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# Achieving community-oriented primary healthcare through collaborative learning: The KwaZulu-Natal Primary Health Care Transformation Committee

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This in-practice article describes the processes involved in the development and functioning of the KwaZulu-Natal Primary Health Care Transformation Committee (PHCTC) as a collaborative learning governance structure. The PHCTC brings together the Department of Health policy-makers, University of KwaZulu-Natal academics, the Office of the Premier, non-governmental organisations, civil society representatives and other sectors. This platform has facilitated multi-level planning and mobilisation informed by a co-developed theory of change towards strengthening primary healthcare (PHC); generated co-developed and impactful public health research that has informed the adoption of evidence-based approaches, innovations and implementation strategies for strengthening PHC; and enabled contextually relevant teaching programmes in line with PHC. Key considerations for similar academic multistakeholder generative, collaborative structures to the PHCTC include the importance of cultural brokering, mutual capacity building, shared values and multi-level long-term planning and service-level agreements to promote sustainability.

**Keywords:** district health services, collaborative learning, primary healthcare

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South Africa (SA)'s health system policy landscape has undergone significant shifts during the past three decades, with much progress toward enabling a more equitable, responsive system built on primary healthcare (PHC) principles.[1,2] Since 2010, SA has embarked on significant health reforms to strengthen PHC as the foundation of its healthcare system through the PHC re-engineering initiative. The latter comprised three key streams: (*i*) nurse-led ward-based family community health worker (CHW) outreach teams (WBPHCOTs); (*ii*) school-based outreach teams; and (*iii*) district clinical specialist teams.[1] Over time, these efforts were integrated into the broader National Health Insurance (NHI) framework – a policy aimed at achieving universal health coverage. The NHI envisions a centralised fund to finance healthcare services from both public and private providers to improve system equity and quality for clients.[3] To improve system parity and quality, a fourth stream was added to PHC re-engineering under the NHI framework – the GP contracting initiative (GPCI) – designed to contract private sector general practitioners (GPs) to deliver time-bound sessions in public-sector PHC facilities to increase access to care for uninsured clients.[4,5]

NHI reform initiatives, including PHC re-engineering, were piloted in selected districts nationwide. Substantial challenges were encountered, including limited resources, fragmented service delivery, inadequate planning, poor communication and weak co-ordination and monitoring systems.[6] These challenges highlight the persistent tension in health systems strengthening: the difficulty of translating policy objectives and evidence-based models into practical, real-world outcomes.

To assist in overcoming these challenges, the chief director for District Health Services (DHS) in KwaZulu-Natal (KZN) initiated a partnership with the University of KZN (UKZN) to harness advocacy support and research capital to assist in closing the PHC re-engineering policy implementation gap in KZN. To this end, a collaborative governance structure of these two entities was formed in 2018, called the Primary Health Care Transformation Committee (PHCTC).[7]

Collaborative governance has consistently been put forward to address complex public health challenges. Collaboration between governments, universities and non-governmental organisations (NGOs) and civil society in public health is crucial for addressing complex health challenges, promoting evidence-based policies and improving overall population wellbeing.[8,9] Collaborative governance involves public agencies and non-state actors engaging in co-operative learning and consensus-oriented, deliberative collective decision-making to develop, implement and manage public policies.[10] This learning is outcome-oriented and relies on co-design, co-production and co-assessing policy implementation processes to achieve systems change.[10-13]

In this in-practice article, we describe the PHCTC, including a brief history, and steps and approaches adopted by the PHCTC in KZN. The experience of the PHCTC offers a set of transferable lessons and key considerations for other academic-led multistakeholder initiatives seeking to establish generative, collaborative governance structures for PHC strengthening. The authors are the key drivers of this initiative, representing both the KZN Department of Health (DoH) and UKZN, supported by various stakeholders.

