The changing fortunes of the District Health System in SA (1994 - 2020): A retrospective review

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Background. The District Health System (DHS) forms the foundation of South Africa (SA)'s public health system. Following years of fragmentation and inequity during the apartheid era, building the DHS was seen as a vital element of the strategy to reform the health system in line with the principles of primary healthcare (PHC). SA has made great strides in establishing and strengthening the DHS, and to date there are 52 districts and 240 subdistricts. This process unfolded in a complex, and often challenging, social and political context.

Objectives. To present an historical account of the DHS as a focus of national-level policy and strategy from 1994 to present. In doing so, we aim to illuminate the factors influencing DHS development over time, and contribute to an historically aware understanding of SA's DHS and its contemporary challenges.

Methods. We conducted a retrospective scoping review of literature on the DHS in SA from 1994 to 2020. We used database searches to identify primary and secondary documentary evidence, supplemented by purposive searches of databases and institutional repositories, and published and unpublished documentary evidence from the personal archives of key stakeholders. We extracted data on the timing of policy developments and contextual factors influencing DHS prioritisation and strategy using a structured data extraction sheet. Once extracted, this information was organised into a timeline.

Results. After full-text review, 134 items were included for analysis. Based on the data analysis, we divided the events of the policy timeline into three periods: 1994 - 2000 (developing the legislative framework for the DHS, establishing local government boundaries and building district-level capacity), 2001 - 2009 (finalisation of the National Health Act, and the effects of the HIV epidemic and vertical health programmes on the DHS), and 2010 - 2020 (development of National Health Insurance legislation and associated efforts to strengthen PHC). This periodisation reflects differences in the pace of policy change, the extent of political prioritisation of the DHS and contextual factors influencing its development.

Conclusion. Sustained political commitment to DHS development in SA is evident. However, the development and implementation of the DHS have been both enabled and constrained by various contextual realities, and is best understood in relation to wider health system and sociopolitical dynamics. Further in-depth analyses of the nature, focus and limits of DHS strengthening efforts are warranted. In particular, history-sensitive analyses of the sociopolitical factors that shaped the development of the DHS will inform strengthening efforts going forward.

Keywords: District Health System, South Africa, retrospective review, periodisation, health system development, policy

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In 1986, 8 years after the Alma Ata conference on primary healthcare (PHC), and in the context of widespread economic crises and health budget cuts, the World Health Assembly (WHA) urged member states to strengthen district health systems as a platform for the delivery of PHC.[1,2] This shift in emphasis was a result of a growing realisation that weak organisation and management of PHC at the lower levels of the health system consistently undermine efforts to achieve health for all.[2] After the WHA, the World Health Organization (WHO) adopted the following definition of a district health system: a 'more or less self-contained segment of the national health system' comprising a 'well-defined population' living in 'a clearly delineated geographic and administrative area', in which all component elements of the health system co-ordinate for the provision of 'promotive, preventive, curative and rehabilitative' health services.[2]

In South Africa (SA), the District Health System (DHS) has been considered the foundation of the health system since 1994, when the newly elected government began the process of health system transformation in line with the values and principles of the post-apartheid democracy. Under apartheid, the health system was fragmented, hospicentric and inequitable.[3,4] The 1994 African National Congress (ANC) National Health Plan committed to bringing the health system 'into line with international thinking and practices' through the development of a SA DHS.[5] In practice, this required dramatically transforming the entire system, including by aligning district health system boundaries to the redrawn local government boundaries, and introducing a coherent decentralised decision-making authority for health.[6-9] This massive reorganisation was complicated by the heterogenous nature of the apartheid public health system.

Some parts of the system (notably the former 'homeland' areas) were already structured in ways resembling the DHS, while other parts required completely new structures.[9] Resources across these systems were highly inequitably distributed. In the years that followed, government made great strides in redressing inequities in access to healthcare, implementing and strengthening the DHS as the primary vehicle for the delivery of PHC, and investing in and revitalising the PHC platform.[10] However, the process has not been straightforward, and has, over time, been shaped, enabled and constrained by political, economic and epidemiological realities in the broader SA context.

