a credible and effective database (Yurdakul, Kamasak, Ozturk, 2021:38).

This study examined the effectiveness of a public-private health forum in addressing health challenges, especially eye care, in the uMgungundlovu district, KwaZulu-Natal. The primary focus was on enhancing eye healthcare and evaluating equitable access to services. The research revealed a current lack of M&E, emphasising the need for improvements to better address health challenges and enhance service provision in the public sector.

7.2 INSIGHTS INTO FUNCTION OF THE FORUM

In response to the identified research questions listed below, the study found:

7.2.1 What are the administrative and management barriers to effective eye health service delivery?

The participants suggested that the administrative and management barriers impacting the delivery of cataract surgery services, resulting in chronic backlogs, were directly linked to the lack of reliable patient information systems and a fractured referral system between primary healthcare facilities and district, regional and tertiary centres where cataract surgery is performed. The lack of an efficient patient information system has a direct impact on the waiting times, the efficiency of health services, and the quality of healthcare overall. The ramifications of the disconnect between PHC systems and hospitals are many. Among these are a lack of evidence-based information to justify resource allocation at centres closest to where people reside. These include human resource and infrastructure allocations. In addition, the absence of a controlled and documented referral system between hospitals and their PHC feeder sites results in a lack of organisational interventions to prevent

duplications on waiting lists across the district and or province. It also impedes budgeting, planning and procurement.

From a management perspective, a key gap identified in the research study was the absence of a dedicated directorate for eye health services. Eye health managers in the district were not eye health professionals by qualification. Instead, eye health services are bundled under 'non-communicable disease'. Monitoring and evaluation of eye health services has been identified as a major gap in the literature and in this empirical study. Whereas statistics are provided by some service providers in the district, there is little known about the context within which they are gathered, or the accuracy of diagnoses, given the shortage of equipment. Furthermore, little is known about the correlation between the indicators reported and the capacity of facilities to identify these within efficient timeframes. Lastly, the co-ordination at provincial and district levels to meet national cataract surgery targets is seemingly devoid of structured and systematic functions.

7.2.2 How can a public-private health forum contribute to improved public health eye service delivery and performance?

The eye health services needed for diagnosis, through vision screening and testing programmes, are offered by optometrists who are unevenly distributed across public health facilities in the country. What is of major concern, is that optometry services are governed by an eye health policy that is separated from the general health policy under which ophthalmology services fall. Significantly, the National Strategy Plan for eye health services has been in a draft format since 2018. The absence of a dedicated directorate for eye health services at the national level has negatively impacted the managerial capacity for eye health services, ultimately impacting evidence-based decision-making strategies to meet eye health needs, within the context of the challenges faced, and highlighted at facility level, in this research. The poor access to optometrists at PHC level, coupled with long waiting lists at hospitals to access care, has resulted in people seeking primary eye health services in the private sector, where screening, some management, and referrals to the state for surgery are made. Despite this long-standing coalition between the private and public sectors, it has not been recognised or formalised. Beyond this, there is no

database or recording system to quantify the private sector's contribution to detection and referral for vision and eye health challenges; nor how this links to the achievement of the national eye health mandate. Again, this anomaly in the public health sector is a major issue for the Department of Public Health to consider in realising and fulfilling its constitutional mandate for enhanced public health service delivery.

Using the forum as a PPP 'vehicle' to address the cataract surgery backlog corroborates with the literature on the value of PPPs in improving the efficiency and effectiveness of eye health service delivery. However, the forum's efforts met a myriad of challenges as was evident in the study undertaken. An equitable approach to providing relief to those on lengthy waiting lists was marred by the communication challenges and barriers in the empirical management of the data. Some patients could not be contacted because of incorrect recording of their contact information on the patient files. The commitment of staff to accuracy and efficiency in record-keeping was found to be severely lacking. In addition, some patients could not be contacted due to a change of contact information, with no updates of these changes at the facility level. Lastly, the record-keeping at the different cataract surgery centres in the district differed considerably. Where one facility recorded it manually in a hard cover book, another facility asked patients to call in routinely to establish their position in the queue, whilst the third facility had a combination of both manual and digital approaches to record-keeping. Such inconsistencies in setting up normative guidelines for proper management and administration of the health forums leave much to be desired, insofar as governance is concerned.

Beyond the efficiency and effectiveness of the short-term interventions, feedback indicated that the donation and installation of a surgical cataract microscope, and the compassion and competence-driven responses by the private sector to design and implement a relief programme with urgency, indicated the commitment of the PPP to address the medium-term strategies to improve the capacity of cataract centres with a view to enhancing their service outputs through targeted interventions to overcome known challenges. Over and above the burden of the cataract backlog being largely attributed to staff shortages; age; or very poor or non-existent infrastructure; poor record-keeping and budget constraints; a series of barriers within the system created

bottlenecks over time, with a lack of reports. In essence, the research revealed that the health forum is in dire straits amidst all the chaos that is currently prevalent within this particular public health sector.

7.2.3 What are management and organisational approaches for the public-private health forum?

Alongside the absence of a clear definition of the roles and responsibilities of stakeholders, little was known about the structure of the forum. While a 'terms of reference' document was made available, and the memorandum of understanding (MoU) between the facilitating civil society organisation and the District Department of Health for permission to undertake engagements to address the cataract backlog was provided, there was no information available detailing activities to legitimise the forum as a structure. No constitution or policy documents were available, and the meetings were guided with the sole agenda of establishing outputs that would reduce the cataract backlog through the pooling of resources between the public and private sectors. Regarding timeframes for the forum's activities, the MoU was approved to run until 2021. However, the advent of COVID-19 in 2020, and the subsequent cancellation of cataract surgeries as elective procedures, coupled with the restrictions on movement, including the overwhelming burden on both the public and private sectors to respond effectively to the pandemic, resulted in a halt in the forum's activities. A change of leadership during this time, at the beneficiary hospital and within the district health management, with an absence of institutional knowledge, and an absence of documentation of the forum's activities, resulted in the inevitable application for the extension not being granted.

The overarching goal of the forum, as understood by all stakeholders, was to reduce the cataract surgery backlog in the district through shared resources between stakeholders. Cataract extraction is a surgical procedure conducted in theatre and relies on the pre- and post-theatre care. It requires skilled personnel at each level and during the procedure itself, as well as post-operative care that is attached to the availability of consumables, including a cataract pack comprising an intra-ocular lens, medication and additional materials for the post-operative care. These are much-needed resources in public health-related matters. However, the cost of

procuring consumables, and the costs incurred at individual stakeholder level, was not communicated back to the forum. There is no record of a feedback meeting and stakeholders could not account for any such meetings either. No designated stakeholder tasked with the M&E of the activities. Clearly, there were no oversight measures in place, leading to the next key question that was addressed in and through the research undertaken.

7.2.4 How effective and efficient are the implemented M&E solutions, as well as the current reporting systems which are in place?

The rationale for the forum convening was to discuss a collaborative strategy to address the cataract surgery backlog in the district, through a targeted intervention based on the estimated number of patients on waiting lists; at the time recorded as an extremely large six thousand. There was no database available to provide the actual number of those in need, taking into consideration death, relocation, or some of them undergoing surgery at another facility in the province/country. Nor was there any indication of the geographical location of the patients, or to identify them by race or gender, in alignment with the fairness and equity mandate entrenched within the public health policy.

The creation of the forum, with the permission and participation of the District Health Manager, was the primary outcome. In the absence of a baseline study to effectively account for the demand, the challenges, and the needs, the main activity of the forum was to identify resources and stakeholder commitment to contributing to the cataract camp. The result was the cataract camps conducted at several sites, with the support of some district eye managers, optometrists and the provincial management. Whilst one can say that the outcome fulfilled the objectives, there was no known policy or framework within which decisions were made or activities were undertaken.

In summary, the study identified the administrative and management barriers contributing to cataract surgery backlogs, including a lack of reliable patient information systems and a fragmented referral system. The disconnect between primary healthcare systems and hospitals led to challenges in resource allocation

and hindered budgeting and planning. The absence of a dedicated directorate for eye health services at both national and provincial level in the province of KwaZulu-Natal impacted on the managerial capacity, hindering evidence-based decision-making. While a public-private health forum aimed to address the backlog, challenges such as communication barriers and inadequate record-keeping were noted, emphasising the need for structured and systematic functions. Stakeholder consensus on the forum's establishment and goals was lacking, with issues related to documentation, stakeholder selection, and the lack of a clear structure identified as barriers to the sustainability of critical public health functions. The forum's overarching goal was to reduce the cataract surgery backlogs, but there was a lack of communication on costs, feedback, monitoring and evaluation. The research has highlighted the need for improved organisation, communication and documentation within the public-private health forum to effectively address and overcome these existing challenges.

From the foregoing discussion, it is evident that the research questions attached to the empirical research yielded the necessary outcomes by exposing the severe shortcomings and gaps in eye health care delivery in the public sector.

7.3 RECOMMENDATIONS EMANATING FROM THE STUDY

Some recommendations emerged from the existing scholarly literature review, the data analysed, and the model proposed for the good clinical outcomes of patients through PPPs for improving eye health services. The structure for a forum is proposed and recommended as a potential model for adoption for a successful eye health forum, which is the new contribution from this study. The results also suggested that the model for a health forum be standardised to address public eye health service delivery throughout the country. Lastly, there are some cross-cutting recommendations, including those for future research; suggestions for health promotion interventions; and recommendations to policy-makers, as well as healthcare professionals, providing eye health services to local communities. Final recommendations are made for a successful PPP structure.

7.3.1 What are the governance approaches used by the forum to address challenges encountered in the public eye health service delivery?

While the activities of the forum to address cataract surgery backlogs in the district resulted in a target-driven coalition (output) with civil society and state sectors to conduct cataract surgery camps at several hospitals in the district (outcome), there was poor consensus amongst stakeholders about the drivers for the establishment of the forum. While the timeframe between the forum and the study has been noted as considerable, the absence of information about the forum was a barrier for some stakeholders to participate in the study. A hospital manager at a participating hospital which contributed considerably to the outcomes of cataract surgery camps withdrew from participating in the study owing to the unavailability of reports from the forum detailing its goals and the role and scope of participants. Participants from the private sector indicated that they were only aware of their own contribution to the cataract camp. There was, unfortunately, no information by way of reports or feedback from participants, with the exception of the facilitating civil society organisation, indicating what the individual goals of the forum were, and what the overall contribution of the forum activities included.

Regarding stakeholders, there was no documented information about the selection criteria for participants. However, the individuals invited to participate were those at managerial and executive levels, which indicated a preference for people with the capacity for, and potential influence in, the decision-making process. The forum did not have documented minutes of meetings and no signed registers. In addition, from an organisational perspective, it was recorded that the forum was chaired by the District Health Manager, with no other administrative roles, such as secretarial or treasurer functions, identified. A barrier to the continuity of the forum's activities, and a hindrance to its sustainability, was the absence of any hand-over of information at the district office or at the facility level. Incumbents in executive posts were partly aware of the forum's outcomes, but had no institutional knowledge, thus limiting their participation in the study. The absence of a secretarial function hindered the documentation of the process and its overall impact.

7.4 STANDARDISED MODEL FOR HEALTH FORUMS TO ADDRESS PUBLIC EYE HEALTH SERVICE DELIVERY

Within the context of this study, the health forum served as a useful model for the PPP. It enabled a platform for collaboration between key stakeholders and facilitated the provision of resources for cataract surgery services to alleviate the district backlogs. Aligned with the framework for PPPs, the requirement for shared decision-making and resource pooling is premised on a collaborative model that respects a balance between roles and power, and a structured operational system that incorporates risk management and improved opportunities to address public health matters. This is best achieved through an operational model with clear roles and responsibilities for all stakeholders, and the necessary indicators for M&E at every level.

Standardising a public-private health forum is beneficial for the creation of a model that can be replicated and adapted for implementation across different programmes within the health sector. Uniformity in the standards of operation as a normative guideline would allow for improved quality in the data collection and reporting. The main priority for the operational model ought to be a systematic design that enables continuity and sustainability of public health care.

7.5 PROPOSED STRUCTURE OF A HEALTH FORUM

The construction of a forum is necessary to leverage strengths from all stakeholders to bridge the data gap and drive sustainable improvements in eye health services. It should also be designed to keep a fair balance of power between stakeholders, reduce the risk of exploitation, and maintain ethical and progressive approaches, with the best interests of programme beneficiaries central to its values.

A comprehensive strategy within eye health service delivery would be to incorporate researchers who could provide invaluable insights into data collection, analysis and research methodologies, whilst aligning with the NDP's emphasis on innovation and knowledge sharing. The inadequacy and paucity of data and literature concerning eye health service delivery in the country significantly contributes to the negative feedback cycle hindering improvements in the public sector's eye health service

system. In embracing the structure outlined in the department framework for PPPs, governance representatives play a crucial role in being entrusted with policy development, oversight, and the regulatory functions to ensure transparency and accountability within the partnership. Equally crucial is the private sector's contribution, as it brings innovation, expertise, technology and much-needed investment to enhance service delivery, whilst fulfilling the need for innovation in healthcare.

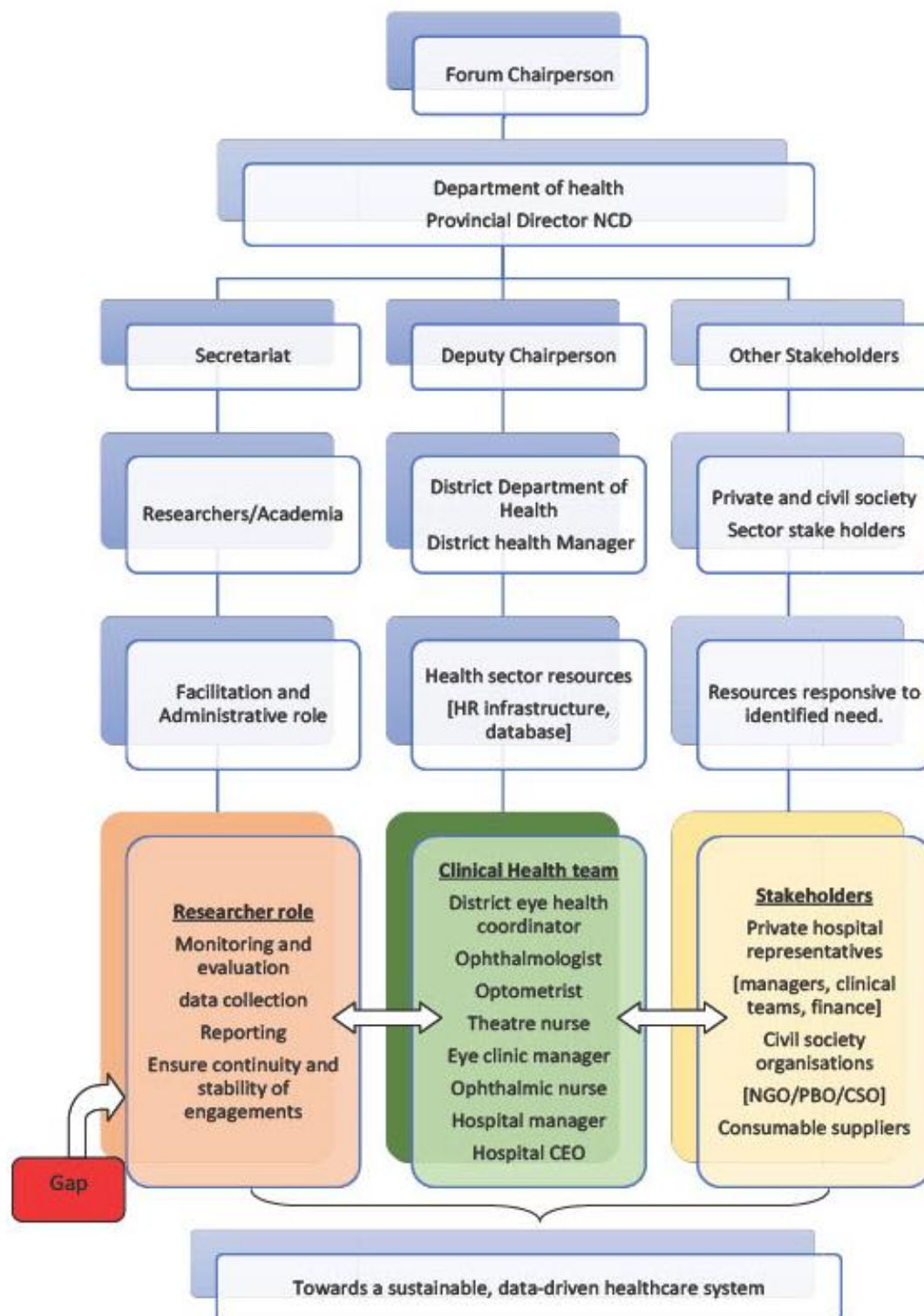
One of the top-ranking criteria is the equitable distribution of roles, as outlined in the PPP Framework, ensuring transparent governance, preventing imbalances and promoting sustainable decision-making. Moreover, the forum, in alignment with the focus on improving service delivery, prioritises community engagement and equal access to healthcare services. Lastly, continuing M&E, guided by the PPP Framework's principles, ensures that the partnership remains aligned with its objectives, enabling ongoing improvements in healthcare service delivery.

Premised on the above, and coupled with emerging research and findings emanating from this study, a key recommendation for the Department of Health is to establish a standardised forum, presiding at district and provincial level, for the oversight and support of eye health services.

The study focused on the challenges impeding efficient cataract surgery service delivery in uMgungundlovu District, attributing this to poorly structured record-keeping systems, high staff turnover, and inadequate procurement processes affecting essential resources for eye health services. As part of the government's commitment to accessible healthcare, the research aimed to evaluate the effectiveness of a public-private health forum in addressing these challenges, as well as inequities in eye health service delivery at the district level. The objectives were centred on identifying barriers; evaluating the forum's impact; understanding governance and management approaches; exploring M&E systems; and lastly, but most importantly, proposing a model for improved district-level engagement as part of the new contribution in this research.

The key questions posed in the study revolved around administrative and management barriers; the potential contribution of a public-private health forum; the governance approaches used; organisational methods; and the effectiveness of M&E solutions. The study's intention was to create a comprehensive model to address these challenges, ultimately striving to bridge the gap in eye health service provision for the local community. By understanding and addressing these barriers, the study aimed to pave the way for more effective, organised and responsive management in the delivery of eye health services in the public sector, in the uMgungundlovu District in particular. De Schepper et al. (2014:2) highlighted that PPPs are complex and demand a significant amount of time; yet under optimal circumstances they can yield substantial benefits for governments, the private sector and consumers. With an appropriate regulatory framework and unwavering political commitment, they can provide governments with cost-effective and offer lucrative prospects for investors (Farlam, 2005:2). A consistent message underscores the importance of thorough feasibility studies by governments, addressing factors such as affordability, value-for-money, and risk transfer for the success of PPPs. Du Toit, Faal, Wiafe, et al. (2013:1) assert that insufficient information is available regarding eye health when approached from a health systems perspective. While there is some supporting information for interventions related to human resources and partnerships, there is limited evidence demonstrating their successful application in enhancing the quality of care and access to comprehensive eye health services at the PHC level and in referrals to specialist eye care, thus necessitating a context-specific planning and holistic approach. Documentation and evaluation of ongoing projects, along with pilot projects for systematic interventions and best practices, are crucial. This study therefore, recommends the inclusion of a research arm within the structure of PPPs to address the data gap that feeds the negative information cycle.

