

'It makes me want to run away to Saudi Arabia': management and implementation challenges for public financing reforms from a maternity ward perspective

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Poor practice by health care workers has been identified as contributing to high levels of maternal mortality in South Africa. The country is undergoing substantial structural and financial reforms, yet the impact of these on health care workers performance and practice has not been studied. This study, which consisted of an ethnography of two labour wards (one rural and one urban), aimed to look at the factors that shaped everyday practice of midwives working in district hospitals in South Africa during the implementation of a public sector reform to improve financial management. The study found that the Public Financing Management Act, that aimed to improve the efficiency and accountability of public finance management, had the unintended consequence of causing the quality of maternal health services to deteriorate in the hospital wards studied.

The article supports the need for increased dialogue between those working in the sexual and reproductive health and health systems policy arenas, and the importance of giving a voice to front-line health workers who implement systems changes. However, it cautions that there are no simple answers to how health systems should be organized in order to better provide sexual and reproductive health services, and suggests instead that more attention in the debate needs to be paid to the challenges of policy implementation and the socio-political context and process issues which affect the success or failure of the implementation.

Key words: health system reform, financial reform, maternal health services, reproductive health, South Africa

Introduction

A number of authors have convincingly made the argument that the two policy areas of reproductive health and health systems 'have developed separately, with apparently little explicit overlap or dialogue' (Lubben et al. 2002), and that this has been to the detriment of both policy areas, but particularly to that of reproductive health (Berer 2002; Mayhew et al. 2003).

The detrimental impact of the lack of this dialogue has been explored in maternal health, specifically by those seeking explanations of why maternal mortality has not been decreasing globally despite more than a decade of effort, and why, of all the Millennium Development Goals, the goal of reducing maternal mortality is seen as one of the targets least likely to be achieved (Freedman et al. 2003; Parkhurst et al. submitted). Freedman, Parkhurst and others other have argued that part of the explanation for this failure is that preventing maternal deaths requires a number of different elements of a health system to be functioning, and yet many of the interventions aiming to improve the situation have been narrowly focused vertical programmes aimed at improving one aspect of maternal health care, such as improving anaesthetic skills of doctors, or ensuring that blood is available (Department of Health 2001). Human resource issues, including management of changing roles, have been particularly neglected in reform processes, which tend to concentrate on financing and accountability rather than the impact of systems changes on staff who have to implement them (Wang et al.

2002). There is some evidence that reform restructuring has led to a decline in quality of care where the needs and capacities of health workers were not properly managed (CHANGE 1998; Bosman 2000). Conversely, where management processes have been properly organized and thought through, systems changes appear to have worked well (Management Sciences for Health 2002).

In South Africa, the health sector has been restructuring in various ways since 1994, with little attention given to the impact of reforms on health workers. This article uses the Public Financing Management Act as a case study to examine the effect on front-line health workers trying to provide services in the context of financing changes. This study emerged out of a broader exploratory study looking at factors that influence nurses behaviour in maternal health services in South Africa. The behaviour of nursing staff is widely recognized as being problematic (e.g. lack of respect for patient dignity and rights; bullying behaviour) and contributing to the relatively high levels of maternal mortality. The Confidential Enquiry into Maternal Deaths for 1999–2001 estimated that poor practice by health care workers contributed to at least 50% of maternal deaths. One of the most common problems is failure to monitor patients (Jewkes 1998; Department of Health 2001).

The study was developed in response to negative discourses about nurses' behaviour (Department of Health 2001) and was designed to move beyond the blaming of providers, to understanding the factors that influence the everyday

practice of nurses. The underlying theoretical approach of the study was that the practice of health care workers could only be understood in the context of their individual lives, the health system as a whole, and the cultural, political and economic environment in South Africa. During the course of this study, it became apparent that at the time of the research one of the most influential health system impacts on nurses behaviour – certainly nurses in ward management positions – was the implementation of the Public Finance Management Act.

The Public Finance Management Act (PFMA) is a public-sector-wide reform aimed at improving financial accountability and efficiency. This article uses ethnographic data collected from two maternity wards in South Africa to provide a new perspective on reform processes and examine the effects of implementing the PFMA on the day-to-day experiences of health workers. The study found that implementation of the PFMA had an unintentional detrimental effect on the quality of maternal health services provided in the hospitals where the research took place. The study highlights the need for dialogue between stakeholders and illustrates how interventions to improve maternal health services can be easily derailed, causing health system reforms to have unintentional effects on maternal health services.