Pre-1994 and in the early years of the new democracy, the issue of what the DHS should be, given the commitments of the Reconstruction and Development Programme (RDP) and the ANC Health Plan, received attention from both academics and practitioners.[11-13] In addition, until the early 2000s, there were significant efforts to evaluate the progress of legislative work to establish the DHS, and to explore the challenges of establishing the DHS amid the post-election upheaval.[14-19] This body of work also included province- or district-specific assessments of readiness for, and progress in, DHS implementation.[20-23] Since the early 2000s, however, academic literature on the DHS has mostly focused on disease-specific or programmatic aspects such as service integration,[24,25] human resource availability[26] and impediments to PHC service delivery.[27-29]

Despite widespread recognition of the DHS as the foundation of the SA health system, its evolution – the efforts undertaken to strengthen it, and the factors that enabled and undermined these efforts over time – has garnered little academic attention. In this article, we present a periodisation of the development of the DHS in SA since 1994, to illuminate its history as a focus of national-level policy and strategy. In doing so, we hope to contribute to a historically aware understanding of the SA DHS as the most decentralised level of the health system, and of its contemporary challenges, and to inform future DHS-strengthening efforts.

Methods

We conducted a retrospective scoping review of primary and secondary evidence on the DHS in SA from 1994 to 2020. We conducted database searches in PubMed, AfricaWide and Web of Science to collect secondary documentary evidence, including articles published in regional and social science publications (which may not be indexed in PubMed). Searches were conducted in September and October 2023. Our search strategy combined four search strings, including 'health', 'district', 'South Africa' and a list of synonyms for 'policy', 'strategy' and 'systems'. To identify primary documentary evidence and supplement the database search, we conducted purposive searches of online databases and organisational repositories including Google, Google Scholar, websites of national and provincial health departments, the Health Systems Trust (including all published issues of the *South African Health Review* and *District Health Barometer*), the WHO and the University of Cape Town library. In addition, we contacted health system actors within the SA Learning Alliance for the DHS (SALAD) with longitudinal experience of DHS policy and strategy, requesting any relevant unpublished material from their personal archives. We included material published between 1990 and 2020 to coincide with the end of the DHS Policy Framework and Strategy 2014 - 2019,[30] and taking into consideration the advent of the COVID-19 pandemic, which introduced new challenges and disrupted systems-strengthening efforts.

The titles and abstracts of identified items were scanned for relevance to the study objectives. We included all documents offering insight into the policy, politics, strategy, legislation, or governance of the SA DHS. This included national- and provincial-level policies and policy processes, although a full accounting of DHS-related policy processes within each of the nine provinces is beyond the scope of this research. We included primary and secondary evidence, spanning peer-reviewed academic articles and book chapters, letters and editorials published in academic journals, policy documents, institutional and research project reports, and internal guidelines and communications. Ultimately, we analysed 134 items, including 92 peer-reviewed academic articles and chapters, as well as commentaries or editorials, research or organisational reports, policy documents and guidelines. Appendix Fig. S1 presents the included material by year and type of evidence. We extracted data on the DHS policy process, contextual factors and policy content using a structured data extraction sheet. For the periodisation presented in this study, we used the information in the data extraction sheet to develop a timeline of key events in the policy process, and contextual factors that influenced either the details of policy content, or the level of priority afforded to the DHS in national policy and strategy. The full timeline is available as Appendix Table S1, and a summary timeline showing key events in each period is presented in Appendix Fig. S2.

Periodisation has been used elsewhere as a useful approach to analysing extended and complex policy processes in a way that accounts for the influence of history and context.[31,32] In this case, the periodisation emerged organically through the process of developing the timeline, and was refined through internal discussions within the authorship team. The periodisation was then triangulated and further refined through discussion with key stakeholders with longitudinal experience of the DHS through the SALAD network.

Results

The development of the DHS in SA can be understood as unfolding in three distinct periods, each characterised by contextual factors that influenced DHS development and functioning. While it is inevitable that many events and processes persist across periods (such as policy formulation processes beginning in one period but only being finalised in a later period), we present a periodisation that accounts for broad trends in DHS development, and accommodates major policy developments as well as lulls in policy processes. In the following sections, within each period, key issues and events are organised thematically (rather than chronologically).