Figure 7.1: Eye Health Forum structure



Source: Author's Perspective (2023)

The components of this proposed forum align with the principles of the NDP (2030) and the PPP Framework, converging to address challenges, while striving for a sustainable, data-driven, healthcare system. By integrating academic research, public oversight, private innovation, equitable roles and continuing evaluation, this multi-sectoral collaboration could yield a comprehensive and effective solution to address the absence of a database, leading to sustainable improvements in eye health services.

As evidenced from the engagement with participants who were directly involved in a PPP for eye health service delivery, using a forum as a 'vehicle' to achieve collective goals, there is a clear correlation between the existence of a database and the effectiveness and efficiency of collaborative programmes to meet service delivery targets. Through policy processes, political leadership and strong support for PPPs, a positive impact can be made. Intersectoral collaboration between government and the private sector is fundamentally important to effectively address eye health care in a more robust manner.

The study has revealed that, whilst health programmes have evolved over time to tackle various determinants of health, a more comprehensive view of public health care is required to address health promotion in the context of eye health care delivery. The study has further highlighted that public health care delivery requires government to make a change in terms of how public health programmes are governed, in particular eye health care. It is hoped that the PPP health forum is one of the most crucial ways to gain support for and action to improve the health of the deserving local communities.

7.6 CROSS-CUTTING RECOMMENDATIONS

7.6.1 A standardised multisectoral forum

Given the varied challenges impacting eye health service delivery across the country, we recommend a standardised multisectoral forum as an approach to addressing the public eye health service delivery challenges.

In support thereof, the National Treasury Report (2022:155) in its overview of PPPs, found that one limitation of the current PPP framework is the absence of an overarching policy framework that mainstreams PPPs as part of a fiscally prudent process. The proposed solution was to design an integrated management system and PPP policy, introduce a PPP champion at senior institution level, and define clear roles and responsibilities. Additionally, it found that there was no centralised approach for PPPs, with no capacitated regulator and no defined guidelines to perform functions. The envisaged solutions include centralising the identification of PPPs, and establishing guidelines, tools and methodologies to enable reporting.

7.6.2 A standardised database for health service information

A standardised database for recording patients, necessary for waiting times (efficiency of service delivery); planning (human resource allocation); procurement (consumables and infrastructure); and risk mitigation (addressing the duplication of people on waiting lists across various facilities), should enable tailor-made solutions through PPPs, with the emphasis on known bottlenecks, established from key data on the database.

A Patients' Rights Charter was launched by the Department of Health, along with care packages, norms and standards for primary healthcare and district hospitals. The Modernisation of Tertiary Services plan and framework were developed, including clinic-building and hospital revitalisation programmes tied to district and hospital improvement plans. National policies on Quality in Health Care and Infection Prevention and Control were introduced. National core standards for health establishments in South Africa (2011), premised on a structured measurement system to assess compliance and the impact of improvement efforts, were established (Schaay, Sanders, Kruger, 2011:13).

Within the domain of clinical care, compliance with guidelines and protocols and the appropriate use of technology and medical records, were highlighted as part of its core standards. These are premised on the goal to deliver inclusive care that is efficient and sustainable. They also cater for the recording of patient clinical information, appointment scheduling, pharmacy schedules, and tracking of patients

from admission into the system to discharge after the required service delivery. The document recognises that this has not been achieved fully and uniformly across health facilities in the country, despite the overwhelming justification for its urgent implementation.

7.6.3 Uniform tools for eye health service delivery reporting

Uniform tools for eye health service delivery reporting should be adopted. Standards of operation should be enforceable and, where service providers exist outside of PPPs, data should be reported through a repository that would give feedback into priority indicators and allow for room to update and improve on these indicators.

McCormick, Mactaggart, Resnikoff, et al. (2022:893), in their overview on the first of its kind 'World Report on Vision', asserted that an updated approach to monitoring and evaluating eye health standards is necessary. They proposed that this is achievable through improved indicators. The suggested list of indicators consists of 22 indicators, including seven core indicators that represent important concepts in eye health for 2020 and beyond. These indicators are deemed 'feasible, actionable, reliable and internationally comparable'. The development of new national eye health monitoring frameworks, using broader UHC monitoring indices to monitor progress on addressing key challenges to eye health at the national level should be considered, so that they can inform more tailored approaches to the eye health challenges currently experienced.

7.6.4 Public administration, efficient and effective eye health service delivery

Public administration practices for effective and efficient eye health service delivery needs to be improved. The referral pathway from PHC level to tertiary level needs to be improved and expanded so that patients accessing primary care in the private sector, with referral to the state for tertiary care, are documented. Access to quality services in public health is an important expression of the economic and social determination of the life of citizens. As a primary right, it is therefore, the duty of the Department of Health in particular, and the state in general, to provide access to such services for the general welfare of the citizenry.

Klinton (2020:2) affirmed the WHO recognition of the private sector's role within mixed health systems as beneficial, where capable health systems generate a 'complementary, reasonable-quality private sector'. However, there are significant risks if such a critical health service is left unregulated. Furthermore, the coverage of the private sector has been considered higher than that of the public sector, owing to the inclusion of unlicensed and uncertified providers.

In eye health services, consumers may opt for informal avenues like static, itinerant, or digital health products and service providers, challenging traditional health system boundaries. These services often fall outside government recognition, categorised loosely under the private sector. The lack of a standardised definition for the private health sector can lead to an underestimation of its widespread presence. The emergence of online platforms as portals for the purchase of eye health devices such as spectacles and contact lenses in an unregulated sphere carries the risk of poor estimation of need for eye health services. It also exacerbates the risk attached to negligent health practices by patients.

7.6.5 Mapping of eye health services at district and provincial level

Mapping of eye health services at district and provincial level is urgently needed. This would allow for the quantification of services at the different service levels, and an inventory of infrastructure, that would allow PPPs to optimise their approach to facilitating more sustainable solutions for equity, and to promote health and well-being as a basic human right and public good.

In reinforcing this suggestion, Holecki, Romaniuk, et al. (2018:1) suggested that a framework for health-needs mapping is an essential component in understanding the health demands at local and national level, in order to develop well-informed interventions to meet these needs. They assert that health-needs maps serve as a robust analytical tool for healthcare management decisions, offering insights into demographic trends, epidemiology, and healthcare infrastructure.

Integrating this tool into the eye healthcare system would enhance decision-makers' effectiveness in allocating physical, intellectual, and financial resources. Maps for eye health services in South Africa are lacking. There is a need to provide

comprehensive data on demographics, population eye health, and healthcare resources.

Well-structured maps ideally include information on resource utilisation, such as hospital treatments and outpatient services. A crucial aspect is the inclusion of prognoses for future health needs, based on predicted population structures and the projected incidence of specific diseases, shaping the demand for medical services (Holecki et al., 2018:2).

7.6.6 Absence of a dedicated directorate for primary eye care providers

In the absence of a dedicated directorate for primary eye care providers, such as optometrists, who are the majority cadre providing entry level vision and eye health services, academia has an important role to play in advancing the national strategic plan for eye health services, which has remained in a draft format since 2018. The motivation for the availability of a directorate is hindered by the negative feedback cycle.

Xulu-Kasaba, Mashige, Naidoo (2021:2-9) have suggested that the lack of direction amongst eye health managers is due to the lack of a dedicated directorate. There is currently no policy stipulating the need for suitably qualified persons to lead eye health services. This, in turn, impacts on the career path options within the public sector, and influences the motivation, or lack thereof, for the retention of skilled staff. In addition, the absence of a directorate is linked to the absence of an integrated eye health promotion policy and inadequate eye care services. The authors assert, based on previous studies, that the absence of a directorate for eye health has far-reaching implications, from policy level to budget and resource allocation, as well as to the quality of services delivered.

7.6.7 Establishment of a dedicated research office for eye health services

The establishment of a dedicated research office for eye health services within public health would enable the improvement of eye health data collection, which is currently a critical gap. It would also allow for the creation of an advisory platform for under-

capacitated departments like the Department of Non-communicable Disease, and would improve opportunities for informed eye health reforms.

In the absence of a structured directorate and an enabling environment for data collection through credible indicators and reliable systems to translate the data into action, it becomes necessary to find innovative and supplementary strategies for data collection. Courtright, Mathengo, Kelle, et al. (2016:1) indicated that targets are necessary for resource mobilisation. However, they need to be updated by data linked to effectiveness and efficiency. Moreover, the evidence generated should include the dynamic nature of disease-specific challenges, including the epidemiology, the complexity of diagnosis and treatment, and the technological resources required for diagnosis and treatment of conditions. It should also include the changing eye care demands in increasingly urbanised communities, and the interconnected systemic issues that affect the quality of care. There needs to be a routine re-evaluation of strategies for HReH and for the task-shifting strategies attached to some eye health surgeries, such as cataracts. This would also allow for redefining the scope of practice and available interventions by primary eye care workers, aligned with the needs of the population, through an evidence-based approach.

7.6.8 Public-private partnerships between academia and public health

Public-private partnerships should exist between academia and the public health sector through MoUs, to achieve two key roles simultaneously. Firstly, they would support the structured and uniform implementation of eye health forums across districts/provinces. Secondly, they would implement a scientifically sound intervention that enables harvesting of empirical data about the eye health status of communities. This data would then empower the public sector with policy improvements; mapping services; addressing HReH backlogs; and enabling sustainable PPPs, based on the bottlenecks within the different areas. Where some areas could have HR issues, others could have infrastructure issues, budgetary constraints, etc.

Goi, Hakeem, Frendy (2022:13) affirmed the role of academic research in knowledge diffusion. Academic research could play a pivotal role in the success of PPPs by bringing unique contributions to the collaborative research space. Their clear understanding of project objectives ensures a cohesive vision among partners and managers, fostering effective collaboration. In the realm of communication, academics act as facilitators, creating interactive spaces that streamline discussions and provide a supervised, objective-driven environment for stakeholders. Through early information sessions, academic scholarly research could ensure that every participant has a minimum level of required understanding, laying a solid foundation for subsequent goal-focused discussions. Moreover, the empirical research could contribute significantly to evidence-based research and knowledge sharing, leveraging diverse knowledge-intensive backgrounds, industry exposure and cultural contexts, with participants. This diversity not only enriches collaborative projects, but also stimulates global participants to consider the applicability of shared knowledge in their own environments, expanding the flow of knowledge in all directions. The study's implications underscore how institutions of higher learning can harness academic researchers to moderate stakeholder interactions, benefiting students, faculty members, and enhancing the effectiveness of regional collaborative projects. This academic involvement extends to industry partners, where engaging with institutions of higher learning as research hubs becomes a catalyst for developing sustainable solutions and overcoming inertia. Furthermore, governments can leverage academic research into PPPs to actively engage with stakeholders, fostering a deeper understanding of sustainability-related issues and facilitating the formulation of shared policy goals. In essence, the study showcases academic research as an indispensable contribution to successful PPPs, addressing strategic shortcomings and exemplifying the potential for transformative collaboration between academia, industry, and government, blending the theory-practice interface.

7.6.9 Record keeping for information management

Technology interventions, such as databases or information management systems, should be used in record-keeping, to keep a comprehensive record of participant details, commitments, and changes in employment status. In addition, a system for

regular updates of participant contact information could be established. This would ensure that changes are promptly recorded and accounted.

The objective of every healthcare facility is to deliver high-quality services to its patients. Nevertheless, ineffective data management obstructs the achievement of this objective and compromises the overall goal of providing quality services. Adane, Gizachew, Kendie (2019:67) suggested that a capable record-keeping system for patient information underscores that effective, high-quality health service delivery is dependent on communication and clinical-decision-making, and underpinned by active M&E.

Iyamu and Nunu (2021:3513) argued that, in South Africa, a substantial volume of healthcare data is present, but is dispersed across various facilities, leading to conscious and unconscious fragmentation. This fragmentation has resulted in the under-utilisation of data, negatively impacting community service delivery. Instances of incorrect diagnoses and the administration of inaccurate medication have occurred, due to duplicated prescriptions, influenced by a lack of real-time information. Public administration practices must ensure co-ordination and integration to avoid duplication and waste of resources. Furthermore, poor health service delivery has been linked to long waiting lists. Challenges with prolonged waiting times, or waiting lists for healthcare services, stemming from an imbalance between demand and resources, can impede timely access to care. By leveraging databases and prioritisation strategies, these approaches aim to restore the equilibrium between supply and demand in healthcare services through targeted interventions (Harding, Lewis, Dennett, et al., 2023:2).

7.6.10 Documentation of best practices at both institutional and individual level

Aligned with record-keeping, documentation of best practices at both institutional and individual level should be encouraged to ensure transparent and accurate recording of participant information and commitments. Allocating clear roles and responsibilities to stakeholders is essential. Human resource and administrative functions should be defined. This would allow for human resource capacity

challenges to be identified and would foster collaboration between the different role players.

Ten Ham-Baloyi, Minnie, van der Walt (2020:1487-88) defined a best practice as one that extends beyond evidence-based methods, embodying the standard for optimal quality care. It encompasses health practices, interventions, procedures or techniques, rooted in high-quality evidence with the aim of enhancing patient and health outcomes. However, the mere existence of evidence is insufficient for ensuring evidence-based decision-making. It rather necessitates the adoption and continual implementation of the evidence. Despite the global development of evidence-based products, such as 'best' practice guidelines or standards, the ongoing challenge lies in effectively implementing and integrating this evidence into everyday clinical practice and decision-making processes. Globally, and in South Africa, the implementation of 'best' practice faces challenges, due to difficulties in accessing and identifying the developed 'best' practices. In addition, contextual factors create barriers, hindering the adoption and implementation of best practices, leading to a lack of change in practices. To address this, a guide incorporating benefit levers can assist organisations or departments in developing an operational plan tailored to a specific context. It stands to reason that an operational plan, which is a component of a strategic plan, outlines practical steps for implementing actions and monitoring plans. It also specifies the human, financial and other resource requirements and outlines how to mobilise these resources. The use of such an operational plan has the potential to facilitate the successful rollout of best practices, ultimately improving patients' health outcomes, as well as the overall health service.

Overall, an identified limitation of the study was its modest sample size due to extraneous factors of the forum members having left for various tangible reasons, heightening the need for support of a strong base to address this crucial area of public health service delivery. The study has provided sufficient empirical evidence that this could be overcome by increasing efforts to recruit a more diverse pool of participants. In a larger study, suggested by the researcher, clear exit protocols need to be determined and applied. This would ultimately contribute to the continuity of institutional knowledge for more effective policy planning from a critical public health care perspective. Whilst the logic to this study was importantly embedded within and

integrated with qualitative interviews, what is proposed, is that a larger study be conducted through a mixed methods approach to increase the practical utility of a much-wider audience to the research. The Department of Health needs to have a better public health programme in place for eye health service delivery to back up the political action to make it happen more seamlessly to the local communities.

7.7 ASPECTS FOR FUTURE RESEARCH

It is hereby suggested that a longitudinal study, designed to observe the function and performance of a PPP in health service delivery, should be conducted over time. Such an approach could provide a more comprehensive understanding of the dynamics, and ensure a more sustainable approach.

A mapping assessment of PPPs for eye health should be conducted at provincial and national levels. This would provide more information on the number and types of PPPs available for eye health and the priority target areas they address. This would create an opportunity to establish a repository for eye health service interventions and best practices, to be able to address the challenges.

7.8 CONCLUDING REMARKS

Public health service delivery in South Africa is fraught with a myriad of challenges, primarily stemming from a fragmented administration system. At the heart of these issues, lies the critical matter of managing patient records and waiting lists, a labyrinthine system that complicates resource estimation, budgeting and healthcare planning. This fragmented approach adversely affects the delivery of essential services, particularly in the case of cataract surgeries, causing backlogs and a decline in the quality of life for patients in need. Here, the role of PPPs, for the public health sector in particular, emerges as a beacon of hope. It provides a vital avenue to alleviate the existing burden on the public healthcare system and could address cataract surgery backlogs. Through empirical evidence and secondary data on PPPs explored in this timely study, it is hoped that these partnerships could leverage the expertise and resources of both the public and private sectors. However, the success of PPPs hinges on one fundamental element: an efficient and comprehensive database system.

A robust database forms the foundation for precise planning, resource allocation and efficient service delivery. It connects key sectors, ensuring that patient information and healthcare needs are readily accessible, minimising under-planning and under-serving. Such an approach is of immense benefit for both the community and healthcare providers, offering targeted and efficient services where they are most needed.

The study highlighted the absence of standardised systems and uniform databases at primary care level as an impediment to the identification of vision and eye health challenges, contributing to disparities and hindering essential services like cataract surgeries. The absence of a streamlined database system restricts the measurement of service effectiveness and ostensibly obstructs the monitoring of patients from diagnosis to discharge. Addressing these limitations by establishing a well-structured database could significantly enhance the effectiveness of public-private collaborations, and ultimately assist in alleviating backlogs and improving the delivery of eye health services.

The South African public health system grapples with significant challenges, due to fragmented administration and disparate healthcare standards. Addressing these challenges through comprehensive databases and strengthening public-private partnerships is crucial to bridge the gap in service delivery, ensuring more equitable and effective healthcare for all communities. The study has revealed that there is a dire need to document public healthcare research to address reform mechanisms and deliver quality health services from a critical healthcare perspective. This study makes new contributions and recommends the standardisation of public-private eye health forums that would facilitate sustainable service delivery and improve the data collected, to positively shape the policy and programmes as long-term measures to achieve universal health outcomes; and in so doing, contribute to fulfilling the strategic intention of the National Development Plan and Sustainable Development Goals of 2030.