We argue that the Public Finance Management Act in South Africa is not, despite negative consequences, inherently ‘bad’ for maternal health services, and that the cause and effect relationship between the reform and deteriorating service is not a simple one. It is not the policy principle, in this case financial accountability, that leads to the undermining of maternal health services, but the complex nature of policy processes, in particular the lack of consideration given to implementation processes and the needs of health workers who implement policies.

In conclusion it will be argued that many of the authors who have written on the topic of health systems and sexual and reproductive health have concentrated on international and national policy process and agendas, sometimes suggesting that one or other form of health system organization is good or bad for sexual and reproductive health services. This approach often downplays the relevance of the local socio-political context and process issues in the implementation and impact of health sector reforms. In providing a context-specific case study from South Africa, we contribute to filling this gap.

Research sites and methodology

The research design chosen to explore the factors influencing the everyday practice of health care workers was an ethnographic approach. The ‘loosely structured, face-to-face encounters’ typical of this approach are rarely used in health systems research, but were considered the best way to explore health care workers’ complicated realities, especially in the context of change in which many health care workers already felt under attack (Pollitt et al. 1990). The focus was on nurses working in maternity wards and not on patients or managers because the aim was to examine the experience of

the front-line health workers who are especially neglected in reform processes. The study was not designed to investigate the implementation of the PFMA; if it had been, it would have been designed very differently. Rather, as the implementation of PFMA emerged as a significant issue for health workers, it was used as the lens through which to examine the effect of systems changes on health workers.

Fieldwork was carried out by a medical anthropologist who spent a number of months in two labour wards observing practice, talking to staff, attending workshops, attending staff and management meetings, and observing communication between the staff working in the labour ward and at levels higher up in the health system. The anthropologist kept four different types of fieldwork notes, as recommended by Spradley (1980). First, short notes were made at the time, often one or two words, or a phrase. Secondly, expanded notes were written up at the end of each fieldwork session, which was usually a shift of about 8 hours duration. Thirdly, a separate journal was also kept where problems or questions arising from the fieldwork were recorded. Finally, a running record of provisional analysis and interpretation was kept. Weekly meetings were held among the research team, consisting of the three authors of this paper, where fieldwork notes, problems that had arisen from fieldwork and preliminary analysis were discussed. Copies of documents and communication both within the hospital and between the hospital and the rest of the health system, as well as hospital records, were also collected.

Analysis was done using grounded theory, as the most appropriate for an ethnographic approach, whereby theories and analysis themes emerged from close study of the data. Preliminary findings were validated with a number of more formal tape-recorded interviews and through feedback sessions at the hospitals. The importance of the PFMA arose out of this process.

Ethics

The researcher was not a trained medical practitioner and so did not get involved in any day-to-day care of patients. Written consent to carry out the research was obtained from the provincial departments involved, the hospital management and the nurses working in the ward. Ethical clearance for the study was obtained from the University of the Witwatersrand Medical Ethics Committee.

Research sites

The research took place in two district hospitals in South Africa. One hospital was in one of the richest and most urbanized provinces in South Africa, and the other in one of the poorest and most rural. Each of these hospitals had about 130 operational beds, and between 20 and 30 maternity beds. The hospitals were selected in collaboration with the provincial departments of health and were identified as neither failures nor successes and with management who would be open to long-term research taking place in their institutions.

An introduction to South African maternal health services

South Africa is a middle-income country and, therefore, does not face many of the challenges to reproductive health services that are found elsewhere in the developing world (Berer 2002). The government is committed to a public health system based on free comprehensive primary health care – including reproductive health services. Sexual and reproductive rights are protected under the Constitution and the government has explicitly prioritized the improvement of reproductive health services. Pregnant women are now exempt from charges at all levels of the public health system and a liberal abortion policy has been introduced.

However, undoing the legacy of apartheid has been a huge challenge for the health system. South Africa has an overall Gini coefficient of about 0.60, which makes it one of the most unequal countries in the world. In terms of health care spending, approximately 8.8% of the GDP is devoted to health care spending, but of this 59% is controlled by the private sector which serves less than a fifth of the population (Doherty et al. 2002).