First period (1994 - 2000): Developing legislative and governance foundations, establishing local government boundaries and building knowledge and capacity

This period, spanning 1994 - 2000, was characterised by concerted formative activity establishing the legislative and governance foundations for the DHS, and by efforts to build local-level capacity and decentralise authority, both within the health system and in government more broadly. However, the process of establishing the DHS was complicated by the intention to align health district boundaries with local government boundaries, which were being redrawn,[16,33] and by delays in finalising the National Health Act 61 of 2003 (NHA).[34]

Developing legislative and governance foundations for the DHS

Shortly after the democratic transition in 1994, the ANC National Health Plan proposed an integrated and equitable National Health System oriented around district-based community health centres (CHCs), which would provide 'promotive, preventive, curative and rehabilitative care'.[5] Provinces would be subdivided

into geographically coherent districts, with each district having at least one CHC and serving between 50 000 and 750 000 people.[5] Following the National Health Plan, the ANC's first macroeconomic plan, the RDP, similarly proposed a decentralised health system and the establishment of district health authorities (DHAs) as the primary bodies responsible for delivering and ensuring access to PHC services.[14,35,36] In addition, various cross-provincial structures were created to support and co-ordinate DHS development. A National DHS Committee was created in 1994, with each province represented by a DHS co-ordinator,[37,38] to support DHS development across provinces. The report of this committee – published for public comment in November 1995 as a draft national 'Policy for the development of a District Health System for South Africa',[35] and officially adopted in 1996 – was the first substantive DHS policy proposal, detailing the process for DHS development and describing the functions of community health committees, district hospital boards and district health councils.[35,37-40] The DHS Committee was maintained over time, with provincial representatives meeting regularly to share experiences on DHS development.[19] Additionally, the National Department of Health (NDoH) established a national DHS Task Team to ensure that DHS development was considered in all planning processes, and a District Financing Task Team to address intraprovincial inequities.[19,41]

From its inception, the first democratic government began devolving authority and responsibility for the delivery of healthcare from national level to the nine, then establishing, provincial governments.[6] By 1997, the new provincial governments had started to appoint district managers and set up interim district management teams (composed of provincial and local health department professionals and community members).[42]

A persistent challenge during this period was that the new NHA remained under development, and, at times, under a 'cloak of secrecy'.[40] In November 1996, the ninth draft of the Act was circulated for comment, and helped give some direction to the development of the DHS, proposing district health councils and governance structures for health facilities.[40,43] However, the NHA was not finalised until 2003, with the result that provinces lacked vital guidance in establishing the DHS, and the NDoH lacked official legal authority to implement its newly developed policies.[43,44]

The interpretation of 'municipal health services' and the allocation of responsibility between local and provincial government

Within the process of legislative development, confusion emerged about the division of responsibilities between provincial and local government. The 1995 draft DHS development policy detailed a wide range of preventive, promotive and curative community-, hospital- and clinic-based services that the DHS would be expected to render, including maternal health, children and youth (including school) health, oral health, mental health and accident and emergency services.[35] This wide scope of responsibility was echoed in the 1997 White Paper for the Transformation of the Health System.[45] However, while the new Constitution, in 1996, established 'municipal health services' as the responsibility of local government, it did not offer a definition of these. Between 1998 and 2000, negotiations on the wording for the amendment (Local Government Municipal Structures Amendment Act 33 of 2000) to the Municipal Structures Act 117 of 1998 (which, like the Constitution, used the term 'municipal health services') made clear that many felt that the scope of 'municipal health services' should be limited to non-personal services, so as to protect local governments from having to fund and deliver a full package of PHC services.[46-49]

In the absence of a clear definition of 'municipal health services', the exact health functions to be allocated to local government remained unclear,[47] resulting in confusion regarding the division of responsibilities and funding between provincial and local government, and considerable interprovincial and interdistrict variation in PHC service delivery.[16,47,50] It was only in the next period of DHS development, with the passing of the 2003 NHA, that the roles and balance of power between provinces and local government around the DHS were clarified. In the interim, most provinces had either passed or drafted their Provincial Health Acts, which then had to be redrafted or formally amended to align with the NHA.[16]

Establishing local government boundaries

Another contextual influence in this period was the concurrent process of redrawing local government boundaries. Given the enormous scale of transformation in the country, local government and health system development occurred simultaneously, creating confusion and uncertainty for many years.[19,47] So, while the transition to democracy was the initial impetus for health system reform in line with the DHS strategy, this transitional context somewhat slowed the pace of DHS development.