Bibliography

- Abera Abaerei, A., Ncayiyana, J., & Levin, J. (2017). Health-care utilization and associated factors in Gauteng province, South Africa. *Global health action*, 10(1), 1305765. <https://doi.org/10.1080/16549716.2017.1305765>
- Abdool, Z., Naidoo, K.S. and Visser, L., (2017). Stakeholders' perspectives on the management of diabetic retinopathy for a district health system–South Africa. *African Vision and Eye Health*, 76(1):1-7. <https://doi.org/10.4102/aveh.v76i1.41>
- Aboobaker S., Courtright P. (2016). Barriers to Cataract Surgery in Africa: A Systematic Review. *Middle East Afr J Ophthalmol*. 23(1):145-9. doi: 10.4103/0974-9233.164615. PMID: 26957856; PMCID: PMC4759895
- Abrahams, G.L. (2021). Transformational leadership in public primary health care. Unpublished Master of administration dissertation. Pretoria: Unisa.
- Abrahams, M. A. (2015). A review of the growth of monitoring and evaluation in South Africa: Monitoring and evaluation as a profession, an industry and a governance tool. *African Evaluation Journal*, 3(1): 1–8. <https://doi.org/10.4102/aej.v3i1.142>
- Ackers, B. (2011). The Auditor's Corporate Social Responsibility Assurance Role: A South African Perspective. University of South Africa, South Africa. https://www.academia.edu/3128130/The_auditors_CSR_assurance_role_a_South_African_perspective
- Adane, K., Gizachew, M., Kendie, S. (2019). The role of medical data in efficient patient care delivery: a review. *Risk Manag Healthc Policy*. 12:67-73. doi: 10.2147/RMHP.S179259. PMID: 31114410; PMCID: PMC6486797.
- African National Congress. (1994). A National Health Plan for South Africa, Policy documents. <https://www.anc1912.org.za/policy-documents-1994-a-national-health-plan-for-south-africa/>
- Ager, A. K., Lembani, M., Mohammed, A., Mohammed Ashir, G., Abdulwahab, A., de Pinho, H., Delobelle, P., & Zarowsky, C. (2015). Health service resilience in Yobe state, Nigeria in the context of the Boko Haram insurgency: a systems dynamics analysis

- using group model building. *Conflict and health*, 9, 30.
<https://doi.org/10.1186/s13031-015-0056-3>
- Ahmad, N., Ullah, Z., Ryu, H. B., Ariza-Montes, A., & Han, H. (2023). From Corporate Social Responsibility to Employee Well-Being: Navigating the Pathway to Sustainable Healthcare. *Psychology research and behavior management*, 16, 1079–1095.
<https://doi.org/10.2147/PRBM.S398586>
- Ahmat, A., Okoroafor, S. C., Kazanga, I., Asamani, J. A., Millogo, J. J. S., Illou, M. M. A., Mwinga, K., & Nyoni, J. (2022). The health workforce status in the WHO African Region: findings of a cross-sectional study. *BMJ global health*, 7(Suppl 1), e008317.
<https://doi.org/10.1136/bmjgh-2021-008317>
- Ahmed, T., Rahman, A.E., Amole, T.G. et al. (2021). The effect of COVID-19 on maternal newborn and child health (MNCH) services in Bangladesh, Nigeria and South Africa: call for a contextualised pandemic response in LMICs. *Int J Equity Health* 20, 77.
<https://doi.org/10.1186/s12939-021-01414-5>
- Akindele, S. T. (1994). Public Administration: A critical revisitational analysis of the paradigm of politics-administration dichotomy and its challenge. *Philippine Journal of Public Administration*. 38 (4):295-312.
- Akuffo, K. O., Sewpaul, R., Dukhi, N., Asare, A. K., Kumah, D. B., Addo, E. K., Agyei-Manu, E., & Reddy, P. (2020). Eye care utilization pattern in South Africa: results from SANHANES-1. *BMC health services research*, 20(1), 756.
<https://doi.org/10.1186/s12913-020-05621-8>
- Alderwick, H., Hutchings, A., Briggs, A., Mays, N. (2021). The impacts of collaboration between local health care and non-health care organizations and factors shaping how they work: a systematic review of reviews. *BMC Public Health* 21, 753.
doi.org/10.1186/s12889-021-10630-1
- Alford, J., and Hughes, O. (2008). Public value pragmatism as the next phase of public management. *The American Review of Public Administration*. 38(2):130-148.
- Alvi, M. (2016). A Manual for Selecting Sampling Techniques in Research. University of Karachi, Iqra University <https://mpa.ub.uni-muenchen.de/70218/>

- Ambersari, R., Soehodho, S., Sumabrata, R.J. (2021). Conceptual Framework for a Decision-Making Model to Select the Public-Private Partnership (PPP) Structure for Urban Rail Transit in Jakarta. Proceedings of the 6th International Conference on Civil Structural and Transportation Engineering (ICCSTE'21)
- Andrews, R. and Entwistle, T., (2015). Public-private partnerships, management capacity and public service efficiency. *Policy & Politics*, 43(2):273-290.
- Aravind Institute. 2021. Available at: <https://aravind.org/our-story>. [Accessed on 20 August 2021].
- Archibong, U., & Adejumo, O. (2013). Affirmative Action in South Africa are we creating new casualties?. *Journal of Psychological issues in organizational culture*, 3(1), 14-27.
- Asante, A., Price, J., Hayen, A., Jan, S., & Wiseman, V. (2016). Equity in Health Care Financing in Low- and Middle-Income Countries: A Systematic Review of Evidence from Studies Using Benefit and Financing Incidence Analyses. *PloS one*, 11(4), e0152866. <https://doi.org/10.1371/journal.pone.0152866>
- Asasira, J., Ahimbisibwe, F. (2019). Public-Private Partnership in Health Care and Its Impact on Health Outcomes: Evidence from Ruharo Mission Hospital in South Western Uganda. Available at SSRN: <https://ssrn.com/abstract=3450562> or <http://dx.doi.org/10.2139/ssrn.3450562>
- Auriacombe, CJ and Schurink, E. 2012. Conceptualising qualitative research through a spiral of meaning-making. *Administratio Publica*. 20(3): 144-169.
- Babbie, E., and Mouton. J. (2006). The practice of social research (South African Edition). Cape Town: Oxford University Press Southern Africa.
- Babu, B.S.G., Ravilla, T.D.(2018). Evidence-based management of eye care delivery. *Community Eye Health*. 31(102):S15-S16. PMID: 30220820; PMCID: PMC6134464.
- Baker, D. L., Miller, A. A., & Bratton, T. (2015). E's are good: Standards of quality in public administration as reflected in discourse on Canadian public policy design. *Teaching Public Administration*. 33(2):130-151.
- Baker and van der Gaag. (1993). Equity in the finance and healthcare: Evidence from five developing countries. London: Oxford University Press.

- Baker, P. A. (2010). From apartheid to neoliberalism: Health equity in post-apartheid South Africa. *International Journal of Health Services*, 40(1):79-95.
- Balabanova, D., McKee, M., Mills, A., Walt, G., Haines, A. (2010). What can global health institutions do to help strengthen health systems in low-income countries? *Health Res Policy Sys*, 8,22
- Balt, K.D. (2015). A METHODOLOGY FOR IMPLEMENTING THE ANALYTICAL HIERARCHY PROCESS TO DECISION-MAKING IN MINING. Masters study research report. University of the Witwatersrand, South Africa.
- Barnes, J. (2011). Designing Public-Private Partnerships in Health. Abt Associates Inc. USAID, America
- Barron, P. & Padarath, A. (2017). *Twenty years of the South African Health Review*, South African Health Review 2017, Health Systems Trust, Durban. 2017(1):1-7.
- Basabih, M., Prasojo, E., & Rahayu, A. Y. S. (2022). Hospital services under public-private partnerships, outcomes and, challenges: A literature review. *Journal of public health research*, 11(3), 22799036221115781. <https://doi.org/10.1177/22799036221115781>
- Bechange, S., Jolley, E., Virendrakumar, B., Pente, V., Milgate, J., & Schmidt, E. (2020). Strengths and weaknesses of eye care services in sub-Saharan Africa: a meta-synthesis of eye health system assessments. *BMC health services research*, 20(1), 381. <https://doi.org/10.1186/s12913-020-05279-2>
- Bekele, W., & Ago, F. (2022). Sample Size for Interview in Qualitative Research in Social Sciences: A Guide to Novice Researchers. *Research in Educational Policy and Management*, 4(1), 42-50. <https://doi.org/10.46303/repam.2022.3>
- Benatar S. R. (2013). The challenges of health disparities in South Africa. *South African medical journal = Suid-Afrikaanse tydskrif vir geneeskunde*, 103(3), 154–155. <https://doi.org/10.7196/samj.6622>
- Binagwaho, A., Scott, K., Rosewall, T., Mackenzie, G., Rehnborg, G., Hannema, S., Presente, M., Noe, P., Mathenge, W., Nkurikiye, J., Habiaremye, F., & Dushime, T. (2015). Improving eye care in Rwanda. *Bulletin of the World Health Organization*, 93(6), 429–434. <https://doi.org/10.2471/BLT.14.143149>

- Bingham, L.B., Nabatchi, T. and O'Leary, R. (2005), The New Governance: Practices and Processes for Stakeholder and Citizen Participation in the Work of Government. *Public Administration Review*, 65: 547-558. <https://doi.org/10.1111/j.1540-6210.2005.00482.x>
- Blumberg, B., Cooper, D.R. and Schindler, P.S. (2005). *Business Research Methods*. McGraw-Hill, Maidenhead.
- Bohman, J. (1996). *Public Deliberation: Pluralism, Complexity and Democracy*. Cambridge, MA: MIT Press.
- Bojović Ž, Klipa Đ, Bojović PD, Jovanović IM, Šuh J, Šenk V. Interconnected Government Services: An Approach toward Smart Government. *Applied Sciences*. 2023; 13(2). <https://doi.org/10.3390/app13021062>
- Borrel, A., Dabideen, R., Mekonen, Y. and Overland, L. (2013). Child eye health in Africa: The status and way forward. *African Child Policy Forum*. Cape Town: ORBIS Africa.
- Boru, T. (2018). Chapter Five Research Design and Methodology. University of South Africa
- Boston, J., Martin, J., Pallot, J., and Walsh, P. (1996). *Public management: The New Zealand Model*. London: Oxford University Press.
- Bouey, J. Z. H., Han, J., Liu, Y., Vuckovic, M., Zhu, K., Zhou, K., & Su, Y. (2023). A case study of HIV/AIDS services from community-based organizations during COVID-19 lockdown in China. *BMC health services research*, 23(1), 288. <https://doi.org/10.1186/s12913-023-09271-4>
- Bourne, R.R.A., Flaxman, S.R., Braithwaite, T., Cicinelli, M.V., Das, A., Jonas, J.B., Keeffe, J., Kempen J.H., Leasher, J., Limburg, H., Naidoo, K., Pesudovs, K., Resnikoff, S., Silvester, A., Stevens, G.A., Tahhan, N., Wong, T.Y., Taylor, H.R. (2017). Vision Loss Expert Group. Magnitude, temporal trends, and projections of the global prevalence of blindness and distance and near vision impairment: a systematic review and meta-analysis. *Lancet Glob Health*. 5(9):e888-e897. doi: 10.1016/S2214-109X(17)30293-0. Epub 2017 Aug 2. PMID: 28779882.
- Bourne, R., Steinmetz, J. D., Flaxman, S., Briant, P. S., Taylor, H. R., Resnikoff, S., Tareque, M. I. et al. (2021). Trends in prevalence of blindness and distance and near

- vision impairment over 30 years: an analysis for the Global Burden of Disease Study. *The Lancet global health*, 9(2):e130-e143.
- Bovaird, T. (2006), Developing New Forms of Partnership With the 'Market' in the Procurement of Public Services. *Public Administration*, 84: 81-102. <https://doi.org/10.1111/j.0033-3298.2006.00494.x>
- Bowling, A., Rowe, G., Lambert, N., Waddington, M., Mahtani, K. R., Kenten, C., Howe, A., & Francis, S. A. (2012). The measurement of patients' expectations for health care: a review and psychometric testing of a measure of patients' expectations. *Health technology assessment (Winchester, England)*, 16(30), i-509. <https://doi.org/10.3310/hta16300>
- Bozeman, B. (2007). *Public values and public interest: Counterbalancing economic individualism*. Washington, DC: Georgetown University Press.
- Braun, V., and Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, 3(2):77-101.
- Brauns, M. and Stanton, A. (2016). Governance of the public health sector during Apartheid: The case of South Africa. *Journal of Governance and Regulation/Volume*, 5(1):23-30.
- Braveman P. A. (2003). Monitoring equity in health and healthcare: a conceptual framework. *Journal of health, population, and nutrition*, 21(3), 181-192.
- Brett, B. M., and Wheeler, K. (2021). *How to do qualitative interviewing*. London: Sage.
- Brien Holden Vision Institute. (2021). Available at: <https://bhvi.org>. [Accessed on 20 August 2021].
- Brien Holden Vision Institute Foundation. (2006). Situational analysis on refractive error and low vision services in east, central and southern Africa, unpublished paper.
- Brien Holden Vision Institute. (2014). Academic Vision Centre handed over in Malawi. [Online]. Available from - <http://www.brienholdenvision.org/media-centre/latest-news/803-academic-visioncentre-handed-over-in-malawi.html>. [Accessed on 12 June 2020].

- Brink, H., Van der Walt, C Van Rensburg, G. (2016). *Fundamentals of Research Methodology for Healthcare Professionals*. Juta.
- Brinkerhoff DW, Bossert TJ. (2014). Health governance: principal-agent linkages and health system strengthening. *Health Policy and Planning* 29: 685–93.
- Brinkerhoff, D.W. and Bossert, T.J. (2014). Health Governance: Concepts, Experience and Programming Options. Health Systems 2020 Policy Brief. Health Systems 2020.
- Brinkerhoff, D.W. and Brinkerhoff, J.M. (2011), Public–private partnerships: Perspectives on purposes, publicness, and good governance. *Public Admin. Dev.*, 31: 2-14. <https://doi.org/10.1002/pad.584>
- Brinkmann, S., and Kvale, S. (2018). *Doing interviews* (Vol. 2). Sage.
- Brown, T. A. (2006). *Confirmatory Factor Analysis for Applied Research*. The Guilford Press: New York.
- Brynard, P, De Coning, C. (2006). Policy Implementation. In Cloete, F., Wissink H. & de Coning, C. (eds.) *Improving public policy*, Pretoria: Van Schaik Publishers.
- Bunniss, S., & Kelly, D. R. (2010). Research paradigms in medical education research. *Medical education*, 44(4), 358–366. <https://doi.org/10.1111/j.1365-2923.2009.03611.x>
- Burger, R.W. (2015). Integrated Metropolitan Environmental Policy of the City of Cape Town: An Implementation Evaluation. Unpublished Master's Thesis. Stellenbosch: University of Stellenbosch.
- Burton, M. J., Ramke, J., Marques, A. P., Bourne, R. R. A., Congdon, N., Jones, I., Ah Tong, B. A. M., Arunga, S., Bachani, D., Bascaran, C., Bastawrous, A., Blanchet, K., Braithwaite, T., Buchan, J. C., Cairns, J., Cama, A., Chagunda, M., Chuluunkhuu, C., Cooper, A., Crofts-Lawrence, J., ... Faal, H. B. (2021). The Lancet Global Health Commission on Global Eye Health: vision beyond 2020. *The Lancet. Global health*, 9(4), e489–e551. [https://doi.org/10.1016/S2214-109X\(20\)30488-5](https://doi.org/10.1016/S2214-109X(20)30488-5)
- Busetto, L., Wick, W., & Gumbinger, C. (2020). How to use and assess qualitative research methods. *Neurological research and practice*, 2, 14. <https://doi.org/10.1186/s42466-020-00059-z>

- Buthelezi, L., & van Staden, D. (2020). Integrating eye health into policy: Evidence for health systems strengthening in KwaZulu-Natal. *African Vision and Eye Health*, 79(1), 10 pages. doi:<https://doi.org/10.4102/aveh.v79i1.549>
- Caballer-Tarazona, M., Clemente-Collado, A., & Vivas-Consuelo, D. (2016). A cost and performance comparison of Public Private Partnership and public hospitals in Spain. *Health economics review*, 6(1), 17. <https://doi.org/10.1186/s13561-016-0095-5>
- Carzis, B., Wainstein, T., Gobetz, L., & Krause, A. (2019). Review of 10 years of preimplantation genetic diagnosis in South Africa: implications for a low-to-middle-income country. *Journal of assisted reproduction and genetics*, 36(9), 1909–1916. <https://doi.org/10.1007/s10815-019-01537-3>
- Casteel, A., and Bridier, N. L. (2021). Describing populations and samples in doctoral student research. *International Journal of Doctoral Studies*, 16(1):339-362.
- Chassin, M. R., & Loeb, J. M. (2013). High-reliability health care: Getting there from here. *The Milbank Quarterly*, 91(3):459-90. doi: 10.1111/1468-0009.12023. PMID: 24028696; PMCID: PMC3790522.
- Chopra, M., Sharkey, A., Dalmiya, N., Anthony, D., Binkin, N., & UNICEF Equity in Child Survival, Health and Nutrition Analysis Team (2012). Strategies to improve health coverage and narrow the equity gap in child survival, health, and nutrition. *Lancet (London, England)*, 380(9850), 1331–1340. [https://doi.org/10.1016/S0140-6736\(12\)61423-8](https://doi.org/10.1016/S0140-6736(12)61423-8)
- Christensen, L. B., Johnson, B. R., & Turner, L. A. (2015). *Research Methods, Design and Analysis* (12th ed.). Pearson Inc.
- Clark, T., Foster, L., Bryman, A., and Sloan, L. (2021). *Bryman's social research methods*. Oxford University press.
- Cloete, F., de Coning, C., Wissink, H. and Rabie, B. (2018). *Improving Public policy: good governance*. 4th edition. Pretoria: Van Schaik Publishers.
- Cockerham, W. (1992). *Medical Sociology*. USA: Prentice Hall, Englewood Cliffs, NJ

- Couper, I. and Hugo, J. (2002). Management of District Hospitals: Suggested Elements for Improvement. Health Systems Trust. Durban. Available at: <http://www.hst.org.za/publications/511> [Accessed on 22 August 2021].
- Courtright P., Mathenge W., Kello AB., Cook C., Kalua K., Lewallen S. (2016). Setting targets for human resources for eye health in sub-Saharan Africa: what evidence should be used? *Human Resources for Health*, 14:11, DOI 10.1186/s12960-016-0107
- Creswell, J. W. (2013). Educational research: *Planning, conducting, and evaluating*. 4th ed. W. Ross MacDonald School Resource Services Library.
- Creswell, J. W., Hanson, W. E., Clark Plano, V. L., & Morales, A. (2007). Qualitative Research Designs: Selection and Implementation. *The Counseling Psychologist*, 35(2), 236-264. <https://doi.org/10.1177/0011000006287390>
- Creswell, J., and Plano Clark, V. (2007). Designing and Conducting Mixed Methods Research. Thousand Oaks, CA: Sage.
- Crotty, M. J. (1998). The foundations of social research: Meaning and perspective in the research process. *The Foundations of Social Research*.
- Crowe, S., Cresswell, K., Robertson, A., Huby, G., Avery, A., & Sheikh, A. (2011). The case study approach. *BMC medical research methodology*, 11, 100. <https://doi.org/10.1186/1471-2288-11-100>
- Cruz, C.O. and Marques, R.C. (2011). Revisiting the Portuguese experience with public-private partnerships. *African Journal of Business Management*, 5(11):4023-4032.
- CSDH. (2008). Closing the gap in a generation Health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/43943/9789241563703_eng.pdf;jsessionid=417DA9D8ECB0E19120F7AC02DC59100E?sequence=1
- De Schepper, S. et al. (2014). Stakeholder dynamics and responsibilities in Public–Private Partnerships: A mixed experience, *Int. J. Proj.Manag.* <http://dx.doi.org/10.1016/j.ijproman.2014.01>.