TIMELINE

**March 2018**
**Initiation**
- Meeting convened by Mr Mndebele
- DoH and UKZN
- Package of community services toward population-based approach

**May 2018**
**First stakeholder engagement**
- COPC Indaba
- District roadshows to build will

**March 2019**
**Capacity building**
- Targeted training and skills development
- Household tools, prescribed training material
- Targeted ward-based PHC outreach teams
- Cascade model

**April 2019**
**KZN PHC conference**
- Ward-based PHC outreach teams showcased work since 2012
- PHCTC formally formed

COVID-19

**April 2021**
**Post-COVID renewal**
- Workshop to renew PHCTC focus and operations

**2021**
**Leveraging grant funding**
- Two new research grants leveraged to test interventions at a learning site

**November 2021**
**Theory of change**
- Shared vision, objectives, structures formalised in a ToC map

**2022 - present**
**Subcommittee activities**
- Subcommittees formed
- Thematic activities undertaken
- Quarterly feedback meetings scheduled

*Fig. 1. Primary Health Care Transformation Committee (PHCTC) timeline. (DoH = KwaZulu-Natal Department of Health; UKZN = University of KwaZulu-Natal; COPC = community-oriented primary healthcare; PHC = primary healthcare; ToC = theory of change.)*

## Brief history of the PHCTC

The PHCTC was initiated in March 2018, convened by Mr Mndebele, the chief director of DHS. The KZN DoH Management Committee (MANCO) formally endorsed the PHCTC to secure high-level managerial support. Subsequently, the PHCTC undertook efforts to garner support for re-engineering PHC at the subregional district level. In May 2018, the first stakeholder engagement occurred through district roadshows. These informational campaigns were co-facilitated by DoH policy-makers and UKZN academics, and culminated in a workshop named COPC (community-oriented primary healthcare) Indaba, led by the MEC for Health to launch the initiative. March 2019 marked the beginning of a capacity-building process, incorporating targeted training of ward-based PHC outreach teams using a cascade training model. The KZN PHC Conference was held in April 2019. The conference facilitated the sharing of best practices among WBPHCOTs and culminated in a pledge to advance PHC re-engineering. However, activities were halted due to the COVID-19 pandemic from March 2020 to March 2021. The pandemic's disruptions led to the expansion of the PHCTC's composition to include the Office of the Premier, NGOs and other governmental sectors, broadening its mandate beyond advocacy to encompass curriculum reforms for healthcare education (Fig. 1). Following the pandemic, in April 2021, a workshop was held to refocus the PHCTC's operations. A theory of change (ToC)[14] was co-developed to guide this process.

## Theory of change

Five workshops were held with the PHCTC stakeholders, guided by academics experienced in the ToC process. To initiate the ToC, the PHCTC adopted and adapted the impact indicators established by the KZN DoH. These indicators were originally developed for the department's 2020/21 - 2024/25 planning cycle, and are aligned with existing departmental policies, strategic priorities and the overarching goals of the National Development Plan (NDP) 2030.[15] The selected indicators include: (*i*) impact – increased life expectancy and outcomes; (*ii*) universal health coverage; (*iii*) improved client experience of care; and (*iv*) reduced morbidity and mortality.[16] A key advantage of this approach is that the monitoring and evaluation framework is aligned with the provincial annual performance plan, thereby ensuring coherence with established performance measurement systems and enhancing accountability using pre-existing, formally documented indicators.

The ToC provided a framework for prioritising programme inputs and activities, including implementation research topics and evidence syntheses required along the identified pathways to achieve intermediate measurable outcomes with associated indicators, and to achieve identified long-term outcomes and impact. It also provided a platform to discuss assumptions underpinning the theory and possible barriers to implementation.

The ToC was developed at three levels: community, PHC facility and organisational managerial levels. The organisational and managerial level was guided by the Ministry of Health and the National DoH policies in SA, within which subnational/provincial governance structures can adapt national frameworks to local conditions, set priorities, and co-ordinate and mobilise local actors to ensure sustained implementation of health programmes. Some of the activities at this level identified through the ToC included: (*i*) orienting the whole of the KZN DoH to a community focus, which included reviewing performance appraisal systems and benchmarking to reinforce the COPC approach; and (*ii*) facilitating decentralised governance and financing to the subdistrict level, with staffing allocated to the clinic catchment areas as opposed to clinics.