The slow processes of creating the third tier of government, local government, began in 1995 ahead of the local elections in November, but there was contestation regarding the demarcation of local government boundaries.[10,51] In 1998, the White Paper on Local Government initiated a process to redraw these boundaries, and later that year, the Local Government Municipal Demarcation Act 27 of 1998 established the independent Municipal Demarcation Board to determine the boundaries of metro, district and local municipalities.[19,52] This process was finally resolved, and stability in local government achieved, only in late 2000, with the Local Government: Municipal Systems Act 32 of 2000 (amending the 1998 Municipal Structures Act) and the local government elections in December.[8,16,53,54] The outcome was that the number of municipal and metropolitan districts was reduced from the 157 demarcated in 1996 to 53, and the number of local municipalities reduced from 834 to 285.[8,15,47,55,56]

Given the NDoH vision of health districts coterminous with local government boundaries, the transitional nature of local government in this period had significant implications for the development of the DHS.[19,35,57] Firstly, in many provinces the process of establishing health district boundaries was already underway, and had to be restarted.[19,47] Secondly, the redrawing resulted in a challenge regarding the size of health districts, with some districts then too big to conform to the WHO norm, requiring the formation of subdistricts that would align with the health districts originally envisioned by the ANC Health Plan.[47] Thirdly, delays in finalising local government boundaries led to different district demarcations across sectors, impeding intersectoral collaboration. It took some years, for example, for education sector policy to be adopted, aligning educational districts with local government boundaries.[58]

Building capacity and raising the profile of the DHS

Managerial and system capacity also proved an impediment to DHS development in this period. In the mid-to-late 1990s, government was run by a mix of often inexperienced leaders catapulted into government from the liberation movement, and existing civil servants and bureaucrats who were guaranteed their positions for 5 years after the transition to democracy.[3] A loss of institutional memory meant that provinces (and the country more broadly) lacked personnel with the necessary administrative and managerial skills to implement DHS and to run health districts, compounded by

mistrust, cultural differences and racial tensions.[51,59,60] Complicating this issue, differences in the service conditions and salaries of provincial and municipal healthcare workers presented a significant challenge both to devolution of authority and to the integration of municipal and provincial PHC services.[8,17,61] In addition, efforts to redistribute human resources between provinces and to underserved areas were undermined, as many healthcare workers opted to take the voluntary severance package offered in 1996, resulting in a loss of human resources to either the private sector or overseas.[41,62,63]

At the same time, there were significant efforts to strengthen local-level capacity by both state and non-state institutions. In 1996, the Health Systems Trust launched the Initiative for Sub-District Support (ISDS) to support and strengthen subdistrict development, and improve quality of care and health outcomes.[18,64] Initially in six subdistricts, the initiative was later expanded to 21 district sites throughout the country as a way of establishing 'best practice districts' to demonstrate effective systems and strategies for health systems development.[65] The ISDS ran until 2005, and produced a number of guidance documents on a range of topics aimed at district managers. However, its impact was somewhat tempered by inadequate resources and insufficient commitment from partners within government.[65]

In 1999, following a successful pilot, a District Health Information System (DHIS) was adopted nationally through a partnership between government and the University of the Western Cape.[66] Vigorous information system development, technical support and short-course training led to near universal DHIS implementation across the country by 2001.[67] In this period, the Health Systems Trust began collating the first district profiles from available data, leading eventually to the launch of the District Health Barometer series in 2004.