- Dennill, K., King, L. & Swanepoel, T. (1999). Aspects of primary health care: Community health care in South Africa (2nd ed). Cape Town: Oxford University Press Southern Africa.
- Department of Performance Management and Evaluation. (2014). *Terms of Reference for Implementation of Forums*. South Africa: The Presidency.
- Dobrowolska, B., Ślusarska, B., Zarzycka, D., McGonagle, I., Pawlikowski, J., and Cuber, T. (2014). Care concept in medical and nursing students' descriptions Philosophical approach and implications for medical education. *Ann Agric Environ Med*, 21(4):854-860.
- DoH-KZN. (2018). *uMgungundlovu District Health Plan 2018/19 - 2020/21*. Retrieved from [http://www.health.gov.za/DHP/docs/DHP201821/kwazulu Natal/Umgungundlovu_DHP_18.19.pdf](http://www.health.gov.za/DHP/docs/DHP201821/kwazulu_Natal/Umgungundlovu_DHP_18.19.pdf)
- DoH-KZN. (2019). Umgungundlovu Health District. Retrieved December 5, 2019, from <http://www.kznhealth.gov.za/umgungundlovu.htm>
- Dul, J., and Hak, T. (2008). Case study methodology in business research. Abingdon, England: Routledge.
- Dunjwa, M. (2016). *Public health facilities audit results: Office of Health Standards Compliance (OHSC) briefing*, Parliamentary Monitoring group, Pretoria, South Africa.
- du Toit, R., Faal, H. B., Etya'ale, D., Wiafe, B., Mason, I., Graham, R., Bush, S., Mathenge, W., & Courtright, P. (2013). Evidence for integrating eye health into primary health care in Africa: a health systems strengthening approach. *BMC health services research*, 13, 102. <https://doi.org/10.1186/1472-6963-13-102>
- Dyer, G. (2006). *Planning for VISION 2020 at the District Level*. 1–122. Retrieved from https://www.iapb.org/wp-content/uploads/Planning-for-VISION-2020-at-the-District-Level_A-Manual.pdf
- Eftimi, A., Sugden, C. (2019). A Guide to Community Engagement for Public-Private Partnerships. Draft for discussion. chrome-extension://efaidnbmninnibpcapjpcglclefindmkaj/https://www.commddev.org/wp-content/uploads/2019/06/PPP-Community-Engagement-Guide_FIN-for-WEB-1.pdf

- Elhami, A., and Khoshnevisan, B. (2022). Conducting an interview in qualitative research: The Modus Operandi. *MEXTESOL Journal*, 46(1):1-7.
- Erasmus, D., Ranchod, S., Abraham, M., Carvounes, A., & Dreyer, K. (2016). *Challenges and opportunities for health finance in South Africa: a supply and regulatory perspective*. FinMark Trust: Johannesburg.
- Etikan, I., Musa, S.A., Alkassim, R.S. (2016). Comparison of Convenience Sampling and Purposive Sampling. *American Journal of Theoretical and Applied Statistics*. Vol. 5, No. 1.1-4. doi: 10.11648/j.ajtas.20160501.11
- Faal, H., & Gilbert, C. (2007). Convincing governments to act: VISION 2020 and the Millennium Development Goals. *Community eye health*, 20(64), 62–64.
- Farlam, P. (2005). Assessing Public-Private Partnerships in Africa. The South African Institute for International Affairs.
- Farrell, C; Hatcher, W and Diamond, J. 2022. Reflecting on over 100 years in public administration education. *Public Administration*. 100(1): 116-128. <https://doi.org/10.1111/padm.12808>
- Fombad, M. (2013). Accountability challenges in public-private partnerships from a South African perspective. *African Journal of Business Ethics*, 7(1):11-19 <https://doi.org/10.4103/1817-7417.119954>
- Fombad, M. (2013). An Overview of Accountability Mechanisms in Public - Private Partnerships in South Africa. *Ufahamu: A Journal of African Studies*, 37(1). <http://dx.doi.org/10.5070/F7371013947> Retrieved from <https://escholarship.org/uc/item/18j0h3ng>
- Forrest, S.L., Mercado, C.L, Engmann, C.M., Stacey, H., Cambera, K. (2023). Does the current global health agenda lack vision? *Glob Health Sci Pract*. 11(1):e2200091. doi: 10.9745/GHSP-D-22-00091. PMID: 36853641; PMCID: PMC9972379 <https://doi.org/10.9745/GHSP-D-22-00091>
- Foster, K. E. (2005). Clinics, Communities, and Cost Recovery: Primary Health Care and Neoliberalism in Postapartheid South Africa. *Cultural Dynamics*, 17(3), 239-266. <https://doi.org/10.1177/0921374005061990>

- Fricke, T. R., Tahhan, N., Resnikoff, S., Papas, E., Burnett, A., Ho, S. M., Naduvilath, T., & Naidoo, K. S. (2018). Global Prevalence of Presbyopia and Vision Impairment from Uncorrected Presbyopia: Systematic Review, Meta-analysis, and Modelling. *Ophthalmology*, 125(10), 1492–1499. <https://doi.org/10.1016/j.ophtha.2018.04.013>
- Friedman, J. (2011). Sticking to the numbers: Performance Monitoring in South Africa 2009-2011, Innovations for successful Societies. Princeton University. <http://successfulsocieties.princeton.edu/>
- Fusch, P., & Ness, L. (2015). Are We There Yet? Data Saturation in Qualitative Research. Qualitative Report, 20, 1408-1416. <https://nsuworks.nova.edu/tqr/vol20/iss9/3>
- Fusheini, A. , Eyles, J. and Goudge, J. (2016) The Social Determinants of Health and the Role of the Health Care System: A Case Study of the Significance of Good Governance in Public Hospitals in South Africa. *Health*, 8, 1288-1306. doi: [10.4236/health.2016.812131](https://doi.org/10.4236/health.2016.812131).
- Gale, N. K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC medical research methodology*, 13, 117. <https://doi.org/10.1186/1471-2288-13-117>
- Gatticchi, G. (2022). SA medical negligence claims top R536bn in seven years. The Outlier, South Africa, 18 August. Available at <https://www.theoutlier.co.za/health/undefined/83198-/sa-medical-negligence-claims-top-r536bn-in-seven-years> Accessed: November 9, 2023
- Gilbert, C., & Foster, A. (2001). Blindness in children: control priorities and research opportunities. *The British journal of ophthalmology*, 85(9), 1025–1027. <https://doi.org/10.1136/bjo.85.9.1025>
- Give, C., Ndimba, S., Steege, R. *et al.* (2019). Strengthening referral systems in community health programs: a qualitative study in two rural districts of Maputo Province, Mozambique. *BMC Health Serv Res* 19, 263. <https://doi.org/10.1186/s12913-019-4076-3>

- Global data on visual impairments. (2010). Geneva: World Health Organization; 2012. Available from: <http://www.who.int/blindness/GLOBALDATAFINALforweb.pdf> [cited 2020 May 04].
- Goi, H.C., Hakeem, M.M., Frendy. (2022). Bridging Academics' Roles in Knowledge Diffusion in Sustainability-Driven Public–Private Partnerships: A Case Study of the SDGs Workshop in Central Japan. *Sustainability*, 14, 2378. <https://doi.org/10.3390/su14042378>
- Govender, J., and Reddy, P.S. (2015). A review of local government experience in South Africa. *Africa Journal of Public Affairs*. 8 (4):12-25.
- Graham R. (2017). Facing the crisis in human resources for eye health in sub-Saharan Africa. *Community eye health*, 30(100), 85–87.
- Grant, B. (2014). *Leadership and the Politics-Administration Dichotomy: A Comparative Study of Political Influences in Four Florida State Agencies* (Doctoral dissertation, The Florida State University).
- Gray, A. and Vawda, Y. (2018). Health legislation and policy. *South African health review*. Health Systems Trust: Durban
- Gray, D.E. (2018). *Doing research in the real world*, 4th ed. London: Sage
- Guba, E. G., and Lincoln, Y. S. (1994). Competing paradigms in qualitative research. *Handbook of Qualitative Research*, 2(163-194).
- Hadebe, B. (2022). Enabling affordable access to quality healthcare through digital transformation. Online article. <https://www.bcx.co.za/industry-insights/enabling-affordable-access-to-quality-healthcare-through-digital-transformation/>
- Haileamlak, A. (2021). The impact of COVID-19 on health and health systems. *Ethiopian journal of health sciences*, 31(6), 1073–1074. <https://doi.org/10.4314/ejhs.v31i6.1>
- Harding, K. E., Lewis, A. K., Dennett, A., Hughes, K., Clarke, M., & Taylor, N. F. (2023). An evidence-based demand management strategy using a hub and spoke training model reduces waiting time for children's therapy services: An implementation trial. *Child: Care, Health and Development*, 1–10. <https://doi.org/10.1111/cch.13154>

- Hassan, B., Ahmed, R., Li, B., Noor, A., & Hassan, Z. U. (2019). A comprehensive study capturing vision loss burden in Pakistan (1990-2025): Findings from the Global Burden of Disease (GBD) 2017 study. *PloS one*, 14(5), e0216492. <https://doi.org/10.1371/journal.pone.0216492>
- Hassan, Z. A., Schattner, P., & Mazza, D. (2006). Doing A Pilot Study: Why Is It Essential? *Malaysian Family Physician: The Official Journal of the Academy of Family Physicians of Malaysia*, 1(2–3). Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/27570591>
- Health Professions Council of South Africa. (2007). Act 56 of 1974(No R.280,Government Gazette (No.29748 7). Pretoria, South Africa.
- Health Professions Council of South Africa. <http://www.hpcsa.co.za/Publications/Statistics>
- Hennink, M., & Kaiser, B. N. (2022). Sample sizes for saturation in qualitative research: A systematic review of empirical tests. *Social science & medicine (1982)*, 292, 114523. <https://doi.org/10.1016/j.socscimed.2021.114523>
- Hesse-Biber, S. N. (2017). The practice of qualitative research. 3rd ed. Thousand Oaks: Sage.
- Heywood, M. (2014). *The broken thread: Primary health care, social justice and the dignity of the health worker*, 2014 edn., Wits Political Studies Department, Pretoria.
- Holecki, T., Romaniuk, P., Woźniak-Holecka, J., Szromek, A. R., & Syrkiewicz-Świła, M. (2018). Mapping Health Needs to Support Health System Management in Poland. *Frontiers in public health*, 6, 82. <https://doi.org/10.3389/fpubh.2018.00082>
- Holzer, M., & Newbold, S. P. (2020). A call for action: Public administration, public policy, and public health responses to the COVID-19 pandemic. *The American Review of Public Administration*, 50(6-7).
- Hood, C. (1991), A PUBLIC MANAGEMENT FOR ALL SEASONS?. *Public Administration*, 69: 3-19. <https://doi.org/10.1111/j.1467-9299.1991.tb00779.x>
- Houria, Z.B., Masmoudi, M., Al Hanbali, A., Ikram, K. et al. (2017). Quantitative techniques for medical equipment maintenance management. *European J of Industrial Engineering*.

- IAPB. (2023). Vision Atlas. International Agency for Prevention of Blindness: London
<https://www.iapb.org/learn/vision-atlas/magnitude-and-projections/projected-change/>
 (Accessed 6/11/2023)
- IAPB. (2014). IAPB AFRICA HUMAN RESOURCES FOR EYE HEALTH STRATEGIC PLAN 2014-2023. Vision for Africa Phase 1 – 2014-2018.
<https://www.iapb.org/learn/resources/iapb-africa-human-resources-for-eye-health-strategic-plan-2014-2023/>
- Ibrahim, A. (2012). Is New Public Management Irrelevant to Developing Countries? Available at
<http://www.e-ir.info/2012/10/19/is-new-public-management-irrelevant-to-developing-countries>
- Igbokwe-Ibeto, C. (2019). African bureaucracy and public administration: Analysing the normative impediments and prospects. *Africa's Public Service Delivery & Performance Review*, 7(1), 11 pages. doi:<https://doi.org/10.4102/apsdpr.v7i1.323>
- Interq. (2023). What is data saturation in qualitative research? Available at: <https://interq-research.com/what-is-data-saturation-in-qualitative-research/>. (accessed 16 October 2023).
- Isett K. R., Provan K. G. (2005). The evolution of dyadic interorganizational relationships in a network of publicly funded nonprofit agencies. *Journal of Public Administration Research and Theory*, 15(1), 149–165.
- Iwegbuna, I. & Iwegbuna, I. (2018). IMPACT OF URBANIZATION ON ENVIRONMENTAL HEALTH QUALITY OF GWAGWALADA TOWN, ABUJA, NIGERIA. *Afribary*. Retrieved from <https://afribary.com/works/impact-of-urbanization-on-environmental-health-quality-of-gwagwalada-town-abuja-nigeria-main-project-chapters-1-2-3-4-and-5>
- Iyamu, T., Nunu, K. (2021). Healthcare data management conceptual framework for service delivery. *Educ Inf Technol* **26**, 3513–3527. <https://doi.org/10.1007/s10639-020-10413-y>
- Jaakkola, E. (2020). Designing conceptual articles: Four approaches. *AMS review*, 10:18-26.

- Jaggernath, J., Overland, L., et al. (2014). Poverty and Eye Health. *Health* 6:1849-1860
Published Online July 2014 in SciRes. <http://www.scirp.org/journal/health>
<http://dx.doi.org/10.4236/health.2014.614217>
- Jarvis, T., Scott, F., El-Jardali, F. et al. (2020). Defining and classifying public health systems: a critical interpretive synthesis. *Health Res Policy Sys* **18**, 68.
<https://doi.org/10.1186/s12961-020-00583-z>
- Jolley, E., Mafwiri, M., Hunter, J., & Schmidt, E. (2017). Integration of eye health into primary care services in Tanzania: A qualitative investigation of experiences in two districts. *BMC Health Services Research* **17**,823. <https://doi.org/10.1186/s12913-017-2787-x>
- Jørgensen, T. B., & Bozeman, B. (2007). Public Values: An Inventory. *Administration & Society*. 39(3):354-381.
- Kabir, S. M. S. (2016). Methods of data collection basic guidelines for research: An introductory approach for all disciplines (first ed:201-275). Bangladesh: Book Zone Publication.
- Kama, Z. S. (2017). *An evaluation of access to health care: Gugulethu Community Health Clinic*. Unpublished Doctoral thesis. Cape Town: Cape Peninsula University of Technology.
- Kampira, A. (2021). A brief introduction to thematic analysis. Afregarde Research. Online Resource, available at https://www.researchgate.net/publication/351051073_A_Brief_Introduction_to_Thematic_Analysis
- Karumanchi, S. M., & Ravilla, T. (2014). Increasing sustainable cataract services in sub-Saharan Africa: an experimental initiative. *Community Eye Health*, 27(88):73-4. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/26113777>
- Katuu, S. (2018). Healthcare systems: Typologies, framework models, and South Africa's health sector. *International Journal of Health Governance*, 23(2):134-48.
- Keel, S., & Cieza, A. (2022). Universal eye health coverage: from global policy to country action. *International health*, 14(Suppl 1), i3–i5.
<https://doi.org/10.1093/inthealth/ihab063>

- Kelly, J., Dwyer, J., Willis, E., & Pekarsky, B. (2014). Travelling to the city for hospital care: access factors in country Aboriginal patient journeys. *The Australian journal of rural health*, 22(3), 109–113. <https://doi.org/10.1111/ajr.12094>
- Kenneth, A. B.; Lakhawat, P.S., and Agymen, C.M. (2017). The Impact of Managerial 5C's on Efficient Hospital Administration (EHA) in providing quality care to patients. *Saudi Journal of Business and Management Studies*. 2 (Iss-5A):513-520.
- Kgasi, K.M. (2022). A multi-dimensional framework for implementing health system reform in South Africa. Unpublish Doctoral Thesis. School of Business Leadership: University of South Africa
- Khanna RC, Marmamula S, Rao GN. (2017). International Vision Care: Issues and Approaches. *Annu Rev Vis Sci*. 15;3:53-68. doi: 10.1146/annurev-vision-102016-061407. PMID: 28937949
- Khoza, L.B., Nunu, W.N., Ndou, N.D., Makgopa, J., Ramakuela, N.G., Manganye, B.S., Tshivhase, S.E, Mambanga, P., Mutwira, T.S. (2020). Barriers related to the provision of cataract surgery and care in Limpopo province, South Africa: Professional ophthalmic service providers' perspective https://www.researchgate.net/publication/342879600_Barriers_related_to_the_provision_of_cataract_surgery_and_care_in_Limpopo_province_South_Africa_Professional_ophthalmic_service_providers'_perspective#fullTextFileContent [accessed Nov 13 2023].
- Kivunja, C., and Kuyini, A. B. (2017). Understanding and applying research paradigms in educational contexts. *International Journal of Higher Education*, 6(5)26-41.
- Klinton, J. (2020). The Private Health Sector: An Operational Definition. Geneva.
- Kocur, I., & Resnikoff, S. (2002). Visual impairment and blindness in Europe and their prevention. *The British journal of ophthalmology*, 86(7), 716–722. <https://doi.org/10.1136/bjo.86.7.716>
- Koelble, T. A., and Siddle, A. (2014). Institutional complexity and unanticipated consequences: The failure of decentralization in South Africa. *Democratization*, 21(6):1117-1133. <http://doi.org/10.1080/13510347.2013.784270>

- Kollapen, J.J., Carnelly, M., Jaichand, V. & Lawrence, M.I. (2017). Issue Paper 33, Project 141, Medico -Legal Claims, 20 May 2017 edn. 1-62. South African Law Reform Commission, Cape Town.
- Kruk, M. E., Gage, A. D., Arsenault, C., Jordan, K., Leslie, H. H., Roder-DeWan, S., Adeyi, O., Barker, P., Daelmans, B., Doubova, S. V., English, M., García-Elorrio, E., Guanais, F., Gureje, O., Hirschhorn, L. R., Jiang, L., Kelley, E., Lemango, E. T., Liljestrand, J., Malata, A., ... Pate, M. (2018). High-quality health systems in the Sustainable Development Goals era: time for a revolution. *The Lancet. Global health*, 6(11), e1196–e1252. [https://doi.org/10.1016/S2214-109X\(18\)30386-3](https://doi.org/10.1016/S2214-109X(18)30386-3)
- Kula, N., & Fryatt, R. J. (2014). Public-private interactions on health in South Africa: opportunities for scaling up. *Health policy and planning*, 29(5), 560–569. <https://doi.org/10.1093/heapol/czt042>
- Kumpunen, S. (2020). Using the logic models for evaluating innovations in health care. Nuffield Trust. Available at: <https://www.nuffieldtrust.org.uk/news-item/using-logic-models-for-evaluating-innovations-in-healthcare#when-should-evaluations-use-a-logic-model>. [Accessed on 22 August 2021].
- Kusak, J. Z., & Rist, R. C. (2001). Building a performance-based monitoring and evaluation system: The challenges facing developing countries. *Evaluation Journal of Australasia*, 1(2), 14-23. <https://doi.org/10.1177/1035719X0100100205>
- Kusak, J.Z., Rist, R.C. (2004). Ten steps to a results-based monitoring and Evaluation System: a handbook for development practitioners. Washington DC: The World Bank.
- Lalla-Edward S.T., Mosam, A., Hove, J., Erzse, A., Rwafa-Ponela, T., Price, J., Nyatela. A., Nqakala, S., Kahn, K., Tollman, S., Hofman, K. and Goldstein S. (2022). Essential health services delivery in South Africa during COVID-19: Community and healthcare worker perspectives. *Front. Public Health* 10:992481. doi:10.3389/fpubh.2022.992481
- Lamidi. K.O. (2015). Theories of Public Administration: An Anthology of Essays. *International Journal of Politics and Good Governance*. Volume VI, No. 6.3 Quarter III.
- Landers, A., Pitama, S. G., Palmer, S. C., & Beckert, L. (2023). Stakeholders' Perspectives on the Quality of End-of-Life Health Care Services for Chronic Obstructive Airways

- Disease: A Focus Group Study. *International journal of integrated care*, 23(3), 3.
<https://doi.org/10.5334/ijic.7274>
- Lannon C. (2018). Causal loop construction: the basics. The systems thinker: Leverage Networks, Inc. retrieved from: <https://thesystemsthinker.com/causal-loop-construction-the-basics/>.
- Law, T.J., Stephens, D. & Wright, J.G. (2022). Surgical wait times and socioeconomic status in a public healthcare system: a retrospective analysis. *BMC Health Serv Res* **22**, 579. <https://doi.org/10.1186/s12913-022-07976-6>
- Lawn, J.E. & Kinney, M.V. (2009). The lancet health in South Africa: Executive summary for the series; 347:2-6.
- Leavy, P. (2023). Research design: Quantitative, qualitative, mixed methods, art-based, and community-based participatory research approaches. New York: The Guilford Press.
- Le Booyesen, F. (2003). Urban–rural inequalities in health care delivery in South Africa, *Development Southern Africa*, 20:5, 659-673, DOI: [10.1080/0376835032000149298](https://doi.org/10.1080/0376835032000149298)
- Lecuona, K., Cook, C. (2011). South Africa’s cataract surgery rates: why are we not meeting our targets? *SAMJ*, 101 (8): 510-512
- Lembani, M., de Pinho, H., Delobelle, P., Zarowsky, C., Mathole, T., Ager, A. (2015). Health systems resilience: a systems analysis. A case study of maternal health service provision in OR Tambo District, Eastern Cape, in the context of chronic poor health performance.
https://assets.publishing.service.gov.uk/media/57a08985e5274a31e0000110/health-systems-resilience_eastern-cape-case-study_final-report.pdf.
- Lepetu, J.P. (2012). The use of analytic hierarchy process (AHP) for stakeholder preference analysis: A case study from Kasane Forest Reserve, Botswana. Full length research paper. Botswana College of Agriculture, University of Botswana.
- Liao, W. H., & Qiu, W. L. (2016). Applying analytic hierarchy process to assess healthcare-oriented cloud computing service systems. *SpringerPlus*, 5(1), 1030. <https://doi.org/10.1186/s40064-016-2686-3>