The PHC facility level is a critical component of the re-engineering of PHC, as the WBPHCOTs and school health teams are linked to PHC facilities and report to their PHC facility operational manager, responsible for the configuration of roles, responsibilities and accountabilities, thus providing a governance base for their activities. As part of the ToC process, some of the activities identified at this level included: (*i*) revising clinical care to be person centred and community focused, with integrated clinical practice guidelines incorporating clinical communications skills; (*ii*) linking WBPHCOT members to clients requiring follow-up visits to promote adherence/provide health promotion/link back into care; and (*iii*) orienting PHC facilities to take on the role of community stewards, where the catchment populations are regarded as the clients as opposed to just those who attend clinic services.

As part of the ToC process, some of the required activities identified to strengthen the community level of care included: (*i*) improving WBPHCOT tools to optimise

person-centred integrated household care for health promotion, adherence support and risk screening, as well as reviewing existing information systems and establishing a real-time digital data system to track referrals made to the PHC facility to optimise linkage to care; (*ii*) empowering communities to play a more active role in their care and wellbeing, including establishing household champions, who are family members identified and capacitated to support family members in managing their health conditions; and (*iii*) optimising communities' control over the services provided through, among other things, clinic-community learning sessions and community clinic audits. The community level of care involves engaging and strengthening the KZN civil society structure, Operation Sukuma Sakhe (OSS). OSS is a provincial, integrated, multisectoral approach to service delivery that brings together government departments, civil society, traditional leadership and communities to respond collectively to social, economic and health-related challenges at the community level (Fig. 2).[17]

### Institutional support for the work of the PHCTC

The PHCTC and ToC were presented to the KZN DoH MANCO to ensure support from the most senior management level. MANCO is led by the head of health and senior DoH managers. This was an important step, as it cemented the legitimacy of the PHCTC; provided a mandate for the policy-makers to be allocated protected time to be part of the PHCTC; provided support for resources, such as transport and accommodation, where required; and facilitated endorsement of participation in PHCTC as part of their role as provincial and district leadership. To this end, a service-level agreement (SLA) was signed between the KZN DoH and UKZN based on the ToC, which was critical as it outlined the expectations, responsibilities and deliverables of each party involved, and was linked to the targets and deliverables of the DoH.

## Establishment of subcommittees

The PHCTC team formed nine subcommittees to support the activities identified in the ToC to achieve its intermediate outcomes. Each subcommittee has independent work plans and engagement strategies, including research activities where needed (see appendix Table 1 for a list of subcommittees and activities). Much progress has been made in achieving the activities outlined in the ToC by the established subcommittees. These achievements are also summarised in appendix Table 1.

## Collaborative research approach

Research activities straddle subcommittees, with the PHCTC providing a platform for enabling truly collaborative research through continuous and sustained engagement with multiple stakeholders, from the development of research grant proposals to research implementation and scaling up of evidence-based innovations emanating from implementation research beyond the timeframe and scope of the funding. Research projects emerging from or conducted alongside the collaborative's activities have secured full ethical approval through the appropriate institutional ethics review processes.

A human-centred design approach underpins the development of innovations and implementation strategies being researched, with the involvement of subgroups of providers and communities (including people with lived experience of conditions investigated) involved in iteratively co-developing prototypes for further testing.[18] This approach at the micro and meso levels optimises appropriateness and relevance for end-users and recipients, with engagement with programme managers and policy-makers fostering ownership and sustainability at a macro level.

## Use of a learning health system approach

A learning health system (LHS) approach relies on collective cyclical learning processes. Relevant data from the health system are analysed to identify bottlenecks and generate possible solutions to change or refine innovations and implementation strategies to improve outcomes further.[19,20] Outcomes of the subcommittee activities are fed back to the PHCTC during quarterly learning sessions. These include data from grant-funded research. Reflection on the meaning of the data ('data to knowledge' phase) is followed by further action of the subcommittees ('knowledge to action' phase). Assessing newly emerging data resulting from implementation ('practice to data' phase) allows for re-initiation of the LHS to improve the implementation based on the data generated, as well as for refining the ToC (Fig. 3). Grant-funded research plays a vital role in these cycles, heuristically informing and being informed by the ToC, its actions and learning sessions.