In 1997, the Wits Centre for Health Policy developed a manual entitled 'Towards well-functioning health districts' in an effort to institutionalise monitoring and evaluation capacity and track progress.[8,55] In the same year, the NDoH embarked on a collaboration with the US Agency for International Development in the Eastern Cape Province, known as the Equity Project, which ran until 2003.[68] Recognising that many district-level staff members were untrained in financial management, the project introduced a District Health Planning and Reporting System to aid district managers in preparing and implementing medium-term plans, reviewing service delivery and financial performance progress against those plans, and reporting progress in achieving their goals.[68,69] The lessons of the project were intended to be shared through the NDoH to improve district-level financial management in other provinces. However, in practice, most districts were given little real authority, with financial and other decision-making remaining centralised at provincial level.

The initiatives led by the Health Systems Trust and other external partners played an important role in bringing a bottom-up perspective on opportunities, assets (people and resources) and challenges that could inform top-down policy and priorities for implementation of the DHS. Collectively, they also raised the profile and status of PHC and the DHS as key platforms in a historically hospicentric health system.

The NDoH also contributed to capacity strengthening at district level in other ways. The department released the *Handbook for District Managers* in 1998,[6,19] and in 1999 launched a national DHS competition to instil the use of data analysis in planning and in defining best practice, as well as to recognise and reward good performance.[8] The success of the ISDS sites in this competition demonstrated the effect of prior capacity-building efforts.[50] In addition, the National District Financing Committee was established in this period to develop guidelines for conducting district expenditure reviews, drawing on studies conducted by the ISDS.[19]

Finally, while the impacts on DHS development are more obvious in the second period, the rapidly unfolding crisis of HIV and its associated impacts on tuberculosis (TB) and maternal and child health established the seeds of a vertical programme orientation in this first period.

Second period (2001 - 2009): NHA consolidates DHS legislation, and the impact of the HIV epidemic and verticalisation

After the initial flurry of policy-making for the DHS and resolving local government boundaries, in the second period of DHS development, the pace of policy development slowed dramatically, and the shift from the RDP to the Growth, Employment and Redistribution strategy significantly constrained public spending.[70-72] In this period, spanning 2001 - 2009, the finalisation of the NHA consolidated legislation for the DHS. However, the period was also characterised by recognition of the catastrophic scale of the HIV epidemic, widespread mobilisation against AIDS denialism and the subsequent launch of a programme of universal access to antiretroviral (ARV) treatment funded through ring-fenced budget lines – all of which impacted significantly on DHS development.

The National Health Act

The National Health Bill, published for public comment in November 2001, became the NHA when passed by parliament in October 2003.[49,73,74] The Act finally provided a legislative framework for the health system as a whole, including the DHS.[49] It confirmed that DHS boundaries were to be coterminous with local government, district and metropolitan municipality boundaries, and made provision for subdistricts to be created if necessary.[75] In addition, the Act resolved the confusion about the definition of 'municipal health services', which were defined as non-personal environmental health services and disease surveillance, and established as a local government responsibility. The delivery of PHC through the DHS became a responsibility of the provinces, and the Act provided for provinces to assume authority over municipal clinics (provincialisation).[15,30,74] The Act also stipulated a clear governance structure for DHSs. In these ways the NHA resolved the lack of clarity that had undermined DHS development heretofore, marking a clear shift to a new period in DHS development.

The impact of the HIV epidemic and vertical health programmes

However, this period also saw DHS development significantly affected by the HIV/AIDS epidemic. The first recorded HIV cases in SA emerged in the early 1980s, but infection rates remained relatively low into the early 1990s.[76] When the new government came to power in 1994, however, the epidemic was expanding rapidly, and attracting increasing attention among public health experts and policy-makers.[8,77] By 1998, ~23% of women accessing antenatal services were HIV-positive, and rates of infection were increasing, impacting on healthcare utilisation and mortality rates.[78,79]

Despite increasingly alarming infection rates, resistance to HIV treatment roll-out solidified under the Mbeki administration, beginning in 1999.[80] In the early 2000s, the epidemic itself, as well as the government's failure to initiate an HIV treatment programme, distracted focus from health system reform efforts.[80-82] Furthermore, when an HIV treatment programme was finally initiated in 2004, it remained, to some extent, a vertical programme. The programme received dedicated funding through

conditional grants, and monitoring and evaluation processes and lines of authority were separate from the broader DHS.[25,83-85] This verticalisation persisted as the ARV programme rapidly expanded. Overall, the health system response to HIV absorbed a large proportion of attention and resources at the expense of broader DHS strengthening efforts.[82,86]