In terms of maternal health, South Africa does well compared with the rest of sub-Saharan Africa, but poorly in comparison with other middle-income countries. The maternal health service infrastructure is well developed, in terms of both facilities and trained staff, and significantly exceeds international recommendations (Penn-Kekana and Blaauw 2002). In addition, utilization of maternal health services is high, with 96% of pregnant women attending antenatal care and 86% being delivered by a trained attendant (Department of Health 2001). Nevertheless, the most recent national estimate of the MMR is between 175–200 per 100 000 births (Department of Health 2003).

However, national figures disguise the significant inequalities that characterize South African society, for example only 60% of poor women in one of the rural provinces have a trained attendant at delivery (Blaauw and Penn-Kekana 2003). Another contributing factor is the poor quality of care – both technical and personal – that pregnant women receive. In the latest report on the Confidential Enquiry into Maternal Deaths, avoidable factors due to health care workers practice were identified in over half of all maternal deaths, and 75% of deaths at the primary care level (Department of Health 2003). The first report of the Enquiry stated that it was not clear whether poor practice by health care workers was due to ‘ignorance or laziness’ (Department of Heath 1999). Numerous studies of maternal health services have found that women are subjected to verbal and sometimes physical abuse in maternity wards, and commonly subjected to unnecessary and unpleasant interventions (Fonn et al. 1998; Jewkes et al. 1998; Smith and Brown 2002). Cruelty to women in maternity services is commonly reported in the media in South Africa and is part of popular discourse around how women are treated in public hospitals when they give birth.

Poor staff attitudes towards patients are not unique to

maternal health services. There have been a number of studies suggesting explanations for this behaviour, some looking at the historical roots of nursing in South Africa (Marks 1994) and others looking at the challenging environment in which nurses are working today (McCoy 1996; Gilson 2003; Walker and Gilson 2004).

Marks gives a number of explanations for problematic nursing behaviour including: the missionary roots of nursing education linking nursing to teaching the ‘ignorant masses’ about hygiene and good morals; the fact that under apartheid black women had almost no other career options except going into nursing; and the impact of apartheid on the nursing profession which created a strict almost military-like hierarchy which still persists today, with separate councils and different pay scales for black and white nurses which existed until the late 1980s (Marks 1994). Resha (1991) argues that the difficult relationship between nurses and community is partly explained by the apartheid regime’s attempts to create a black middle class. For example, in many townships nurses were given better houses in specially built sections which had better amenities than other areas (Resha 1991). Other authors have pointed to the contemporary pressures that nurses face as women in South Africa, and as workers in a changing health system faced with many problems, not least the HIV/AIDS epidemic. The argument is that because nurses are themselves struggling and over-worked with little support and often challenging working conditions, they do not have the emotional or physical energy, or the time, to treat patients as they should, or in many cases as they would like (Fonn et al. 1998; Walker and Gilson 2004).

The Public Finance Management Act

The Public Finance Management Act (PFMA) was passed by the South African parliament in 1999. It forms part of a range of reforms outlined by a strong National Treasury to try to regulate spending in the public sector and to link spending to outcomes (Fourie 2001). The Act’s preamble states that it aims to ‘ensure that all revenue, expenditure, assets and liabilities (of government) are managed efficiently and effectively’ (South African Government 1999). Financial decision-making is theoretically devolved down to managers who better understand the local realities and local policy priorities. Managers are meant to be allowed to manage, but they are also held responsible (Department of Health 2001; Fourie 2002). Although only stated in a small section towards the end of the Act, the most discussed element of the PFMA is that, as a public manager, if you overspend on your approved budget, you have committed a legal offence and can be sent to jail. The fear of this outcome has been found in other studies, for example work done by the authors looking at the perspectives of provincial and national managers on the nature of their work and the pressures that they face (Penn-Kekana et al. 2001).

Implementation of the PFMA has involved a number of workshops initially run by the Treasury but then cascaded throughout the public sector, including the Department of Health. Complying with the PFMA has also been

incorporated into staff performance management, and when appointed to the public sector, staff have their responsibilities explained in terms of the PFMA. All managers at the two hospitals where research was being carried out had been on training on the PFMA, and saw conforming to the PFMA as one of their primary responsibilities as managers and certainly something which, if they failed at, could result in their losing their job, being prosecuted or ending up in jail.