A key building block of the LHS approach usually involves shared, interoperable databases fit for the learning process.[21] Given the scope and breadth of the PHCTC goals and the lack of available routine data for much of its focus areas, centralised shared data were less prominent as the primary source of data-to-practice. Instead, the PHCTC's ToC was populated through a range of different data sources, including results and findings from research programmes, routine data indicators, current policy directives and, most importantly, participatory workshopping within the learning collaborative. With recent expansions of LHS operationalisation, this is in step to include a mix of data sources as a basis for strategising, and addresses an over-reliance on large, 'big data' quantitative databases as the primary source for strategising in earlier LHS approaches in high-income settings.[22] Further, while a learning collaborative is the usual central driving structure in the LHS approach, the PHCTC decentralised this into nine thematic subcommittees, each forming its learning collaboratives, ultimately feeding into the broader PHCTC ToC.[23]

Key considerations for similar academic multistakeholder generative, collaborative structures are described below.

## Cultural brokerage

ZL acted as a cultural broker or boundary spanner, a role which was identified as a key to the success of the PHCTC. Public health researchers and practitioners have long acknowledged the disconnect between research and practice in public health.[24] Calls for more interaction between policy-makers and researchers are familiar. They are essential for promoting the identification of different policy areas requiring research attention on the one hand, and meaningful engagement around research findings and policy implications on the other, to optimise the impact of public health research.[25] These interactions are, however, challenging to navigate, given that researchers and practitioners view problems through different lenses.

Researchers focus on the required knowledge gaps for research, from conceptual thinking to evidence gaps. In contrast, policy-makers and implementers are focused on gaps in tangible outcomes linked to service delivery and coverage of the population. Researchers focus on what works, generally at a small scale, while policy-makers and implementers are driven by demonstrating population coverage. Collaborations where researcher partners are responsive to practice-identified outcome gaps, and generate evidence on what works, how, and in what contexts, are essential for policy-makers to understand how best to scale up evidence-based interventions, including policy changes that may be required to create an enabling environment for implementation. However, understanding the goals