In fact, while the intention was for integration of health services as a part of the devolution process, vertical programme management persisted for a number of health programmes, including HIV/AIDS.[54] Decision-making authority for budgets and service delivery of these programmes was centralised from national level, with district managers largely disempowered, and only playing a co-ordinating role.[54] In addition, in this period health system goals, and therefore DHS strengthening efforts, were oriented around the achievement of the Millennium Development Goals (MDGs), introduced in 2000,[87,88] which had a programmatic focus on reducing child mortality, improving maternal health and combatting HIV, TB and malaria.[89]

It is important to acknowledge, nevertheless, that significant investments in HIV and other vertical programmes were ultimately intended for services delivered through existing facilities, in large part PHC facilities. This period thus saw sustained growth in real expenditure on the PHC system extending into the third period, enabling progress toward equitable financing of health districts across the country.[90]

Third period (2010 - 2020): Efforts to strengthen PHC and the development of NHI legislation

The third period of DHS development, from 2010 to 2020, marked a return to concerted efforts in DHS strengthening. A critical stimulus for district and subdistrict strengthening efforts in this period was the ANC's re-commitment to National Health Insurance (NHI) at its Polokwane conference in 2007,[91,92] as well as the subsequent leadership change and new political term in 2009.[92] Overall, this third period of DHS development was characterised by the development of NHI legislation, as well as broader efforts to strengthen the PHC platform, both of which had significant impact on DHS functioning. While the country's inequitably resourced private sector had long been an issue for DHS development (for example, through a human resource 'brain drain' from public to private sectors), it was only in this period that policy measures were introduced to incorporate private providers into the DHS.

PHC and DHS strengthening

In 2010, the NDoH released a strategic document outlining a 10-point plan for the creation of a well-functioning health system.[93] In the foreword, Minister of Health Motsoaledi called for a reorientation toward the vision of the 1997 White Paper for the Transformation of the Health System, which included establishing the DHS to facilitate PHC.[93] As part of a strategy to 'overhaul the healthcare system and improve its management', the plan included 'refocusing the health system on PHC' and strengthening decentralised management of health districts through the establishment of district management teams in all 52 districts, tasked with the development and monitoring of district health plans.[24,93,94] Shortly thereafter, the PHC re-engineering strategy was launched.[92,95-97] The strategy included school health services, ward-based PHC outreach teams (WBPHCOTs) and district-based clinical specialist teams (DCSTs).[92,95,98] DCSTs reflected the programmatic orientation of the MDGs, and were intended to improve clinical governance, provide clinical training, monitoring and evaluation and to help strengthen the DHS through communication and collaborative activities.[99]

Two other noteworthy policy documents in this period focused on strengthening DHS governance. The District Health System Policy Framework and Strategy 2014 - 2019,[30] the first of its kind, built on the foundations laid by the 1995 Policy for the Development of the DHS. The goals of the strategy included improving district governance, management and leadership to facilitate service delivery and improve the integration of services.[30] The 2017 District Health Planning and Monitoring Framework was intended to reform district planning and monitoring into a cohesive action plan, able to respond to both programmatic and health system priorities by disaggregating district targets to subdistricts and health facilities, and improving feedback and reporting mechanisms between local, district and provincial levels.[100]

NHI policy development implications for the DHS

The 10-point plan also included the implementation of NHI.[93] In 2011, the NHI Green Paper was published calling for 'an overhaul of the entire healthcare system and a comprehensive package of care defined by re-engineered primary health care'.[101] The Green Paper proposed DHAs, supported by the NHI Fund, as district-level authorities with responsibility for contracting with NHI in the purchasing decisions for health services, ensuring adequate and accessible services for populations in their defined districts, and monitoring the performance of service providers.[30,101] In 2012, as part of the first phase of NHI implementation, 11 districts were selected as pilot sites across the nine provinces, to introduce certain aspects of PHC re-engineering.[102-104] Within the NHI pilot districts, multidisciplinary Facility Improvement Teams were instituted to expedite quality improvement and ensure national core standards were met.[105,106] In addition, to ensure that PHC facilities met the norms and standards required for accreditation by the new independent Office of Health Standards Compliance, the NDoH commenced with the Ideal Clinic Realisation and Maintenance programme (or Ideal Clinic programme) in 2013.[106,107]