- Lilian, R.R, Railton, J., Schaftenaar, E., Mabitsi, M., Grobbelaar, C.J., Khosa, N.S., Maluleke, B.H., Struthers, H.E., McIntyre, J.A., Peters, R.P.H. (2018). Strengthening primary eye care in South Africa: An assessment of services and prospective evaluation of a health systems support package. *PLoS One*. 13(5):e0197432. <https://doi.org/10.1371/journal.pone.0197432>
- Lindberg, L. D., van der Vusse, A., Muelle, J., Kirstein, M. (2020). Early impacts of the COVID-19 pandemic: Findings from the 2020 Guttmacher survey on reproductive health experiences. New York: Guttmacher Institute. <https://guttmacher.org/early-impacts-covid-19pandemic-findings-2020-guttmacher-survey-reproductive-health>. (accessed 23 October 2023).
- Longe, B. (2021). Primary vs secondary Data: 15 key differences and similarities. Formplus. Available at: <https://www.formpl.us/blog/primary-secondary-data>. (accessed on 13 October 2023).
- Lou, L., Ye, X., Xu, P., Wang, J., Xu, Y., Jin, K., & Ye, J. (2018). Association of Sex With the Global Burden of Cataract. *JAMA ophthalmology*, 136(2), 116–121. <https://doi.org/10.1001/jamaophthalmol.2017.5668>
- Loughman, J., Moodley, V.R., Holden, B. and Naidoo, K. (2014). Access to Optometric Education: Challenges in Sub-Saharan Africa. *Literacy Information and Computer Education Journal (LICEJ)*, Volume 5, Issue 3, ISSN:2040, 2589. doi:10.21427/gjc2-6w19
- Luborsky, M.R., Rubinstein, R.L. (1995). Sampling in Qualitative Research: Rationale, Issues, and Methods. *Res Aging*. 17(1):89-113. doi: 10.1177/0164027595171005. PMID: 22058580; PMCID: PMC3207270
- Luthuli, L.P., Kalusopa, T. (2017). The management of medical records in the context of service delivery in the public sector in KwaZulu-Natal, South Africa: the case of Ngwelezana hospital. <http://sajlis.journals.ac.za>
- Ma, L., Christensen, T., & Zheng, Y. (2023). Government technological capacity and public–private partnerships regarding digital service delivery: evidence from Chinese cities. *International Review of Administrative Sciences*, 89(1), 95-111. <https://doi.org/10.1177/00208523211018849>

- Maake, M., & Moodley, V. (2018). An evaluation of the public sector optometric service provided within the health districts in KwaZulu-Natal, South Africa. *African Vision and Eye Health*, 77(1), 9 pages. doi:<https://doi.org/10.4102/aveh.v77i1.407>
- Maake, N.E. (2014). An Evaluation of the Public Sector Optometric Service Provided within the eThekweni and the surrounding health districts in Kwa Zulu-Natal, South Africa. (dissertation UKZN)
- Mabaso, R.G., Oduntan, A.O. (2014) The prevalence and causes of visual impairment and blindness among adults with diabetes mellitus aged 40 years and older receiving treatment at government health facilities in the Mopani District, South Africa. *S Afr Optom*. 73(1):8-15. <https://doi.org/10.4102/aveh.v73i1.2>
- Magagula, D., Mukonza, R., Manyaka, R., & Moeti, K. (2019). Towards strengthening collaboration between district and local municipalities in South Africa: Insights from Ehlanzeni District Municipality. ***The Journal for Transdisciplinary Research in Southern Africa***, 15(1), 10 pages. doi:<https://doi.org/10.4102/td.v15i1.673>
- Maguire, M., & Delahunt, B. (2017). Doing a Thematic Analysis: A Practical, Step-by-Step Guide for Learning and Teaching Scholars. *AISHE-J*, 9, 3351. <http://ojs.aishe.org/index.php/aishe-j/article/view/3354>
- Majid, H., Maluleke, A.S., Fraser, J.A., Zihindula, G., Rasengane, T.A., Subban, M. (2023). The delivery of Prescribed Minimum Benefits (PMBs) by optometrists in South Africa. Unpublished paper.
- Majid, H and Subban, M. (2021). Human resources challenges related to the delivery of eye health care services in South Africa: A narrative review. 2021. Proceedings of the 12th International Conference on Social Sciences (SSIRC). e-ISBN 978-0-620-96741-9(e-book).
- Malakoane, B., Heunis, J.C., Chikobvu, P. Kigozi, NG., Kruger, WH. (2020). Public health system challenges in the Free State, South Africa: a situation appraisal to inform health system strengthening. *BMC Health Serv Res* 20, 1-14. <https://doi.org/10.1186/s12913-019-4862-y>
- Maloba, D.M. (2015). *Monitoring Good Governance in South African Local Government and Its Implications for Institutional Development and Service Delivery: A case study of*

the sub-councils and councilor support department. Thesis Submitted to the Faculty of Management and Commerce, University of the Western Cape, June 2015.

- Managa, A. (2012). *Unfulfilled promises and their consequences: A reflection on local government performance and the critical issue of poor service delivery in South Africa*, Policy Brief: Africa Institute of South Africa, Pretoria
- Mandiriza, T., Fourie, D.J. (2023). The Role of Stakeholders in the Adoption of Public–Private Partnerships (PPPs) in Municipal Water Infrastructure Projects: A Stakeholder Theory Perspective. *World* **2023**, 4:416-30. <https://doi.org/10.3390/world4030026>
- Manyisa, Z.M and van Aswegen, E.J. (2017) Factors Affecting Working Conditions in Public Hospitals: A Literature Review. *International Journal of Africa Nursing Sciences*, 6, 28-38. <https://doi.org/10.1016/j.ijans.2017.02.002>
- Maphumulo, W. T., & Bhengu, B. R. (2019). Challenges of quality improvement in the healthcare of South Africa post-apartheid: A critical review. *Curationis*, 42(1), e1–e9. <https://doi.org/10.4102/curationis.v42i1.1901>
- Maphunye, K.J. 2011. The relevance of the developmental state model to South Africa's and Botswana's public services: A comparative perspective. *Journal of Public Administration*, 46(1):608-621.
- Marszalek, J., De Villiers, P.J.T. (2006). Morbidity profile of admissions to GF Jooste Hospital, Manenberg, Cape Town. *S A Fam Pract*. 2006;48:15.
- Mathebeni. B.P. (2015). Management of medical records for healthcare service delivery at the Victoria Public Hospital in the Eastern Cape Province: South Africa. University of Fort Hare, South Africa.
- Mathee, A., de la Rey, A., Swart, A., Plagerson, S., & Naicker, N. (2014). 'Urban insight': A high level of undiagnosed need reflects limited access to and availability of eye-care services in South Africa. *South African medical journal = Suid-Afrikaanse tydskrif vir geneeskunde*, 104(6), 407–408. <https://doi.org/10.7196/samj.8100>
- Martínez-Mesa, J., González-Chica, D. A., Duquia, R. P., Bonamigo, R. R., & Bastos, J. L. (2016). Sampling: how to select participants in my research study?. *Anais brasileiros de dermatologia*, 91(3), 326–330. <https://doi.org/10.1590/abd1806-4841.20165254>

- Marutha, N.S. and Ngoepe, M. (2018), "Medical records management framework to support public healthcare services in Limpopo province of South Africa", *Records Management Journal*, Vol. 28 No. 2, pp. 187-203. <https://doi.org/10.1108/RMJ-10-2017-0030>
- Mashwama, N., Thwala, W. D., & Aigbavboa, C. (2018). *The role of public private partnership in improving service delivery in South Africa*. <https://uicontent.ui.ac.za/esploro/outputs/conferencePaper/The-role-of-public-private-partnership/9912008707691#file-0>
- Marume, M., Mutongi, C. & Madziyire, N. (2016). An Analysis of Public Policy Implementation. IOSR Journal of Business and Management (IOSR-JBM) Volume 18, Issue 4. Ver. I (Apr. 2016). 86-93.
- Maserumule M. H., Mashigo P. (2010). Public administration and economics: Twin-sciences that [should] go together for rounded-knowledge? *Journal of Management and Marketing Research*, 3.
- Mashige, K., & Oduntan, O. (2011). Factors influencing South African optometry students in choosing their career and institution of learning. *African Vision and Eye Health*, 70(1), 21-28. doi:<https://doi.org/10.4102/aveh.v70i1.90>
- Mashige, K. P., Oduntan, O. A., & Hansraj, R. (2015). Opinions of South African optometry students about working in rural areas after graduation. *African journal of primary health care & family medicine*, 7(1), 799. <https://doi.org/10.4102/phcfm.v7i1.799>
- Mayes, R. (2004). Universal Coverage: The Ellusive Quest for National Health Insurance, University of Michigan Press, Ann Arbor. https://www.researchgate.net/publication/263275030_Universal_Coverage_The_Elusive_Quest_for_National_Health_Insurance
- Mayosi, B. M., & Benatar, S. R. (2014). Health and health care in South Africa--20 years after Mandela. *The New England journal of medicine*, 371(14), 1344–1353. <https://doi.org/10.1056/NEJMSr1405012>
- Mazibuko, S. M., Nadasan, T., & Govender, P. (2023). Public-private partnership models for rehabilitation service delivery: A scoping review. *The South African journal of physiotherapy*, 79(1), 1856. <https://doi.org/10.4102/sajp.v79i1.1856>

- McCormick I. (2022). The rapid assessment of avoidable blindness (RAAB) survey methodology. *Community eye health*, 35(117), 4.
- McCormick, I., Mactaggart, I., Resnikoff, S., Muirhead, D., Murthy, G. V., Silva, J. C., Bastawrous, A., Stern, J., Blanchet, K., Wang, N., Yusufu, M., Cooper, A., Gichangi, M., Eye Health Indicators Prioritisation Project Group, Burton, M. J., & Ramke, J. (2022). Eye health indicators for universal health coverage: results of a global expert prioritisation process. *The British journal of ophthalmology*, 106(7), 893–901. <https://doi.org/10.1136/bjophthalmol-2020-318481>
- McIntyre, D., Kruger, E., Valentine, N., van Zyl, N., Jacobs, T. (1997). An Evaluation of Existing Part-time District Surgeon Services and Alternative Mechanisms for Future Contracting with General Practitioners. South Africa: Health Economics Unit, Department of Community Health, University of Cape Town and Centre for Health Systems Research and Development, University of the Free State. <http://www.hst.org.za/uploads/files/dimac.pdf>
- McLaughlin, J. A., and Jordan, G. B. (1999). Logic Models: A tool for telling your performance story." *Evaluation and Program Planning*, 22(1):65-72.
- McLaughlin, J. A., & Jordan, G. B. (2015). Using logic models. Handbook of practical program evaluation. San Francisco: Jossey-Bass.
- Mehta, M. C., Narayanan, R., Thomas Aretz, H., Khanna, R., & Rao, G. N. (2020). The L V Prasad Eye Institute: A comprehensive case study of excellent and equitable eye care. *Healthcare (Amsterdam, Netherlands)*, 8(1), 100408. <https://doi.org/10.1016/j.hjdsi.2019.100408>
- MeTA. (2014). Client Satisfaction with Services in Uganda's Public Health Facilities. Medicines Transparency Alliance, Uganda.
- Mgobozi, P., & Mahomed, O. H. (2021). Epidemiology of patient safety incidents in a long-term rehabilitative hospital in KwaZulu-Natal, South Africa (April 2011 to March 2016). *Curationis*, 44(1), e1–e6. <https://doi.org/10.4102/curationis.v44i1.2151>
- Mihret, D. G., & Yismaw, A. W. (2007). Internal Audit Effectiveness: An Ethiopian Public Sector Case Study. *Managerial Auditing Journal*, 22, 470-484.

- Mkhize, M. (2019). The Knowledge Gap in Private Public Partnerships- a Sensemaking analysis in the case of Eskom. Unpublished Masters Thesis. Stellenbosch University, South Africa.
- Ministry of Foreign Affairs. (2017). Economic Opportunities in the Healthcare Infrastructure Sector in South Africa. Report prepared for the Embassy of the Kingdom of the Netherlands in South Africa. *Netherlands Enterprise Agency RVO-184-1701/RP-INT* available at <https://www.rvo.nl/sites/default/files/2017/12/economic-opportunities-in-the-healthcare-infrastructure-sector-in-south-africa.pdf>
- Mkhabela, N. (2003). Government introduces code of conduct: Public to come first and have powers of redress. *City Press*: 15, 5 January.
- Mogashoa, M. G., & Pelser, G. P. J. (2014). An analysis of the implementation of the national core standards in public hospitals. *Africa Insight*, 44(2):142-157.
- Mohammed, A.O.R., Harputlugil, T. (2020). Conceptual Framework for a Decision-Making Model Based on the Analytic Hierarchy Process (AHP) To Select the Best Public Private Partnership (PPP) Model for Airports. Conference Paper, March 2020.
- Mokoena, M.J. (2017). Perceptions of professional nurses on the impact of shortage of resources for quality patient care in a public hospital: Limpopo Province. Unpublished Master's dissertation. Pretoria: University of South Africa.
- Mongkol, K. (2011). The Critical Review of New Public Management Model and its Criticisms. *Research Journal of Business Management*, 5:35-43
- Moore, M. (1995). *Creating public value: Strategic management in government*. Cambridge, MA: Harvard University Press.
- Morris, A. (2018). A practical introduction to in-depth interviewing. London: SAGE.
- Mosewu, O., Rakemane, D. (2020). The role of records management in ensuring good governance in Africa: impediments and solutions. *JOURNAL OF SASA* (53)2020.
- Moyakhe, N. P. (2014). Quality healthcare: An attainable goal for all South Africans. *South African Journal of Bioethics and Law*, 7(2):80-83.
- Moyimane, M. B., Matlala, S. F., & Kekana, M. P. (2017). Experiences of nurses on the critical shortage of medical equipment at a rural district hospital in South Africa: a

- qualitative study. *The Pan African medical journal*, 28, 100.
<https://doi.org/10.11604/pamj.2017.28.100.11641>
- Muhwava, L. S., Murphy, K., Zarowsky, C., & Levitt, N. (2018). Policies and clinical practices relating to the management of gestational diabetes mellitus in the public health sector, South Africa - a qualitative study. *BMC health services research*, 18(1), 349.
<https://doi.org/10.1186/s12913-018-3175-x>
- Mutshatshi TE, Mothiba TM, Mamogobo PM, Mbombi MO. Record-keeping: Challenges experienced by nurses in selected public hospitals. *Curationis*. 2018 Jul 30;41(1):e1-e6. doi: 10.4102/curationis.v41i1.1931. PMID: 30198294; PMCID: PMC6111626
- Nabatchi, T., Steen, T., Sicilia, M., and Brand, D. (2016). Understanding the diversity of coproduction: Introduction to the IJPA special issue on coproduction. *International Journal of Public Administration*. 39(13):1001-1005.
- Naidoo, I., Holtzhausen, N. (2020). Contextualising Public Value Theory and its Measurement in Public Administration. *Administratio Publica*, 28(2):191-204
- Naidoo K., Jaggernath, J., Bilotto, L., Chinanayi, F., and Govender P. (2014b). WCO Public Health Survey: Public Health Education in Optometric Institutions. Unpublished study.
- Naidoo, K., Sweeney, D., Jaggernath, J., & Holden, B. (2013). A population-based study of visual impairment in the Lower Tugela health district in KZN, SA. *African Vision and Eye Health*, 72(3), 110-118. doi:<https://doi.org/10.4102/aveh.v72i3.284>
- Naidoo K. (2007). Poverty and blindness in Africa. *Clinical & experimental optometry*, 90(6), 415–421. <https://doi.org/10.1111/j.1444-0938.2007.00197.x>
- Naidoo, K. S., Jaggernath, J., Ramson, P., Chinanayi, F., Zhuwau, T. and Overland, L. (2015). “The prevalence of self-reported vision difficulty in economically disadvantaged regions of South Africa.” *African Journal of Disability*, vol. 4, no. 1. *Gale Academic OneFile*, link.gale.com/apps/doc/A455415236/AONE?u=anon~e97bb8c3&sid=googleScholar&xid=180454d4 [Accessed 19 Nov. 2023]
- Naidoo, K., Gichuhi, S., Basáñez, M. G., Flaxman, S. R., Jonas, J. B., Keeffe, J., Leasher, J. L., Pesudovs, K., Price, H., Smith, J. L., Turner, H. C., White, R. A., Wong, T. Y.,

- Resnikoff, S., Taylor, H. R., Bourne, R. R., & Vision Loss Expert Group of the Global Burden of Disease Study (2014). Prevalence and causes of vision loss in sub-Saharan Africa: 1990-2010. *The British journal of ophthalmology*, 98(5), 612–618. <https://doi.org/10.1136/bjophthalmol-2013-304081>
- Nassaji, H. (2020). Good qualitative research. *Language Teaching Research*, 24(4), 427-431. <https://doi.org/10.1177/1362168820941288>
- National Department of Health. (2017). *District Health Planning and Monitoring Framework*. (August 2017). Retrieved from [http://www.health.gov.za/DHP/docs/DHP and M Framework and Guidelines 25Aug DG.pdf](http://www.health.gov.za/DHP/docs/DHP_and_M_Framework_and_Guidelines_25Aug_DG.pdf)
- National Department of Health. (2018). *Presidential Health Summit: strengthening the South African health system towards an integrated and unified health system*. Johannesburg: The Presidency, Republic of South Africa. Retrieved from: https://www.gov.za/sites/default/files/gcis_document/201902/presidential-health-summit-report.pdf
- National Treasury. 2022. Budget Review, Annexure E: Public-Private Partnerships. Pretoria, South Africa
- National Department of Health. (2019). Draft National Eye Health Policy and Strategic Framework (2020-2025). Non Communicable Diseases Directorate. Pretoria, South Africa
- National Institute for Communicable Diseases. (2020). Impact of COVID-19 intervention on TB testing in South Africa. Available at: <https://tbsouthafrica.org.za/sites/default/files/news/20200510%20Impact-of-Covid19-interventions-on-TB-testing-in-South-Africa-10-May-2020.pdf>. (accessed 23 October 2023).
- National Treasury. (2017). *2017 Budget Report Public-private partnerships*. Retrieved from [http://www.treasury.gov.za/documents/national budget/2017/review/Annexure E.pdf](http://www.treasury.gov.za/documents/national_budget/2017/review/Annexure_E.pdf)
- Nel, D. (2015). Pre and Post Public Administration, Management and Governance Reform. *Administratio Publica*, 23(2): 73-97.