The management level to which budget responsibility has been devolved within the health system varies from one province to the next. In the rural hospital in this study, the hospital management was responsible for the hospital budget, whereas in the urban province, the health department had implemented a cost centre approach, where responsibility for budgets was supposed to be devolved down to the ward level. Therefore, in the rural hospital, all of the discourse around the PFMA was at the hospital management level and very little permeated down to the maternity ward. Ward staff were unaware of what the PFMA was and what it attempted to do. At the urban hospital, on the other hand, the PFMA was part of the daily discourse in the labour ward and frequently blamed for problems that existed in the ward.

Findings from the wards

It is difficult within a word limit to paint a full picture of how the PFMA was viewed by the hospital management and ward staff. The focus of this study was the ward staff. Data are presented in the form of three vignettes that will attempt to give readers a flavour of the reality of everyday practice in the two labour wards studied, and the impact of the PFMA on this everyday practice. The first vignette was selected because the problem described defined to some extent the relationships between staff in the labour ward, and between staff and management in the hospital, for one of the periods of fieldwork. The other two vignettes were chosen as they are particularly illustrative of how specific policies of the maternal health directorate, aiming to improve the quality of care given to women in childbirth and to reduce maternal mortality, were undermined by the way the PFMA was being implemented.

Vignette 1: Avoiding wastage (urban hospital)

The sister-in-charge of the maternity ward ordered extra-large gloves for the newly appointed maternity doctor who had rather large hands. Unfortunately, the doctor resigned soon afterwards leaving a large stock of unused extra-large gloves. When the sister-in-charge put in a requisition for smaller gloves for the nurses in the ward her requisition form was returned, and she was told, “*these are the days of the PFMA, no wastage is allowed*”. She was informed that she would not be allowed to order small gloves until all the large gloves had been used.

This issue caused untold upset in the ward with many angry confrontations between nurses, the sister-in-charge of the ward, the budget committee and the hospital management. Literally hours of nurses’ time was spent arguing over this

issue. Ward nurses complained that it was unjust; it showed how little nurses were regarded; and how the management did not understand or appreciate what they did every day. They claimed that management did not care about the health risks to their patients and themselves, arguing that working with gloves that were too big compromised the quality of their work and put them at greater risk of needle-stick injuries – a significant concern given South Africa’s high prevalence of HIV.

The problem clearly increased the nurses’ levels of stress. All patients suffered, as it was observed time and again in the labour ward that when the nurses were stressed they picked on the women they least respected – the poor, the teenagers, the foreigners, the ‘difficult ones’ and the mothers who had not booked. In the few weeks during which this ‘battle’ was raging, the ward sister-in-charge recorded higher absenteeism among nurses allocated to deliveries (where gloves were essential), than those working in post-natal care or the nursery.

Vignette 2: The provision of pain relief (urban hospital)

The sister-in-charge of the maternity ward in the hospital was very committed to providing increased quality of care to patients in her ward. She had received advanced training in midwifery, and since she returned from training had introduced a number of changes in practice in line with current knowledge. She had stopped a great deal of the unnecessary and unpleasant interventions that are common in most public hospitals (Smith and Brown 2002). She also attempted to increase the availability of pain relief to women who wanted it, by ensuring that all the nurses on the ward knew that the drugs were available on standing order,¹ that patients knew that pain relief was available if they needed it, as well as giving in-house training to nurses working in the ward on providing pain relief. However, at the same time as she was attempting to increase the amount of pain relief available to women, as had been recommended by the national maternity guidelines, she was made, very much against her will, to sign a contract under the PFMA that made her the accounting officer for the ward. She was told that she was responsible for the ward’s finances. If she overspent she would go to jail. She was also told that they considered her drug budget to be too high. Her response to these comments was to take the standing order down, take down the notices for patients, and stop promoting the provision of pain relief for women. She said that she was too scared to promote the use of more drugs as she had two kids and a diabetic father who depended on her: “*Sometimes I lie awake at night feeling sick with worry. . . I worry that I have made a mistake . . . I worry about who will look after my kids and my father if I go to jail*”.