The NHI White Paper was published in December 2015.[108] A key change from the Green Paper was the expansion of PHC re-engineering to include contracting of private health practitioners at non-specialist level.[108] In addition, the White Paper outlined interventions for improved service delivery, which included District Health Management Offices (DHMOs) to manage district health services and health promotion.[108] The draft NHI Bill was released for public comment in 2018, and tabled in 2019.[109,110] The Bill stated that DHMOs 'must manage, facilitate, support and co-ordinate the provision of primary healthcare services', and mandated the establishment of district-level contracting units for primary healthcare (CUPS) to contract with the NHI Fund and manage the provision of PHC as the fourth stream of PHC re-engineering.[109,111] It remains unclear whether the NHI agenda served to strengthen the DHS in this period, or if the focus on high-level reforms ultimately distracted from sustained efforts to improve the functioning of health districts.

Conclusion

In the SA health system, the DHS is still considered the platform for PHC service delivery in theory, but its full realisation remains a work in progress, with impacts on PHC delivery.[112,113] This exploration of the history of the DHS is an important step in understanding how the DHS has evolved, and the factors that have influenced its development. The periodisation presented here suggests sustained political commitment to progressive health system reform in line with the principles of PHC, and significant progress in establishing and strengthening the DHS. However, since 1994, DHS policy and strategy development and implementation have been complicated by a range

of exogenous and endogenous contextual realities. In the 1994 - 2000 period, the imperative to reorganise local government systems in the wake of apartheid, and the decision to align health district boundaries with recently redrawn local government boundaries, resulted in health districts much larger than recommended by the WHO, and the need to introduce subdistricts. In the 2001 - 2009 period, the combined effect of the HIV epidemic and the MDG agenda resulted in a focus on vertical health programmes (with the DHS at times conceived of simply as a series of geographical loci for their implementation), and the neglect of efforts to tackle systemic issues to strengthen the DHS, such as financing, human resources and governance challenges. In the 2010 - 2020 period, the NHI policy agenda drove a reinvestment in systems strengthening for health districts as the loci for the delivery of quality PHC through integration of public and private services, the effects of which largely remain to be seen. Ultimately, the decentralisation project of the DHS first envisaged in 1994 remained incomplete by 2020.

In recent years, concerted efforts to integrate services, the COVID-19 pandemic and, most markedly, the move toward implementation of NHI, have renewed attention on strengthening the DHS as a platform for PHC service delivery. Under the NHI plans, a central health fund, the National Health Insurance Fund, will disburse funds to subdistrict-level contracting units known as CUPs.[108] DHMOs will need to be able make appropriate decisions about service delivery, and to be held accountable for these decisions.[108] As such, the NHI will be dependent on well-functioning district, and subdistrict, health systems.

Health system reform is inevitably a complex process, unfolding in an ever-changing social, political, economic and epidemiological context. However, as noted above, rigorous policy and process-focused analysis of the SA DHS remains rare, and formal 20- or 30-year review processes seldom consider the historical drivers or contemporary challenges in depth. For this reason, further in-depth review of the development of the DHS, aspects of DHS development that may have been neglected and the challenges that continue to constrain full realisation of the promise of decentralised, PHC-oriented health systems is warranted. Potential areas for rigorous, historically informed research with real-world utility include provincialisation and the balance of powers between provinces and local governments, trends in resource allocation and the prioritisation of districts and subdistricts, and the systemic factors affecting human resource capacity at district and subdistrict levels, among others. A better understanding of the social and political realities that have historically shaped the development of the DHS is vital for more appropriate solutions to contemporary challenges.

Data availability. Documentary evidence used for this study is available from the authors on request.

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