- New IAPB report on 'universal eye health' launched on world sight day. (2012). [Internet]. London: International Agency for the Prevention of Blindness. Available from: <http://www.iapb.org/news/new-iapb-report%E2%80%98universal-eye-health%E2%80%99-launched-world-sight-day> [cited 2020 May 04].
- Netcare. (2017). Partnership enables cataract surgery for disadvantaged South Africans. <https://www.netcare.co.za/News-Hub/Articles/partnership-enables-cataract-surgery-for-disadvantaged-south-africans>
- Nishtar, S. (2007). Politics of health systems: WHO's new frontier. *Lancet (London, England)*, 370(9591), 935–936. [https://doi.org/10.1016/S0140-6736\(07\)61442-1](https://doi.org/10.1016/S0140-6736(07)61442-1)
- Nkonki, L., Bhengu, N., Ramokgopa, M., Fonn, S. (2019). The Health Market Inquiry and its potential contribution to improving health systems in South Africa. *South African Health Review* 2019.
- Nkwanyana, N. M., Voce, A. S., Mnqayi, S. O., Sartorius, B., & Schneider, H. (2019). A health system framework for perinatal care in South African district hospitals: a Delphi technique. *BMC health services research*, 19(1), 402. <https://doi.org/10.1186/s12913-019-4200-4>
- Ntsoane, M. D., Oduntan, O. A., & Mpolokeng, B. L. (2012). Utilisation of public eye care services by the rural community residents in the Capricorn district, Limpopo Province, South Africa. *African Journal of Primary Health Care & Family Medicine*, 4(1), 412. <https://doi.org/10.4102/phcfm.v4i1.412>
- Nutt, P. C. (2006). Comparing Public and Private Sector Decision-Making Practices. *Journal of Public Administration Research and Theory: J-PART*, 16(2):289-318. <http://www.jstor.org/stable/3840369>
- Oduntan, A. (2007). Introducing low vision care into the Government eye care services in South Africa. *African Vision and Eye Health*, 66(4), 163-175. doi:<https://doi.org/10.4102/aveh.v66i4.253>
- Oduntan AO, Raliavhegwa M. (2001). An evaluation of the impact of the eye care services delivered to the rural communities in the Mankweng Health sub-district of the Northern Province. *S Afr Optom*. 2001; 60.

- Oduntan, O.A., Mashige, K.P., Kio, F.E., Boadi-Kusi, S.B. (2014). Optometric education in Africa: historical perspectives and challenges. *Optom Vis Sci.*;91(3):359-65. doi: 10.1097/OPX.000000000000153. PMID: 24374636.
- Oduntan, O., Mashige, K., Hansraj, R., & Ovenseri-Ogbomo, G. (2015). Strategies for reducing visual impairment and blindness in rural and remote areas of Africa. *African Vision and Eye Health*, 74(1), 5 pages. doi:<https://doi.org/10.4102/aveh.v74i1.25>.
<https://avehjournal.org/index.php/aveh/article/view/25/326>
- Odusote K. (2007). The challenges of advocacy in sub-Saharan Africa. *Community eye health*, 20(64), 61.
- Omotoso, K. O., & Koch, S. F. (2018). Assessing changes in social determinants of health inequalities in South Africa: A decomposition analysis. *International Journal for Equity in Health*, 17(1), 1–13. <https://doi.org/10.1186/s12939-018-0885-y>
- Orbis Institute. 2021. Available at: <https://www.orbis.org/en>. [Accessed on 20 August 2021].
- Osborne, S.P. (2000). Public-private partnership. Theory and practice and International perspective. London: Routledge.
- Osborne, S. P. (2010). *The new public governance: Emerging perspectives on the theory and practice of public governance*. London: Routledge.
- Osei-Kyei, R., Chan, A. P., Yu, Y., Chen, C., Ke, Y., & Tijani, B. (2019). Social responsibility initiatives for public-private partnership projects : a comparative study between China and Ghana. *Sustainability*, 11(5). <https://doi.org/10.3390/su11051338>
- Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful Sampling for Qualitative Data Collection and Analysis in Mixed Method Implementation Research. *Administration and policy in mental health*, 42(5), 533–544. <https://doi.org/10.1007/s10488-013-0528-y>
- Patel, I., Munoz, B., Burke, A. G., Kayongoya, A., McHiwa, W., Schwarzwald, A. W., & West, S. K. (2006). Impact of presbyopia on quality of life in a rural African setting. *Ophthalmology*, 113(5), 728–734. <https://doi.org/10.1016/j.ophtha.2006.01.028>
- Patton, M. Q. (2015). *Qualitative research and evaluation methods* (4th ed.). Sage.
- Patton M. Q. (1990). Qualitative evaluation and research methods. SAGE Publications, inc

- Paxton, A., & Frost, L. J. (2018). Using Systems Thinking to train future leaders in global health. *Global public health*, 13(9), 1287–1295. <https://doi.org/10.1080/17441692.2017.1349160>
- Paul, A. (2010). *The implementation of the 1997 white paper for social welfare with specific reference to children in conflict with the law: a case study of the Mangaung one stop child justice Centre*. Unpublished doctoral thesis. University of Western Cape, South Africa.
- Pearson, P., Steven, A., Howe, A., Sheikh, A., Ashcroft, D., Smith, P., & Patient Safety Education Study Group. (2010). Learning about patient safety: organizational context and culture in the education of health care professionals. *Journal of health services research & policy*, 15 Suppl 1, 4–10. <https://doi.org/10.1258/jhsrp.2009.009052>
- Pereira, B. A. D., & Ckagnazaroff, I. B. (2021). Contributions to consolidate the new public governance: Identifying dimensions of analysis. *Cadernos EBAPE. BR*. 19 (1):111-122.
- Peters, B.G. and Pierre, J., (1998). Governance without government? Rethinking public administration. *Journal of public administration research and theory*, 8(2):223-243.
- Pillay, Y., Pienaar, S., Barron, P., & Zondi, T. (2021). Impact of COVID-19 on routine primary healthcare services in South Africa. *South African medical journal = Suid-Afrikaanse tydskrif vir geneeskunde*, 111(8), 714–719. <https://doi.org/10.7196/SAMJ.2021.v111i8.15786>
- Pillay, R. (2010). 'The skills gap in hospital management: A comparative analysis of hospital managers in the public and private sectors in South Africa', *Health Services Management Research: An Official Journal of the Association of University Programs in Health Administration/HSMC, AUPHA* 23.
- Pillay-Van Wyk V., Msemburi W., Laubscher R., Dorrington R.E., Groenewald P., Glass T. et al. (2016). 'Mortality trends and differentials in South Africa from 1997 to 2012: Second National Burden of Disease Study', *The Lancet Global Health* 4. [10.1016/S2214-109X\(16\)30113-9](https://doi.org/10.1016/S2214-109X(16)30113-9)
- Plaatjies, D. (2008). Decentralised co-operative governance of the public health system in South Africa. South Africa: Unpublished doctoral degree, School of Public Development Management, University of Witwatersrand.

- Pope, C., and Mays, N. (Eds.). (2020). *Qualitative research in health care*. Oxford, UK: Wiley-Blackwell.
- Powers, J., McGree, J. M., Grieve, D., Aseervatham, R., Ryan, S., & Corry, P. (2023). Managing surgical waiting lists through dynamic priority scoring. *Health care management science*, 26(3), 533–557. <https://doi.org/10.1007/s10729-023-09648-1>
- Prozesky, D., Porter, R., Odusote, K., Morris, D.S., Francombe, J., Stevens, S., Gilbert, C., Astbury, N., Faal, H., Khan, A.A. and Thulasiraj, R.D. (2007). Advocacy for eye health. *Community Eye Health Journal*, 20(64).
- Pule, M-W-P. (2014). IMPACT OF INTERNAL AUDIT MANAGEMENT ON PUBLIC SECTOR ADMINISTRATION IN THE NORTH WEST PROVINCE. Mini dissertation. North West University.
- Punch, K. (2005) *Introduction to Social Research: Quantitative and Qualitative Approaches*. 2nd Edition, Sage, London.
- Pusari N. D. (1998). Eight 'Cs' of caring: a holistic framework for nursing terminally ill patients. *Contemporary nurse*, 7(3), 156–160. <https://doi.org/10.5172/conu.1998.7.3.156>
- Qazzafi, S. (2019). Consumer buying decision process toward products. *International Journal of Scientific Research and Engineering Development*, 2(5):130-134.
- Ramkisson, P. (2014). Recruitment and retention of optometrists in the public sector of kwaZulu-Natal. Master Thesis: University of KwaZulu-Natal.
- Ramodipa, T., Engelbrecht, K., Mokgobu, I., & Mmereki, D. (2023). Status of health care waste management plans and practices in public health care facilities in Gauteng Province, South Africa. *BMC Public Health*, 23(246). <https://doi.org/10.1186/s12889-023-15133-9>.
- Ramson P. (2016). Recruitment and retention of optometrists in the public sector of KwaZulu-Natal. Master These: UKZN
- Rawlings, L. (2011). *The role of cooperatives in global poverty reduction*. Vision clinics, BroadReach Healthcare. Viewed 28 June 2020, from <http://www.cooperativeunionofcavite.com>

- Reagon, G., Irlam, J., & Levin, J. (2004). The National Primary Health Care Facilities Survey: The equity project. Durban: Health Systems Trust and Department of Health.
- Regchand, S. (2015). The Pietermaritzburg High Court had ordered the Escourt Hospital to hand over medical records to attorney. *The Mercury*, South Africa, 8 April p.2.
- Regmi, K., Naidoo, J., Pilkington, P. A., & Greer, A. (2010). Decentralization and district health services in Nepal: understanding the views of service users and service providers. *Journal of public health (Oxford, England)*, 32(3), 406–417. <https://doi.org/10.1093/pubmed/fdp116>
- Reich M. R. (2000). Public-private partnerships for public health. *Nature medicine*, 6(6), 617–620. <https://doi.org/10.1038/76176>
- Republic of South Africa. (1997). White Paper on Transforming Public Service Delivery (Batho Pele White Paper), No. 1459 of 1997. *Government Gazette*. Department of Public Administration..
- Republic of South Africa. (2003). National Health Act no 61 of 2003. Pretoria
- Republic of South Africa. (2007). *Policy framework for the Government-wide Monitoring and Evaluation System*. Retrieved from www.thepresidency.gov.za
- Republic of South Africa. (2018). *Economic transformation, inclusive growth, and competitiveness: Towards an Economic Strategy for South Africa Prepared by Economic Policy, National Treasury*. Retrieved from <http://www.treasury.gov.za/>
- Republic of South Africa. (2019a). *National Health Act 2019* (3rd ed.; Section 27, Ed.). Siber Ink.
- Republic of South Africa. (2019b). *Presidential Health Summit Compact*. Retrieved from <http://www.surgeon.co.za/wp-content/uploads/2019/08/PRESIDENTIAL-HEALTH-SUMMIT-COMPACT-BUSINESS-31May-2019- version-8-FINAL-with-a-synopsis-3.pdf>
- Republic of South Africa. (1996). *Constitution of the Republic of South Africa 1996*. Pretoria: Government Printers. Retrieved from: <http://www.info.gov.za>
- Republic of South Africa. The Constitution of the Republic of South Africa 1996, Act 108 of 1996. Pretoria: Government Printer; 1996.

- Republic of South Africa. (2020). *From the desk of the President*. Retrieved from <https://mailchi.mp/presidency.gov.za/president-desk-24-feb20>
- Republic of South Africa. (2011d). National Development Plan. Vision for 2030. National Planning Commission. Pretoria: Government Printer.
- Reynolds, L., London, L., & Sanders, D. (2005). The Draft Charter of the Private and Public Health Sectors of the Republic of South Africa: health for all, or profits for few?. *South African medical journal = Suid-Afrikaanse tydskrif vir geneeskunde*, 95(10), 742–743.
- Rheeder, R. (2021). Corruption in the public health sector in South Africa: A global bioethical perspective. *South African Journal of Bioethics and Law*. 14(3):4.
- Rispel L, Setswe G. (2007). Stewardship: protecting the public's health. In: Harrison S, Bhana R, Ntuli A (eds). *South African Health Review (SAHR) 2007*. Durban: Health Systems Trust: 3–18.
- Rispel, L. C., de Jager, P., & Fonn, S. (2016). Exploring corruption in the South African health sector. *Health policy and planning*, 31(2), 239–249. <https://doi.org/10.1093/heapol/czv047>
- Ritchie, J., Lewis, J., Nicholls, C.M. and Ormston, R., Eds. (2013) *Qualitative Research Practice: A Guide for Social Science Students and Researchers*. Sage, Thousand Oaks, CA.
- Roach, M. S. (2013). Caring: The human mode of being. *Caring in nursing classics: An essential resource*, 165-79. New York: Springer Publishing Company, LLC.
- Robin, A. L., Nirmalan, P. K., Krishnadas, R., Ramakrishnan, R., Katz, J., Tielsch, J., Thulasiraj, R. D., & Friedman, D. S. (2004). The utilization of eye care services by persons with glaucoma in rural south India. *Transactions of the American Ophthalmological Society*, 102, 47–55.
- Rodrigues, N. J. P., & Carvalho, J. M. S. (2023). Public-private partnership in the Portuguese health sector. *Heliyon*, 9(8), e19122. <https://doi.org/10.1016/j.heliyon.2023.e19122>
- Robson, C. (2002). *Real World Research: A Resource for Social Scientists and Practitioner-Researchers* (2nd ed.). Oxford: Blackwell Publishers Ltd.

- Roemer, M. (2001). Health care systems. in Lock, S., Last, J.M. and Dunea, G. (Eds). The Oxford Illustrated Companion to Medicine. Oxford University Press, New York, NY.
- RSA Department of Performance Management and Evaluation. (2011). *National Evaluation Policy Framework*. South Africa. Government House.
- Rubakula, G. (2014). The New Public Management and its Challenges in Africa. Public Policy and Administration Research 4(4): 85-96
- SA Red Cross Air Mercy Service. (2019). Cataract Surgery Programme Kicks off in KwaZulu-Natal. <https://ams.org.za/cataract-surgery-programme-kicks-off-in-kwazulu-natal/> [Accessed 14/11/2023]
- Saaty, T. L., & Wong, M. M. (1983). Projecting average family size in rural India by the analytic hierarchy process. *The Journal of mathematical sociology*, 9(3), 181–209. <https://doi.org/10.1080/0022250X.1983.9989942>
- Saaty, T.L. and Vargas, L.G. (2012). Models, Methods, Concepts & Applications of the Analytic Hierarchy Process. Springer Science & Business Media, New York. <https://doi.org/10.1007/978-1-4614-3597-6>
- Sacharowitz, H. (2005). Visual impairment in South Africa: achievements and challenges. *African Vision and Eye Health*, 64(4), 139-149. doi:<https://doi.org/10.4102/aveh.v64i4.239>
- Sabherwal, S, Javed, M, Sood, I. (2002). Public-Private Collaborations in Eye Care. Delhi Journal of Ophthalmology 32(5):93-96. DOI: 10.4103/dljo.dljo_52_23
- Sajid, M. S., & Baig, M. K. (2007). Quality of health care: an absolute necessity for public satisfaction. *International journal of health care quality assurance*, 20(6), 545–548. <https://doi.org/10.1108/09526860710819477>
- SALGA, & SACN. (2016). *Economic Development in Municipalities: KZN Case Studies synthesis report Synthesis Report (A) of findings and insights With research*.
- Santerre, R.E. and Neun, S.P. (2010). Health Economics: Theory, Insights, and Industry Studies. Ohio: Cengage Learning.
- Sarvari H., Valipour A., Yahya N., Noor N. M., Beer M., Banaitiene N. (2019). Approaches to Risk Identification in Public–Private Partnership Projects: Malaysian Private Partners’

- Saunders, M., Lewis, P. and Thornhill, A. (2007). *Research Methods for Business Students*. 4th Edition, Financial Times Prentice Hall, Edinburgh Gate, Harlow.
- Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., Burroughs, H., & Jinks, C. (2018). Saturation in qualitative research: exploring its conceptualization and operationalization. *Quality & quantity*, 52(4), 1893–1907. <https://doi.org/10.1007/s11135-017-0574-8>
- Savas, E. S. (2000). *Privatization and public-private partnerships*. Sage.
- Senjam, S. S.(2017). Public-Private Partnership for Eye Health Care Delivery in Developing Nations. *BAOJ Ophthalmol* 1: 009. 1-3
- Seixas, B. V., Dionne, F., & Mitton, C. (2021). Practices of decision making in priority setting and resource allocation: a scoping review and narrative synthesis of existing frameworks. *Health economics review*, 11(1), 2. <https://doi.org/10.1186/s13561-020-00300-0>
- Seyed-Nezhad, M., Ahmadi, B., & Akbari-Sari, A. (2021). Factors affecting the successful implementation of the referral system: A scoping review. *Journal of family medicine and primary care*, 10(12), 4364–4375. https://doi.org/10.4103/jfmprc.jfmprc_514_21
- Scotland, J. (2012). Exploring the philosophical underpinnings of research: Relating ontology and epistemology to the methodology and methods of the scientific, interpretive, and critical research paradigms. *English Language Teaching*, 5(9); 9-16.
- Scott, V., Schaay, N., Schneider, H., & Sanders, D. (2017). Addressing social determinants of health in South Africa: the journey continues. In A. Padarath, & P. Barron (Eds.), *South African Health Review 2017* (pp. 77-88). Durban: Health Systems Trust
- Schaay, N., Sanders, D., Kruger, V. (2011). *Overview of Health Sector Reforms in South Africa*. DFID Human Development Resource Centre, London.

- Shakir, M., and ur Rahman, A. (2022). Conducting pilot study in a qualitative inquiry: Learning some useful lessons. *Journal of Positive School Psychology*, 6(10):1620-1624.
- Shuping, S., Kabane, S. (2007). Public-private partnerships: a case study of the Pelonomi and Universitas Hospital Co-Location Project. In: Harrison S, Bhana R, Ntuli A (eds). *South African Health Review (SAHR)*. Durban: Health Systems Trust: 151–8.
- Sibbald, S. L., Paciocco, S., Fournie, M., Van Asseldonk, R., & Scurr, T. (2021). Continuing to enhance the quality of case study methodology in health services research. *Healthcare management forum*, 34(5), 291–296. <https://doi.org/10.1177/08404704211028857>
- Sibiya, C. B., & Subban, M. (2018). Innovating management through strategy execution in the KwaZulu-Natal Department of Agriculture and Environmental Affairs. *Journal of Contemporary Management*, 15:329-353. doi: 10.10520/EJC-16a3ea27d0
- Siddle A.M. (2011). 'Decentralisation in South African Local Government: A critical evaluation', Degree of Doctor of Philosophy, Doctoral thesis, University of Cape Town.
- Signé, L. (2017). Policy implementation—A synthesis of the study of policy implementation and the causes of policy failure. *OCP Policy Center*.1-26.
- Silva, L. C., Macedo, I. M., & Thompson, M. (2024). Revisiting the debate on institutions, the state and institutional change: The relevance of institutional theory to public administration teaching. *Teaching Public Administration*, 42(1), 73-94. <https://doi.org/10.1177/01447394231159985>
- Sinanovic, E., & Kumaranayake, L. (2006b). Quality of tuberculosis care provided in different models of public-private partnerships in South Africa. *The international journal of tuberculosis and lung disease : the official journal of the International Union against Tuberculosis and Lung Disease*, 10(7):795–801.
- Sinanovic, E., Palmer N. (2000). Primary health care contracting study: Eastern Cape district surgeons (Final Report). Cape Town: Health Economics Unit, University of Cape Town
- Singh, K. (2007). Quantitative social research methods. SAGE: New Delhi.