The ‘mistake’ she was worried about was not around the care that she was providing to patients, but around her financial accounting in the ward.

Both of these incidents seriously undermined the status and the morale of the sister-in-charge. Over the months it was clear that not only did her enthusiasm for trying to improve practice in the ward diminish, but also she was less able to

persuade her staff to maintain the improvements that she advocated. The fact that she was not able to get some ward stock was seen by many of the rest of the staff as an indication that she was not committed to them, and was also not held in high regard by the hospital management. The sister-in-charge told me in one of our many discussions on the PFMA: “*it makes me want to run away to Saudi Arabia*”. When feeding back the results of this study to the hospital, we were informed that she had resigned her post and accepted a job in Saudi Arabia.

Vignette 3: No longer allowing lodgers (rural hospital)

It has been the traditional policy at this hospital that if a woman presented at the hospital at 40 weeks pregnant or above, even if she was not in active labour she was to be offered the opportunity of admission. This practice, referred to as lodging, was carried out as nurses were aware that many patients struggled to get to the hospital in time when they went into labour due to problems of distance and cost of transport, especially at night. There is wide recognition of the problem in maternal health circles in South Africa that poor and rural women in particular struggle to get to hospital to deliver. Having all women deliver in institutions is a policy aim of the Department of Health.

However, the hospital management committee at this hospital was worried that they were overspending on their budget. They banned ‘lodgers’ from all wards including maternity, and instructed doctors to discharge women who were not in active labour. Protests from the staff in the labour ward were ignored, as the management committee felt that complying with the PFMA was a priority.

Soon after this decision was taken, there was a case of a 17-year-old who presented at the hospital 40 weeks pregnant. She reported she was suffering from ‘pains’, but when examined was found not to be in labour. Despite her protest that she did not have money to go home, and had to wait for someone to come and collect her, she was discharged from the ward. She presented again at the hospital a week later. This time it was discovered that she had suffered an inter-uterine death. She reported to staff that her waters had broken soon after she had returned home after the visit. Her grandmother refused to give her money to return to the hospital as she was not having pains and she was worried that her granddaughter would be sent home again. It was only 7 days after her waters broke that she was able to borrow money from a neighbour and return to the hospital. The nurses were extremely distressed about this incident, and blamed it on the new policy. When it was raised at the hospital Mortality and Morbidity meeting, the matron of the hospital reported that they did not have any choice; if the management committee did not cut the budget, they could end up in jail.

Discussion: the human consequences of reform management

There are a number of insights to be gained from the vignettes on the complex nature of the policy implementation process and the social context in which it is occurring.

The challenges of managing change

On one level it is possible to conclude that the vignettes illustrate problems with the management of the hospitals studied. Good managers, for example, would probably have dealt with the issue around the availability of the correct size gloves differently. Problems with management are, however, not unique to the implementation of the PFMA, or to South Africa. Many health reforms and reproductive health programmes face weak management capacity in lower levels of the health system. The question is how to incorporate recognition of this problem into policy making and planning, and support management to implement change (Mills et al. 2001).

The fieldwork was carried out in the relatively early days of implementation, particularly of the cost centre approach devolving financial accountability to the ward level. As a response to feedback of the results, one of the managers of the hospital stated that ‘you can’t make omelettes without breaking eggs’ and that many of the problems that were observed may, in part, be due to the fact that the research was identifying the teething problems of a necessary reform. This may be true. But this again illustrates a challenge facing those trying to implement policy. In this case the ‘teething’ problems led to a midwife – highly trained at the government’s expense – leaving the public sector, nurses being left with a feeling that the hospital management did not care for them, as well as a deterioration in the quality of care for patients. This deterioration was directly contrary to stated priorities of the Department of Health to improve the quality of maternal health care and to reduce maternal mortality.

If such unintended negative consequences are to be avoided, management of change when reforms are being implemented needs to ensure that the staff who implement the changes feel part of the process. Front-line staff need to be included in consultations as well as their managers.