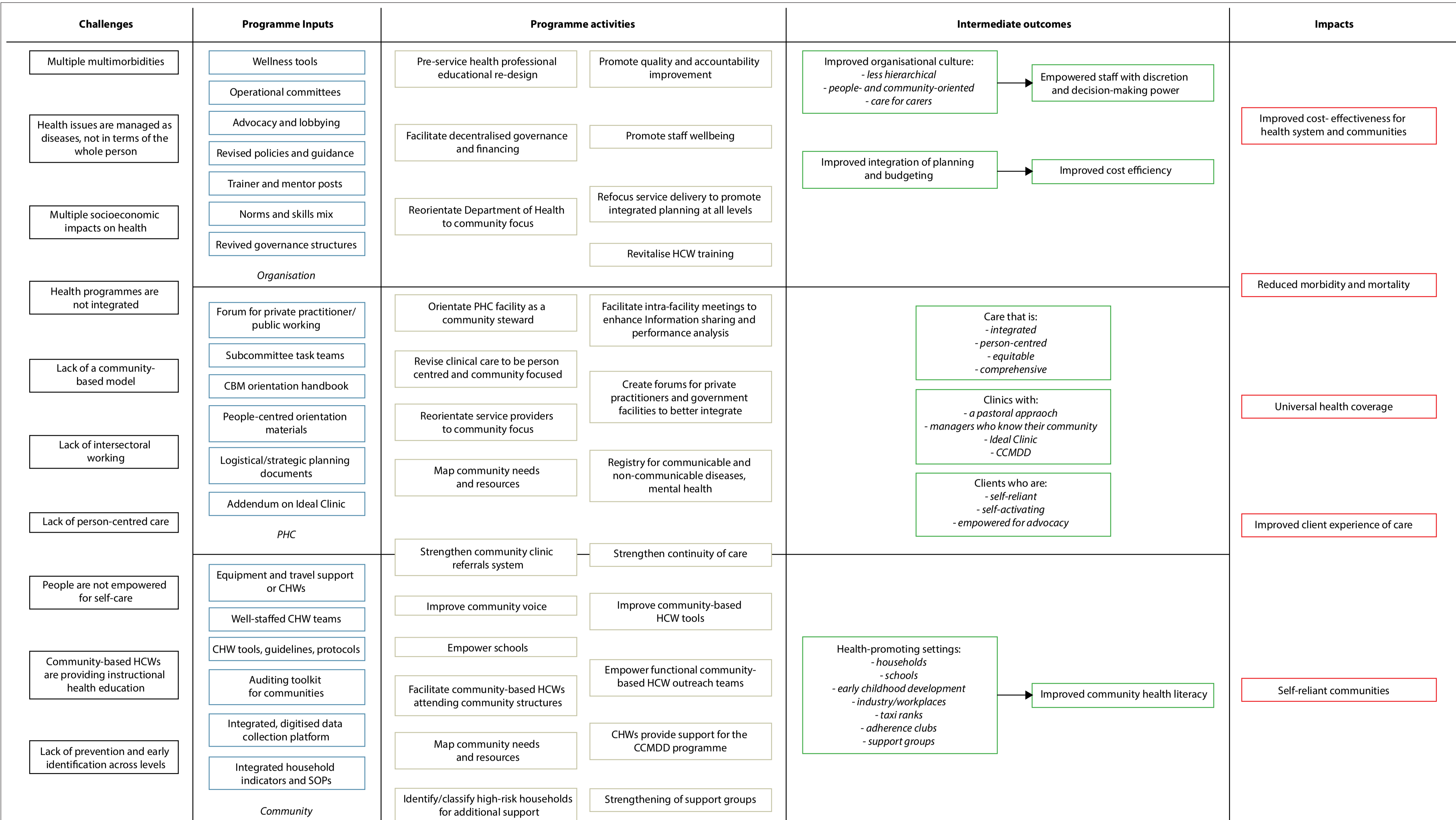


*Fig. 2. Theory of change guiding the Primary Health Care Transformation Committee (PHCTC). (CBM = community-based monitoring; PHC = primary healthcare; CHW = community health worker; SOP = standard operating procedures; HCW = healthcare worker; CCMDD = Central Chronic Medicines Dispensing and Distribution.)*