- Sithole, H., & Oduntan, O. (2010). Eye health promotion in the South African primary health care system*. *African Vision and Eye Health*, 69(4), 200-206. doi:<https://doi.org/10.4102/aveh.v69i4.144>
- Sithole, H-L. (2013). A critical analysis of the South African health policies and programmes with regard to eye health promotion. Doctorate thesis: Philosophy: University of South Africa.
- Sithole, H. (2015). An overview of the National Health Insurance and its possible impact on eye healthcare services in South Africa. *African Vision and Eye Health*, 74(1), 6 pages. doi:<https://doi.org/10.4102/aveh.v74i1.18>
- Sithole H. L. (2017). A situational analysis of ocular health promotion in the South African primary health-care system. *Clinical & experimental optometry*, 100(2), 167–173. <https://doi.org/10.1111/cxo.12452>
- Sithole, H. (2017). Perceptions of South African National and Provincial Health Directorate managers on eye health promotion. *African Vision and Eye Health*, 76(1), 6 pages. doi:<https://doi.org/10.4102/aveh.v76i1.394>
- Sithole, H. (2022). Eye health promotion-oriented policy statements in various national and provincial health policy documents in South Africa. *African Vision and Eye Health*, 81(1), 7 pages. doi:<https://doi.org/10.4102/aveh.v81i1.597>
- Skhosana, J. S. (2019). Applying the 7-C Protocol to assess the implementation of immigration policies in the Department of Home Affairs: A case study. Unpublished Master's dissertation. Cape Town: Stellenbosch University.
- Slipicevic, O., & Masic, I. (2012). Management knowledge and skills required in the health care system of the Federation bosnia and herzegovina. *Materia socio-medica*, 24(2), 106–111. <https://doi.org/10.5455/msm.2012.24.106-111>
- Snider, K. F., & Rendon, R. G. (2012). Public Procurement: Public Administration and Public Service Perspectives. *Journal of Public Affairs Education*, 18(2):327-348. <http://www.jstor.org/stable/23208657>
- Sommer, A., Taylor, H. R., Ravilla, T. D., West, S., Lietman, T. M., Keenan, J. D., Chiang, M. F., Robin, A. L., Mills, R. P., & Council of the American Ophthalmological Society

- (2014). Challenges of ophthalmic care in the developing world. *JAMA ophthalmology*, 132(5), 640–644. <https://doi.org/10.1001/jamaophthalmol.2014.84>
- Sorrentino, M., De Marco, M., and Rossignoli, C. (2016). Health care co-production: Co-creation of value in flexible boundary spheres. In Borangiu, T., Dragoicea, M., and Nóvoa, H. (Eds.), *Exploring services science: 7th International Conference*. Bucharest, Romania: Springer.
- Sorrentino, M., Sicilia, M., and Howlett, M. (2018). Understanding co-production as a new public governance tool, *Policy and Society*, 37:3, 277-293, DOI: [10.1080/14494035.2018.1521676](https://doi.org/10.1080/14494035.2018.1521676)
- South Africa Department of Health. (2002). Annual Report 2001/2002. Printed by Formset.
- South Africa National Department of Health. (2013). Annual performance plan 2013/14 to 2015/16. Pretoria: NDoH.
- South Africa National Department of Health. (2011). National Health Insurance in South Africa. Pretoria: National Department of Health
- South Africa National Treasury. (2012). Project List. <http://www.ppp.gov.za/Pages/projectlist.aspx>
- South Africa National Treasury. (2004). Public-private Partnership Unit. PPP Manual. Module 1: South Africa regulations for PPPs. <http://www.ppp.gov.za/Legal%20Aspects/PPP%20Manual/Module%2001.pdf>
- South African Department of Health. (2002). National Guideline – Prevention of Blindness in South Africa. Pretoria: DOH.
- South African Government. (2018). Let's grow South Africa together 2018/2019, available at: <https://www.gov.za/about-government/government-system/public-administration>, accessed 15 May 2020.
- South African Medical Association. (2015). Submission to Minister of Health, National Department of Health Comments in respect of White Paper for National Health Insurance for South Africa: Towards universal coverage. Pretoria. Available at <https://www.mm3admin.co.za/documents/docmanager/f447b607-3c8f-4eb7-8da4-11bca747079f/00105160.pdf> Accessed: May 16, 2023.

- South African National Development Plan (2021). NDP 2030: Our future - make it work
NATIONAL DEVELOPMENT PLAN 2030 EXECUTIVE SUMMARY. Available at:
<https://www.gov.za/sites/default/files/Executive%20Summary-NDP%202030>.
[Accessed on 22 August 2021].
- Sriram, N., Misomnai, C., Metasuttirat, J., & Rajphaetyakhom, C. (2019). A Comparative
Analysis of New Public Management New Public Service and New Public
Governance. *Asian Political Science Review*. 3(2):32-39.
- St. Catherine University. (2017). *BSN in the college for adults*. [PowerPoint slides]. Retrieved
from
<https://stkate.desire2learn.com/d2l/le/content/100418/viewContent/1221279/View>
- Stake, R. E. (1995). *The art of case study research* London: Sage Publications Ltd.
- Starman, A. B. (2013). The case study as a type of qualitative research. *Journal of
Contemporary Educational Studies/Sodobna Pedagogika*, 64(1):28-43.
- Statistics South Africa. Community survey 2016 statistical release P0301
[www.statssa.gov.za]. [cited/accessed 2017 Mar 09]. Available from:
www.statssa.gov.za
- Statistics South Africa. Mid-year population estimates 2014. Statistical release P0302
[document on the Internet]. c2014 [cited 2015 Mar 12]. Available from:
<http://beta2.statssa.gov.za/publications/P0302/P03022014.pdf> 22.
- Statistics South Africa. (2016). Statistical release general household survey. *ISibalo house,
Koch Street Salvokop Pretoria*. Available at
<https://www.statssa.gov.za/publications/P0318/P03182016.pdf>. Accessed 10 July
2020).
- Steffen, J., & Mustak, H. (2022). Impact of COVID-19 on surgical specialist training as
quantified by trainee complication rates for cataract surgery. *South African journal of
surgery. Suid-Afrikaanse tydskrif vir chirurgie*, 60(3), 199–203.
<https://doi.org/10.17159/2078-5151/SAJS3764>
- Stevens, F. (2010). The Convergence and Divergence of Modern Health Care Systems. S.
434–454 in: W. Cockerham (Hrsg.), *The New Blackwell Companion to Medical
Sociology*. Oxford, UK: Wiley-Blackwell.

- Steinmetz, J.D., Bourne, R.R., Briant, P.S., Flaxman, S.R., Taylor, H.R., Jonas, J.B., Abdoli, A.A., Ahrha, W.A., Abualhasan, A., Abu-Gharbieh, E.G. and Adal, T.G. (2021). Causes of blindness and vision impairment in 2020 and trends over 30 years, and prevalence of avoidable blindness in relation to VISION 2020: the Right to Sight: an analysis for the Global Burden of Disease Study. *The Lancet. Global health*, 9(2), e144–e160. [https://doi.org/10.1016/S2214-109X\(20\)30489-7](https://doi.org/10.1016/S2214-109X(20)30489-7)
- Stillman, R. J. (1973). Woodrow Wilson and the study of administration: A new look at an old essay. *The American Political Science Review*, 67(2):582-588.
- Stuckler, D., Basu, S., & McKee, M. (2011). Health care capacity and allocations among South Africa's provinces: Infrastructure–inequality traps after the end of apartheid. *American Journal of Public Health*, 101(1):165-72.
- Suarez-Balcazar, Y.(2005). Empowerment and Participatory Evaluation of a Community Health Intervention: Implications for Occupational Therapy. *OTJR: Occupation, Participation and Health.*; 25(4):133-142.
- Subban, M., & Vyas-Doorgapersad, S. (2014). Public Administration Training and Development in Africa: The Case of the Republic of South Africa. *Journal of Public Affairs Education*, 20(4), 499–514. <http://www.jstor.org/stable/24369834>
- Sukati, V. N., Moodley, V. R., & Mashige, K. P. (2018). A situational analysis of eye care services in Swaziland. *Journal of public health in Africa*, 9(3), 892. <https://doi.org/10.4081/jphia.2018.892>
- Sunday Tribune. (2015). Family of Miss Blanche Brown (35) blame the hospital for her death, 08 March, 2015, Charmel Payet, KwaZulu-Natal, South Africa.
- Surender, R. (2014). *The drivers of universal health care in South Africa: The role of ideas, institutions and actors*, UNRISD project on towards universal social security in emerging economies: Process, institutions and actors, UNRISD, Geneva
- Svara, J. H. (2001). The myth of the dichotomy: Complementarity of politics and administration in the past and future of public administration. *Public Administration Review*, 61(2):177-183.
- Tabriz, A. A., Flocke, S. A., Shires, D., Dyer, K. E., Schreiber, M., & Elston Lafata, J. (2020). Logic model framework for considering the inputs, processes and outcomes of a

- healthcare organisation-research partnership. *BMJ quality & safety*, 29(9), 746–755.
<https://doi.org/10.1136/bmjqs-2019-010059>
- Taherdoost, H. (2021). Data Collection Methods and Tools for Research; A Step-by-Step Guide to Choose Data Collection Technique for Academic and Business Research Projects, *International Journal of Academic Research in Management*, 10(1): 10-38
<https://elvedit.com/journals/IJARM/wp-content/uploads>
- Taherdoost, H. (2021a). Handbook on research skills: The essential step-by-step; Guide on How to Do a Research Project (Kindle ed.). Amazon.
- Tana, V.V. (2013). *Experiences of chronic patients about long waiting time at a community health care centre in the Western Cape*. Master of Nursing Sciences in the Faculty of Health, University of Stellenbosch.
- Tateke, T., Woldie, M., & Ololo, S. (2012). Determinants of patient satisfaction with outpatient health services at public and private hospitals in Addis Ababa, Ethiopia. *African Journal of Primary Health Care & Family Medicine*, 4(1), 384.
<https://doi.org/10.4102/phcfm.v4i1.384>
- Ten Ham-Baloyi W, Minnie K, van der Walt C. (2020). Improving healthcare: a guide to roll-out best practices. *Afr Health Sci*. 1487-1495. doi: 10.4314/ahs.v20i3.55. PMID: 33402998; PMCID: PMC7751558.
- Tenny, S., Brannan, J. M., Brannan, G. D. (2022). Qualitative study. Florida: StatPearls Publishing LLC. <https://www.ncbi.nlm.nih.gov/books/NBK470395/> [Accessed: 13/11/2023]
- The Centre For Development And Enterprise (CDE). (2011). *Reforming healthcare in South Africa: What role for the private sector?*, South Africa.
<https://www.cde.org.za/reforming-healthcare-in-south-africawhat-role-for-the-private-sector/>
- Thivhafuni G. (2011). Availability, accessibility and affordability of optometric services to the rural communities of the Mutale Municipality, Vhembe district, Limpopo Province, South Africa. Unpublished Master's dissertation, University of Limpopo, South Africa.
- Thomas, F. B. (2022). The role of purposive sampling technique as a tool for informal choices in a social Sciences in research methods. *Just Agriculture*, 2(5):1-8.

- Thulasiraj R. (2007). Advocacy to improve the delivery of eye care. *Community eye health*, 20(64), 66–67.
- TimesLIVE. (2018). Eight alarm bells at South African state hospitals, South Africa. Available at <https://www.timeslive.co.za/news/south-africa/2018-06-14-eight-alarm-bells-at-south-african-state-hospitals>.
- Tracy, S. J. (2020). *Qualitative research methods: Collecting evidence, crafting analysis, communicating impact* (2nd ed.). John Wiley & Sons.
- Trebilcock, M., Rosenstock, M. (2015). Infrastructure Public–Private Partnerships in the Developing World: Lessons from Recent Experience, *The Journal of Development Studies*, 51:4:335-354, DOI: [10.1080/00220388.2014.959935](https://doi.org/10.1080/00220388.2014.959935)
- Tshabalala, K., Rispel, L.C. (2023). Piercing the veil on the functioning and effectiveness of district health system governance structures: perspectives from a South African province. *Health Res Policy Sys* **21**, 89. <https://doi.org/10.1186/s12961-023-01044-z>
- Tsimanyane, M., Koetsie, K., Makgotloe, A. (2023). Operating theatre efficiency at a tertiary eye hospital in South Africa. *South African Medical Journal* Vol 113, No. 5. 59-64.
- Twala, C., Lues, L. (2017). Public Administration and Management Variables Influencing the Strengthening of Democracy in South Africa. *Administratio Publica* 25(1): 190-211.
- UNESCO. (2016). Designing effective monitoring and evaluation of education systems for 2030: A global synthesis of policies and practices. *UNESCO Education Sector*, (January 2016).
- Uwizeyimana, D.E. and Maphunye, K.J. (2014). The changing global Public Administration and its theoretical and practical implications for Africa. *Journal of Public Administration and Policy Research*, 6(4):90-101.
- Vasileiou, K., Barnett, J., Thorpe, S., & Young, T. (2018). Characterising and justifying sample size sufficiency in interview-based studies: systematic analysis of qualitative health research over a 15-year period. *BMC medical research methodology*, 18(1), 148. <https://doi.org/10.1186/s12874-018-0594-7>

- Van der Waldt, G. (2018). Theories for research in Public Administration. *African Journal of Public Affairs*. 9. 183-202.
- van Rijnsoever F. J. (2017). (I Can't Get No) Saturation: A simulation and guidelines for sample sizes in qualitative research. *PloS one*, 12(7), e0181689. <https://doi.org/10.1371/journal.pone.0181689>
- Van Rensburg, H.C.J.; Engelbrecht, M.C. (2012). Transformation of the South Africa health system: post-1994. In: Van Rensburg HCJ, editor. *Health and health care in South Africa*. 2nd ed. Pretoria: Van Schaik Publishers.
- Van Rensburg, H.C.J. (2004). National health care systems: structure, types and dynamics", *Health and Health Care in South Africa*. Pretoria: Van Schaik Publishers. W.C. (Ed.). *The Blackwell Companion to Medical Sociology*. Oxford: Blackwell Publishing
- Van Ryneveld, M., Schneider, H. & Lehmann, U. (2020). Looking back to look forward: a review of human resources for health governance in South Africa from 1994 to 2018. *Hum Resour Health* **18**, 92. <https://doi.org/10.1186/s12960-020-00536-1>
- Virtanen, P., Jalonen, H. (2023). Public value creation mechanisms in the context of public service logic: an integrated conceptual framework, *Public Management Review*, DOI: [10.1080/14719037.2023.2268111](https://doi.org/10.1080/14719037.2023.2268111)
- Vian, T., Koseki, S., Feeley, F. G., & Beard, J. (2013). Strengthening capacity for AIDS vaccine research: analysis of the Pfizer Global Health Fellows program and the International AIDS Vaccine Initiative. *BMC health services research*, 13, 378. <https://doi.org/10.1186/1472-6963-13-378>
- Vilakazi, S. A., and Adetiba, T. C. (2020). Political and administrative dichotomy in South Africa: The principle of separation of powers at local government level. *Acta Universitatis Danubius. Administratio*. 12(1):48-64.
- Wadee, H., Gilson, L., Blaauw, D., Erasmus, E., Mills, A., Consortium, H., ... Unit, H. E. (2004). Public-Private Interactions in the South African Health Sector: Experience and Perspectives from National , Provincial and Local Levels. <https://indexmedicus.afro.who.int/iah/fulltext/ppi.pdf>

- Wahyuni, D. (2012). The research design maze: Understanding paradigms, cases, methods and methodologies. *Journal of Applied Management Accounting Research*, 10(1):69-80.
- Walck-Shannon, E. M., Rowell, S. F., & Frey, R. F. (2021). To What Extent Do Study Habits Relate to Performance?. *CBE life sciences education*, 20(1), ar6. <https://doi.org/10.1187/cbe.20-05-0091>
- Walwyn, D.R., Nkolele, A.T. (2018). An evaluation of South Africa's public-private partnership for the localisation of vaccine research, manufacture and distribution. *Health Res Policy Sys* **16**, 30. <https://doi.org/10.1186/s12961-018-0303-3>
- Wang, B., Congdon, N., Bourne, R., Li, Y., Cao, K., Zhao, A., Yusufu, M., Dong, W., Zhou, M. and Wang, N. (2018). Burden of vision loss associated with eye disease in China 1990–2020: findings from the Global Burden of Disease Study 2015. *British Journal of Ophthalmology*. 102(2): 220-224.
- Wang, H., Xiong, W., Wu, G., & Zhu, D. (2018). Public-private partnership in *Public Administration* discipline: a literature review, *Public Management Review*, 20:2, 293-316, DOI: [10.1080/14719037.2017.1313445](https://doi.org/10.1080/14719037.2017.1313445)
- Watson, D. E., Broemeling, A. M., & Wong, S. T. (2009). A results-based logic model for primary healthcare: a conceptual foundation for population-based information systems. *Healthcare policy = Politiques de sante*, 5 Spec no(Spec No), 33–46.
- WHO. (2000). The World health report 2000: Health systems – Improving performance. World Health Organization, Geneva.
- WHO. (2010). *Regional High-level Consultation in the Eastern Mediterranean Region on the Prevention and Control of Non-communicable Diseases in Low-and Middle-Income Countries Hosted in Tehran by the Government of the Islamic Republic of Iran Background Paper*.
- WHO. (2016). Global strategy on human resources for health: workforce 2030. Geneva: World Health Organization.
- WHO. (2020). Global Tuberculosis Report 2020. Geneva: World Health Organization. Available at: <https://www.who.int/publications/item/9789240013131> (accessed 23 October 2023).