Too much change all at once

More difficult than the challenges of managing any change is the challenge of managing a number of simultaneous changes, especially when they are relatively un-integrated and pushed by a range of different actors with different agendas (Mills et al. 2001). At both hospitals, staff at the hospital management level, had attended during the year of fieldwork over 92 different workshops on the public sector, health department and maternal health policies that they were supposed to be implementing. In this context of multiple demands on their time and energy, it is not surprising that health care workers prioritize. A reform that threatens jail time if you do not comply is not surprisingly prioritized over others that do not carry similar sanctions. Lipsky and others have used the idea of ‘street level bureaucrats’ as a way of explaining problems with implementation, with front-line providers failing to implement reforms that do not conform to their sense of what is right and possible (Lipsky 1980). In this study it was more often observed that health care workers did not actively refuse to implement any policy reform or to knowingly subvert it, but instead, faced with a plethora of policies, attempted to implement

whichever policy they had been told about most recently, or which policy they were being inspected on next. Because of the relative powerlessness of patients within the system, patients' needs and desires almost invariably were not prioritized in comparison with the demands of managers further up the health system.

Underlying the PFMA appears to be the common assumption, not unique to the PFMA, that the health system operates as some sort of machine that is not working and needs to be fixed. And that fixing it is relatively simple and just requires well-packaged interventions that tackle the immediate problem. This study illustrates that implementing reforms is often more complex than this. Workers and health care managers are not merely compliant beings who obey rules, but have their own sets of beliefs and operate in social and historical contexts (Blaauw et al. 2003). This can clearly be seen in the way that health care workers in the maternity wards believed the PFMA to be about something very different from what was intended by the policy makers.

The proponents of the PFMA meant it to be a tool to ensure that good financial management went hand in hand with the government meeting its policy objectives, including the improvement of maternal health services. The PFMA was meant to be about decentralization of decision-making. They saw 'value for money' for government as something that was for the common good. A very different set of meanings was attached to the PFMA by the time it reached ward level. Instead of ward sisters feeling empowered, they lay awake at night worried that they would go to jail if they made a mistake. Nurses felt they had to do the managers' dirty work for them, on top of the clinical work that they were trained for. Many of the nurses did not automatically view 'value for money' for the government as being for the common good. They saw the government as some sort of nebulous power above them that used up money, paid its leaders too much money, that did not pay them enough and took too much in taxes. One nurse, commenting on the promotion of a member of the management team, stated: "*All this fuss about the gloves ... just so Mr XXX could get a new car and a new job*".

Her interpretation of the PFMA, which must in turn affect her level of co-operation with implementation, bears no resemblance to that of the national proponents of the PFMA. She saw it as a way her boss could please his boss and get rewarded, predominantly at her expense.

When attempting to successfully implement any kind of health sector reform, more attention needs to be given to how meaning is managed in the implementation process. It needs to be recognized that communication and learning in organizations is a complex process, that information does not just cascade down the system without being interpreted and distorted in certain ways in response to a range of contexts. This becomes particularly problematic when the context into which the policy is implemented is one of poor treatment of patients. The reform, despite what was intended, becomes yet another reason to treat patients badly.

This argument is supported by other work carried out in

South Africa looking at reform of the abortion legislation and primary health care services (Walker and Gilson 1994). All support the argument that if policy design and implementation processes included properly managed consultation with front-line health workers, in which their views and concerns were voiced as well as their managers', clashes in interpretation and meaning could be minimized.

Conclusion

In conclusion any attempts to improve maternal health services can clearly be undermined by wider health system policy changes. As Freedman et al. (2003) suggest, one of the reasons that reducing maternal mortality has been an international public health failure must partly reflect the fact that, although the technical interventions needed are known, achieving the necessary level of health system functioning is more of a challenge. This study has illustrated how poor management of the implementation of reforms, and a lack of understanding of implementation contexts, can contribute to deterioration in the functioning of health systems, and ultimately to disillusionment of staff and declining quality of maternal health care.

An increased level of discourse between those working in the field of health systems and those working in the field of maternal health is undoubtedly the first step in trying to meet this challenge. However, this discourse has to move beyond looking at international and national policy frameworks, and the search for simple solutions, and to start looking at issues around implementation and its impact on health workers; issues that have been largely missing in much of the debate around the relationship between health systems and health system reform and sexual and reproductive health.

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Endnotes

¹ When a standing order is issued for a drug it means that nurses can administer the drug without calling the doctor.

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