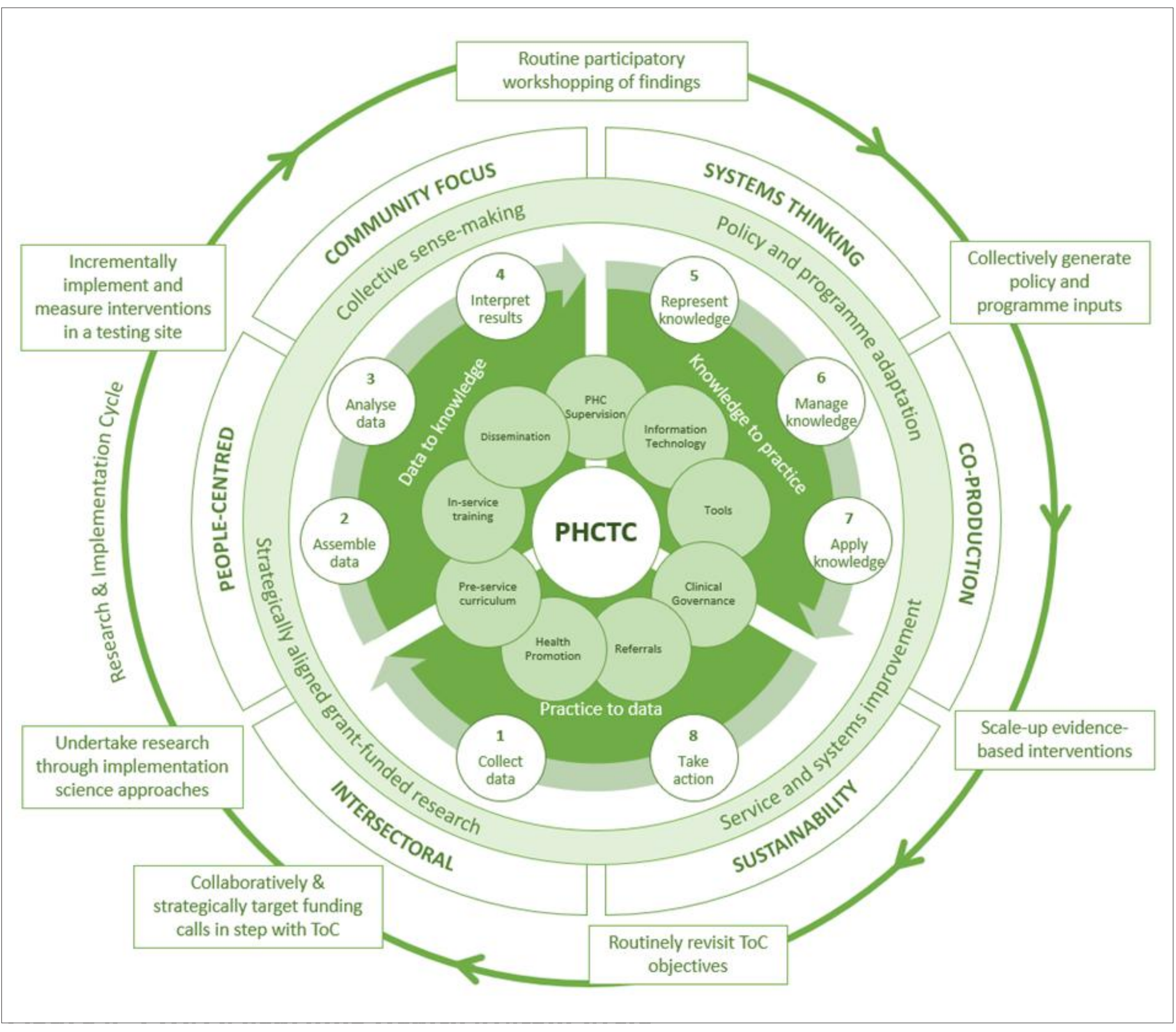


*Fig. 3. Primary Health Care Transformation Committee (PHCTC) learning health system cycle. (ToC = theory of change; PHC = primary healthcare.)*

and incentives driving each party is essential to reach collaborative working arrangements. Policy-makers and implementers must be sensitive to the incentives that drive researchers, such as attracting grant income and publishing in peer-reviewed journals. On the other hand, academics and researchers need to be sensitised to the goals and incentives that drive policy-makers and implementers.

The cultural broker fosters a generative and collaborative working relationship within the PHCTC, strengthening the link between academic researchers and policy and practice communities. Experience in academia and in service delivery within the KZN DoH are fundamental to this brokerage role, facilitating mutual understanding and bridging the diverse perspectives of stakeholders. Brokers, by definition, facilitate transactions such as sharing resources and information between otherwise unconnected people, groups, or communities.[26] In the case of KZN PHCTC, the cultural broker helped to translate research jargon into ordinary language for the policy-makers and practitioners, while offering a similar process for the research team so that they could understand the DoH processes and culture – thus connecting research producers and users to catalyse knowledge exchange. Through this process, it was possible to identify common goals, negotiate a research agenda, organise partnership meetings and facilitate communication.

To function successfully, brokers need to have critical attributes, such as an entrepreneurial spirit, which allow for managing the functioning and alignment of the dynamics of the two worlds. They need to be respected and trusted by both parties as credible and transparent communicators, as they play a crucial role in developing a communication strategy that links these different worlds and helps to arbitrate disagreements and challenges.[27]

In the case of the PHCTC, the cultural broker played a vital role in setting up regular meetings and engagements, allowing the teams to immerse themselves in each other's worlds. Part of the brokerage process involved functioning as a co-chair during the meetings, from developing the agenda to ratifying the agenda and invitations, and co-chairing during meetings. The chairing process included reading the room to promote flexibility and adaptation during meetings to ensure that both worlds were included and catered for during the engagements. The broker was also responsible for expanding the network, thus introducing participants identified as having value to the work of the PHCTC.