- WHO. (2022). Blindness and vision impairment. Geneva: World Health Organisation. Available at: <https://www.who.int/news-room/fact-sheets/detail/blindness-and-visual-impairment> Accessed: 10 June 2023.
- WHO. (2022). Chronic staff shortfalls stifle Africa's health systems: WHO study. Brazaville: World Health Organisation. Available at <https://www.afro.who.int/news/chronic-staff-shortfalls-stifle-africas-health-systems-who-study> Accessed: 15 May 2023.
- Wholey., J. S. (1987). "Evaluability Assessment: Developing Program Theory." In L. Bickman (ed.), *Using Program Theory in Evaluation*. New Directions for Program Evaluation, no. 33. San Francisco: Jossey-Bass.
- Wiesel, F. and Modell, S. (2014), From New Public Management to New Public Governance? Hybridization and Implications for Public Sector Consumerism. Financial Accountability & Management, 30: 175-205. <https://doi.org/10.1111/faam.12033>
- Wimble, K. (2019). *Active Citizens Movement*. Retrieved from <https://www.acm-pmb.co.za/sample-page/projects-and-initiatives/public-private-health-forum/>
- Wong, T. Y., Zheng, Y., Jonas, J. B., Flaxman, S. R., Keeffe, J., Leasher, J., Naidoo, K., Pesudovs, K., Price, H., White, R. A., Resnikoff, S., Taylor, H. R., Bourne, R. R., & Vision Loss Expert Group of the Global Burden of Disease Study (2014). Prevalence and causes of vision loss in East Asia: 1990-2010. *The British journal of ophthalmology*, 98(5), 599–604. <https://doi.org/10.1136/bjophthalmol-2013-304047>
- World Health Organisation. (2012). *European Action Plan for Strengthening Public Health Capacities and Services*. Retrieved from https://www.euro.who.int/__data/assets/pdf_file/0005/171770/RC62wd12rev1-Eng.pdf
- World Health Organisation. (2019). Blindness and vision impairment. Retrieved December 8, 2019, from <https://www.who.int/news-room/fact-sheets/detail/blindness-and-visual-impairment>
- World Health Organisation. (2020). Eye health | WHO | Regional Office for Africa. Retrieved March 22, 2020, from <https://afro.who.int/health-topics/eye-health>

- World Health Organization. (2019). *World report on vision*. Geneva: World Health Organization. Retrieved from: <https://apps.who.int/iris/bitstream/handle/10665/328717/9789240017184-ara.pdf>
- World Health Organisation. (2018). Time to deliver: report of the WHO Independent High-level Commission on Noncommunicable Diseases. <http://www.who.int/ncds/management/time-to-deliver/en/> accessed: June 6, 2020
- World Health Organization (1989). Informal consultation on analysis of blindness prevention outcomes. Geneva: WHO/PBL/98.68.
- World Health Organization. (1981). Global Strategy for Health for All by the Year 2000. Geneva
- World Health Organization. (2012). Global data on visual impairments 2010. Geneva. Available from: <http://www.who.int/blindness/GLOBALDATAFINALforweb.pdf> [cited 2020 May 04].
- World Health Organization. (2013). Draft action plan for the prevention of avoidable blindness and visual impairment 2014–2019. Geneva: Available from: http://www.iapb.org/sites/iapb.org/files/A66_11-en.pdf [cited 2020 May 04].
- World Health Organization. (2017). *Africa Health Forum*. Kigali, Rwanda.
- World Health Organization. (2017). Drug use disorders: impact of a public health rather than a criminal justice approach. *World Psychiatry*; 16:213-214.
- Xulu-Kasaba, Z., Mashige, K., & Naidoo, K. (2021). An assessment of human resource distribution for public eye health services in KwaZulu-Natal, South Africa. *African Vision and Eye Health*, 80(1), 8 pages. doi:<https://doi.org/10.4102/aveh.v80i1.583>
- Xulu-Kasaba, Z., Mashige, K., & Naidoo, K. (2021). Knowledge, Attitudes and Practices of Eye Health among Public Sector Eye Health Workers in South Africa. *International journal of environmental research and public health*, 18(23), 12513. <https://doi.org/10.3390/ijerph182312513>
- Yadav, S. (2011). REVIEW ARTICLE: PUBLIC ADMINISTRATION IN 21ST CENTURY [Review of *Public Administration In The Globalisation Era: The New Public Management*

- Perspective*, by U. Medury]. *The Indian Journal of Political Science*, 72(1), 317–322.
<http://www.jstor.org/stable/42761832>
- Yang, L. (2019). Public Administration as a Dynamic Balance and Integrative Science Across Politics, Management, and Law: Rosenbloom's Framework and Chinese Experiences. *The American Review of Public Administration*, 49(1), 79-97.
<https://doi.org/10.1177/0275074018759337>
- Yes Media. 2019. uMgungundlovu District Municipality - Demographic. Retrieved December 5, 2019, from <https://municipalities.co.za/demographic/120/umgungundlovu-district-municipality>
- Yin, R. K. (2003). *Case study research: Design and methods*. London: Sage.
- Yin, R. K. (2009). *Case study research, design and method*. 4th edition. London: Sage Publications Ltd.
- Young, M. (2016). Private vs. public healthcare in South Africa. Unpublished Honors research. USA: Western Michigan University.
- Yurdakul, H., Kamasak, R., Ozturk, T.Y. (2021). Macroeconomic drivers of Public Private Partnership (PPP) projects in low income and developing countries: A panel data analysis. *Borsa _ Istanbul Review*, 22(1):37-46.
- Zainal, Z. (2007). Case study as a research method. *Journal Kemanusiaan*, (9)1-6.
- Zihindula, G. (2020). Universal Health Coverage and Access to care for people with disability in South Africa. *South Africa Health Review 2020 Edition*. Durban: Health Systems Trust (In Press).
- Zihindula G, Meyer-Weitz A, Akintola O. Lived experiences of Democratic Republic of Congo refugees facing medical xenophobia in Durban, South Africa. *Journal of Asian and African Studies*. 2017;52(4):458–70.
- Zihindula, G, Ross, A. J., Dumsani, M. G. & MacGregor, R. G. | De Wet, N. (Reviewing editor) .(2019). A review on the contributions of NGOs in addressing the shortage of healthcare professionals in rural South Africa, *Cogent Social Sciences*, 5:1, DOI: [10.1080/23311886.2019.1674100](https://doi.org/10.1080/23311886.2019.1674100)

Zohrabi, M. (2013). Mixed method research: Instruments, validity, reliability and reporting findings. *Theory and Practice in Language Studies*, 3(2):254–262.
<https://doi.org/10.4304/tpls.3.2.254-262>

ANNEXURES

Annexure A: Approval



KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

DIRECTORATE:

DISTRICT DIRECTOR

Private Bag X9124, Pietermaritzburg, 3200
Physical Address: 1711 Ixosan Haffjee, Pietermaritzburg 3219
Tel: 033 9971002 Fax : 033 9971075 e-mail: 1711ixosanhaffjee@kzn.gov.za

Enquiries: Thule Nzimanmde
22 October 2021

TO: HASEENA MAJID
Senior Atlantic Fellow - Health Equity and Social Justice
B.Optom(OT); MPhil(HIV/AIDS); CAS (Diabetes); AC (Global Eye Health
Management and Planning)
Public health consultant
Affiliated to the uMgungundlovu District Municipality Civil Society
Executive for responses to HIV/AIDS and GBVF

Dear Haseeba Majid


**RE: MONITORING AND EVALUATION OF EYE HEALTH SERVICE DELIVERY: A
PUBLIC-PRIVATE CASE STUDY IN UMGUNGUNDLOVU DISTRICT, KWAZULU-
NATAL**

I have pleasure in informing you that permission has been granted to you by Umgungundlovu Health District to conduct research on "***MONITORING AND EVALUATION OF EYE HEALTH SERVICE DELIVERY: A PUBLIC-PRIVATE CASE STUDY IN UMGUNGUNDLOVU DISTRICT, KWAZULU-NATAL***".

PLEASE NOTE THE FOLLOWING

1. Please ensure that you adhere to all policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received the full ethics approval has been received and the confirmation from the Provincial Health Research Committee in the KZN Department.
3. Please ensure that this office is informed before you commence your research.
4. The District Office will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the District Office.

Thank you,


DR M.T ZULU
DISTRICT DIRECTOR:
UMGUNGUNDLOVU HEALTH DISTRICT

GROWING KWAZULU-NATAL TOGETHER

Annexure B: Language Certification

ETHEL ROSS

English language editing and proofreading

24 November 2023

To whomever it may concern:

This letter serves to confirm that I worked as the proofreader and language editor on Haseena Majid's Ph.D. thesis:

Monitoring and evaluation of eye health service delivery: A public-private case study in the uMgungundlovu District, KwaZulu-Natal

In no way did I change the content.

Yours faithfully



Ethel Ross (BA Hons; H Dip Ed)

Email: elanross1@icon.co.za

Tel: 083 954 5412

Annexure C: Gatekeeper's Letter



ACTIVE
Citizens Movement

Address: 101 New England Road
Pietermaritzburg
3201
P O Box 1122
Pietermaritzburg
3200.
Email: wimble@amweb.co.za
Cell: 071 481 9760
NPO: 214-713 NPO
PBO: 930062338

08 August 2021

The HSSREC
University of KwaZulu-Natal

Dear Madam/Sir

RE: Monitoring and evaluation of eye health service delivery: A public-private case study in uMgungundlovu District, KwaZulu-Natal

I write on behalf of the organisation Active Citizens Movement, Pietermaritzburg to confirm that permission has been given to Haseena Majid, UKZN student number 211549760, to conduct research on the outcomes of the Public Private Health Forum with respect to the eye health service delivery interventions which were facilitated by the Active Citizens Movement in the uMgungundlovu District.

Kind Regards,

Yours Sincerely

Keith Wimble (Dr)

Annexure D: Interview Consent

UKZN HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE (HSSREC)

APPLICATION FOR ETHICS APPROVAL

For research with human participants

Information Sheet and Consent to Participate in Research

Date: 23 October 2021

My name is Ms Haseena Majid, a student in Public Administration at the University of KwaZulu-Natal, School of Management, IT and Governance in the Discipline of Public Governance. I am undertaking a research study towards the D. Admin Degree. My contact details are: Cell No.0835031023 or e-mail: 21154970@stu.ukzn.ac.za and my Supervisor is Professor M. Subban, e-mail address: subbanm@ukzn.ac.za

You are being invited to consider participating in a study that is entitled: ***Monitoring and evaluation of eye health service delivery: A public-private case study in the uMgungundlovu District, KwaZulu-Natal.*** The aim and purpose of this research is to monitor and evaluate the effectiveness of a public-private health forum to address ongoing health challenges and improve service provision in the public sector. The study is expected to enrol 32 participants representing forum participants and eye health stakeholders in the public, private and civil society sectors in the uMgungundlovu District. The study will involve the following procedures i.e. setting up consultation on a virtual bases to gauge the extent of engagement in the forum and to examine how the operation of the forum influenced the output and impact on the public-private cataract surgery service delivery in the district. The duration of your participation if you choose to enrol and remain in the study is expected to be approximately 25 minutes. The study is not funded by any organisation or individual.

The study will not involve any risks and/or discomfort. The study will provide no direct benefits to participants. It is hoped that the study will improve the operational effectiveness of the forum. Participants are free to choose an interview contact session in compliance with the COVID-19 Regulations. This option will require 1.5m social distancing, wearing of face mask and constant hand sanitising. The other option requires Zoom virtual interviews and, in this option, participants will be sent necessary links for the session.

There are no potential risks associated with participating in the study. This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (approval number_____).

In the event of any problems or concerns/questions, you may contact the researcher at: Cell 0835031023 or e-mail: 211549760@stu.ukzn.ac.za or the UKZN Humanities & Social Sciences Research Ethics Committee, contact details as follows:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001

Durban

4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604557- Fax: 27 31 2604609

Email: HSSREC@ukzn.ac.za

Participation in the research is voluntary and participants may withdraw their participation at any point, and that in the event of refusal/withdrawal of participation the participants will not incur penalty or loss of treatment or other benefit to which they are normally entitled. There are no potential consequences

to the participants for withdrawal from the study, a verbal indication to withdraw will be regarded as orderly withdrawal from participating in the study. The indication of withdrawal from participating in the study will be welcomed, and the participant will be immediately terminated from the study.

There will be no costs to be incurred by participants as a result of participation in the study. There are no incentives or reimbursements for participation in the study.

The study does not involve personal/clinical information, and there are no limits of confidentiality applicable. Electronic data will be stored in an online Dropbox where the student and supervisor have access to the file. The supervisor will have access via the encryption of the data. Hard copy responses from interviewees will be stored with the Supervisor for safekeeping for a period of 5 years in accordance with the University policy for postgraduate research. The data will be disposed by shredding hard copies and deleting files that refer to same in accordance with the University policy.

CONSENT

I _____ have been informed about the study entitled:
Monitoring and evaluation of eye health service delivery: A public-private case study in the uMgungundlovu District, KwaZulu-Natal by Ms Haseena Majid.

I understand the purpose and procedures of the study.

I have been given an opportunity to answer questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any of the benefits that I usually am entitled to.

If I have any further questions/concerns or queries related to the study, I understand that I may contact the researcher at: Cell No. 0835031023 or e-mail: 211549760@stu.ukzn.ac.za

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001

Durban

4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604557 - Fax: 27 31 2604609

Email: HSSREC@ukzn.ac.za

Additional consent, where applicable

I hereby provide consent to:

Audio-record my interview / focus group discussion YES / NO

Signature of Participant

Date

Annexure E: Interview Schedule

Interview

Category: Please tick the relevant category

☐ **Governance**

☐ **Public eye health service delivery**

☐ **Forum participants**

☐ **Civil society organisation**

Section A: Biographical data

1. Age and gender : _____
2. Sector : _____
3. Role : _____
4. Number of years in this role: _____

Section B: Forum awareness

1. Are you aware of the Public-Private Health Forum in the uMgungundlovu District to address cataract surgery backlogs?

2. Have you participated in this forum, and in what manner?

3. How have you contributed to the programmes of this forum in any way?

4. What are your views about the current status of public eye health service delivery in the uMgungundlovu District?

5. What are your views about public-private partnerships to address challenges within public eye health service delivery?

Section C: Sector specific information on public eye health service delivery

1. Administrative barriers

1.1 What are the immediate administrative causes of backlogs for eye health service delivery?

1.2 How are patients on waiting lists recorded?

1.3 What reporting systems are in place to enable planning and procurement for patients on waiting lists?

2. Management barriers

2.1 What are the management and reporting barriers in public eye health service delivery from a clinic to tertiary level?

2.2 What is the reporting process for communities presenting to the eye clinic from community clinic level to district level?

2.3 What are the priority indicators reported in relation to eye health service delivery?

2.4 What is the feedback process once reports are submitted?

2.5 How is patient information transferred between departments and/or institutions where referrals are made?

2.6 Who manages the asset register for eye health services?

2.7 How long is the procurement process?

2.8 What are the top 3 management and administrative needs to alleviate cataract surgery backlogs?

2.9 How do you think Public-Private Partnerships can play a role to achieve this goal?

3.Public-Private Health Forum

3.1 Forum purpose addressing cataract surgery as public eye health service need:

3.1.1 How was the need for a forum established?

3.1.2 What were the goals of the forum?

3.2 Did all stakeholders contribute fairly to the development of goals? Describe this process.

3.3 How did the role of the stakeholders influence their willingness and commitment to drive the process?

3.4 What was the main anticipated outcome/s of the forum?

3.5 What is the scope of the forum in relation to providing an intervention for public health eye service delivery?

4. Construct of the Forum

4.1 What is the construct of the forum regarding the capacity of stakeholders?

4.2 What capacity did you/your office occupy in the forum?

4.3 What process was legitimised for the deliberation of public eye health service interventions?

4.4 What was the identified time frame for this collaboration to exist?

4.5 Were there any costs attached to the operation of the forum?

4.5.1 What were the costs for?

4.5.2 Who funded these costs?

5. Forum management and organisation system

5.1 Record keeping:

5.1.1 Who documented the engagements and activities of the forum?

5.1.2 Where are these records stored?

5.1.3 How has accountability and transparency been incorporated within the planning and activity processes?

5.1.4 What were the ethical considerations to be factored into the planning and design of the forum and the interventions?

5.2 Policies:

5.2.1 What are the policies or terms of reference of the forum?

5.2.2 What framework/guideline was used to develop the policies?

5.2.3 Who was tasked to develop the policies and/or terms of references?

5.2.4 At which stage of the process was the policies or terms of reference developed?

5.2.5 Was it adopted/accepted by all the forum stakeholders?

5.2.6 What accountability model has been implemented by the forum?

5.2.7 What are the challenges to accountability experienced by the forum?

5.3 Forum Inputs:

5.3.1 How were causal factors of the surgical backlog deconstructed as an initial process to establish the interventions?

5.3.2 What interventions were decided upon to address the current problem?

5.3.3 What was the time frame to deliver these interventions?

5.3.4 What were the key criteria to shape/guide the interventions?

5.3.5 How was resources determined?

5.3.6 How was the distribution of resources managed?

5.3.7 What were the challenges encountered to acquire resources?

5.3.8 How well/poor was the commitment to provide resources honoured by stakeholders?

5.4 Forum Activities:

5.4.1 What were the key activities undertaken by the forum to implement the interventions?

5.4.2 How was risk sharing distributed amongst stakeholders for/during activities?

5.4.3 Activities in the session

Provide details on the activities of the session in relation to the number, time, and location.

5.4.4 How were the activities documented?

5.4.5 Who was tasked to document it?

5.5 Forum Outputs

5.5.1 What was the key outputs of the forum?

5.5.2 How many cataract surgeries were conducted secondary to the activities of the forum?

5.6 Forum Outcomes

5.6.1 What benefit or change was achieved by the forum for the public eye health service delivery model and the public in general?

5.6.2 Were these benefits only limited to the participants for the duration of the activities?

5.6.3 Highlight how the forum reduced demand on the state sector borrowing as one measure for achieving long-term goals?

5.7 Forum Impact

5.7.1 What are the long-term consequences of this intervention?

5.7.2 How sustainable are the interventions?

5.7.3 What resources are required for the sustainability of the forum?

5.7.4 Who is responsible for the management of its sustainability

5.8 Barriers to the implementation of interventions:

5.8.1 What were the barriers to the implementation of interventions?

5.8.2 How were they identified, and by whom?

5.8.3 Were they correctable whilst the process was ongoing, and how so?

5.8.4 What was the impact of the barriers on achieving the intended outcome?

6. Monitoring and Evaluation

6.1 Activities:

6.1.1 Is there a detailed guideline tracking the cataract intervention program aligned with agreed goals by the forum?

6.1.2 Does the guideline track collection of information, intervention implementation with timelines, manage and track costs and document challenges arising from management, ownership, and credibility?

6.1.3 Does the guideline enable transparent, factual, and credible reporting at any specific time?

6.1.4 How often was results and feedback provided to the forum?

6.1.5 Who was tasked to produce this information?

6.1.6 How was the information presented and what were the outcomes of the presentations?

6.2 Reporting:

6.2.1 How did the information (collected and reported) shape the way forward to next steps?

6.2.2 To what extent has it influenced the way the cataract backlog is now managed?

6.2.3 Did sharing of findings or lack thereof influence stakeholder responses, commitment, and resource allocations?

6.2.4 How was civil society included in the process of distributing information regarding cataract backlogs?

6.3 Evaluation:

6.3.1 Has there been continuity and sustainability in the reporting?

6.3.2 How are stakeholders held accountable for this intervention?

6.3.3 What structures exist within the forum to continue with the cataract intervention program aligned to goals?

6.3.4 Is there anything else you wish to share about the health forum, public-private partnerships for eye health service delivery or eye health service delivery in general?

Thank you for making time to participate in this study.

Annexure F: Ethics Approval



11 November 2021

Haseena Majid (211549760)
School Of Man Info Tech & Gov
Westville Campus

Dear H Majid,

Protocol reference number: HSSREC/00003579/2021

Project title: Monitoring and evaluation of eye health service delivery: A public-private case study in the uMgungundlovu District, KwaZulu-Natal

Degree: PhD

Approval Notification – Expedited Application

This letter serves to notify you that your application received on 04 November 2021 in connection with the above, was reviewed by the Humanities and Social Sciences Research Ethics Committee (HSSREC) and the protocol has been granted FULL APPROVAL.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number. PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

This approval is valid until 11 November 2022.

To ensure uninterrupted approval of this study beyond the approval expiry date, a progress report must be submitted to the Research Office on the appropriate form 2 - 3 months before the expiry date. A close-out report to be submitted when study is finished.

All research conducted during the COVID-19 period must adhere to the national and UKZN guidelines.

HSSREC is registered with the South African National Research Ethics Council (REC-040414-040).

Yours sincerely,



Professor Dipane Hlalele (Chair)

/dd

Humanities and Social Sciences Research Ethics Committee

Postal Address: Private Bag X54001, Durban, 4000, South Africa

Telephone: +27 (0)31 260 8350/4557/3587 Email: hssrec@ukzn.ac.za Website: <http://research.ukzn.ac.za/Research-Ethics>

Founding Campuses: ■ Edgewood ■ Howard College ■ Medical School ■ Pietermaritzburg ■ Westville

INSPIRING GREATNESS