## Capacity building

The availability of well-trained and capable research scientists with the ability to understand and structure research at the intersection

of science, policy and practice was essential for establishing and maintaining the PHCTC. Capacity building of all the role-players was one of the objectives of the PHCTC. An egalitarian approach to capacity building is a *sine qua non*, with policy-makers sharing knowledge on policy-making, governance and related routine data findings to guide the targeting process. The DoH team was capacitated by the research team in the implementation research approaches, such as ToC and continuous quality improvement (CQI), as a strategic way to enhance the skills of programme leads and stakeholders in designing, implementing and scaling effective health interventions.[28]

Learning by doing was the capacity-building approach adopted. Understanding the ToC as a tool to map pathways for achieving desired outcomes was achieved by co-developing the PHCTC ToC. Similarly, CQI capacity-building efforts were achieved through PHCTC members applying and practising CQI principles and methods in their daily work, supported by mentorship. This apprenticeship approach was extended to within the research team, with early career researchers participating in all aspects of the research process as part of a research team led by more senior, experienced researchers.

## Long-term planning and sustainability

The KZN-PHCTC collaboration is viewed as a long-term commitment rather than a short-term endeavour. Such a collaboration requires flexibility and adaptability to respond to changing circumstances and emerging challenges, with a willingness to adjust strategies, methodologies and activities based on evolving needs and opportunities. This flexibility enables the partnership to remain relevant, effective and responsive to the dynamic nature of public health and societal needs. In the KZN-PHCTC, this is done through continuous reflection on pertinent new policies and the latest empirical evidence, and depends intensely on a commitment to the shared values and acknowledgement of the benefit all parties bring to the endeavour. Further, an SLA was signed, thus embedding PHCTC institutional memory and operational resilience into programmes, reducing dependence on individuals and enabling long-term success. Partaking in the PHCTC is seen as part of the role of the DHS leadership, as part of the sustainability plan beyond individuals. In the case of academics, the project is part of the institution's strategic imperatives.

## Shared values

Solidarity driven by the *ubuntu* principles underpins the PHCTC, requiring egos and the positions and roles held at the workplace to be put aside to pursue societal impact. Alongside solidarity is sharing resources, with the DoH and UKZN sharing resources and spaces equally. Valuing and sharing all forms of knowledge as valid is also critical, with respect for and sharing of knowledge of each party, which is vital for success. To ensure high-quality, contextually appropriate and equitable healthcare, scientific integrity and rigour are regarded as central to the endeavours of the PHCTC, as is the involvement of communities as generators and beneficiaries of healthcare.

## Limitations and challenges

One unexpected challenge was the need for financial resources to support the activities and engagements that were unplanned but necessary to support activities. This is mitigated through sharing resources and harnessing support from externally funded NGOs.

Members of the PHCTC who are employed as academics and policy-makers within government departments are not dedicated project staff; instead, they participate in PHCTC activities as an additional responsibility. This dual role often makes it difficult to align schedules and co-ordinate effectively. The formal nomination of members and the integration of PHCTC participation into the job descriptions of provincial and district policy-makers have facilitated more structured engagement. Furthermore, incorporating PHCTC activities into the official calendars of academics and policy-makers institutionalises their involvement, allowing these efforts to be recognised as part of their core responsibilities and reported through higher-level strategic management structures. This, in turn, enhances visibility, garners institutional support and aids in resource mobilisation.

Limited private sector participation only through the GPCI is a shortcoming.

## Conclusion

The PHCTC exemplifies how a collaborative learning governance structure can facilitate a shared culture towards systems change. This structure enables public health research capital to be harnessed for the DoH to address complex public health challenges and promote evidence-based policies and practices. For public health researchers, it substantially strengthens the capacity of research partners to conduct truly collaborative, contextually relevant implementation research,[29] optimising societal relevance and impact. The PHCTC facilitates the flow of information and collaboration between research, policy and practice to improve the health and wellbeing of individuals and populations across the province of KZN as part of the strategies toward realising PHC re-engineering for universal health coverage.

**Data availability.** The data used for this study are available from the authors on request.

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**Conflicts of interest.** None.

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