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Governance and Leadership Constraints in District Health Systems: A Qualitative Study from South Africa

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Abstract

The present study set out to pinpoint and investigate the leadership obstacles that prevent the effective provision of high-quality healthcare in two district municipalities located in the North West Province of South Africa. A qualitative phenomenological approach was applied. Senior healthcare managers were deliberately chosen from the Bojanala Platinum District (BPD) and the Ngaka Modiri Molema District (NMMD) using purposive sampling. Information was gathered through six focus group discussions (FGDs), each involving 6–10 participants, and eight individual in-depth interviews (IDIs). The collected data underwent thematic and narrative analysis. Ethical clearance was obtained in advance, and all participants provided informed consent.

Five major themes emerged from the participants' accounts: (1) Restricted leadership empowerment, defined by over-centralised decision-making that created bottlenecks and curtailed the independence of local managers; (2) Ineffective performance management stemming from inadequate rollout and minimal application of the Performance Management and Development System (PMDS); (3) Fragile policy implementation connected to unstable governance arrangements and insufficient monitoring systems; (4) Challenges in resource allocation and stewardship, marked by budget limitations and supply chain weaknesses that resulted in ongoing shortages of vital medicines and neglected equipment upkeep; and (5) Deficient primary healthcare infrastructure combined with poor governance, which eroded patient trust, encouraged bypassing of facilities, and undermined overall service standards. These results represent one of the earliest qualitative explorations of leadership barriers inside South Africa's district health system. They demonstrate how excessive central control, deficient performance management practices, and severe resource shortages specifically undermine healthcare delivery within the North West Province. The study offers locally grounded observations and practical suggestions for greater decentralization, improved governance, and more effective resource use. Such evidence can help shape health system improvements in other similar low- and middle-income environments.

Keywords: Healthcare leadership, Governance, Primary healthcare, Performance management, Resource management, Policy implementation

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Introduction

Across the globe, healthcare systems are increasingly understood as complex adaptive systems. These systems call for leaders skilled at handling unpredictability, bringing diverse stakeholders together, and maintaining high service standards even when resources are scarce. In low- and middle-income countries (LMICs), where both funding and personnel are frequently in short

supply, capable leadership at every tier is indispensable for bettering population health. South Africa, described by the United Nations and the International Monetary Fund as an "emerging and developing" economy [1], allocates a relatively large share of its national budget to healthcare compared with other countries at a similar stage of development. Yet, its health achievements fall short of expectations [2]. The country struggles to reach satisfactory health results owing to a multifaceted set of pressures. These include a quadruple disease burden, a widespread HIV/TB crisis, elevated rates of child and maternal deaths, increasing non-communicable illnesses, and substantial levels of violence and trauma [3]. The situation is made worse by steady population growth, partly fuelled by migration [4], which strains healthcare capacity and deepens imbalances in staff distribution, above all between cities and the countryside [4].

Within the North West Province, healthcare funding accounted for an average of 29.38% of the provincial budget (roughly R25.96 billion) between 2020/21 and 2023/24 [5], while the province accounted for 6.3% to 6.9% of South Africa's total population [6]. Despite this investment, health indicators remain disappointing. Average malnutrition levels stood at 16.83% during the same years, just under the national rate of 17.5% [5]. Maternal mortality figures in the province remained above the national benchmark, rising from 125/100,000 in 2019 to 188.5/100,000 in 2021, before dropping to 116.8/100,000 in 2022 [7]. In parallel, the under-5 mortality rate (U5MR) reached 55,7% in the North West in 2022, noticeably higher than the national estimate of 40 [8].

Research on healthcare leadership is extensive, and several up-to-date models help clarify how leaders can navigate complex environments. Transformational leadership centers on inspiring change through a clear vision and empowering teams; complexity leadership stresses flexibility and the natural development of solutions within fluid, non-linear settings; while systems leadership highlights partnership and coordination across layered, interconnected health structures [9–13]. Although these ideas are receiving growing attention in wealthy nations, their relevance and application within LMIC district health systems have received far less scrutiny. In South Africa, long-standing patterns of centralized authority and slow-moving bureaucracy mean that managers at the district level often lack sufficient decision-making freedom or backing to introduce flexible, area-specific solutions. Weak financial oversight, uneven sharing of supplies, and gaps in workforce skills all harm service quality, especially in remote rural zones.

This knowledge gap carries extra weight given South Africa's planned National Health Insurance (NHI) overhaul. NHI intends to reshape how healthcare is funded and governed so that universal coverage and equal access become a reality. While the initiative offers hope, the transition brings intense leadership demands. District managers will need to adjust to revised accountability rules, manage tight budgets under new purchasing systems, and maintain care standards while the entire structure is being reorganized. Learning how these leaders actually perceive and cope with such demands is crucial for reinforcing the national health system and helping NHI succeed.

The current qualitative investigation examines the specific leadership difficulties that block high-quality healthcare in two districts of the North West Province: the Bojanala Platinum District (BPD) and the Ngaka Modiri Molema District (NMMD). By carefully analyzing these difficulties, the research aims to support well-focused actions and policy changes that can strengthen leadership capacity, better utilize available resources, and raise residents' health standards. Through detailed, evidence-based findings rooted in the local context, the study extends the use of recognized leadership frameworks (transformational, complexity, and systems leadership) to a setting marked by limited resources and ongoing decentralization efforts. In doing so, it offers concrete suggestions to guide both policy decisions and daily practice as South Africa continues to reform its health sector.

Materials and Methods

This study employed an interpretive-hermeneutic-phenomenological methodology to examine the lived realities of leadership as experienced by senior healthcare managers across the North West Province, South Africa. The chosen methodology enabled the research to transcend straightforward accounts and instead uncover the deeper meanings participants assigned to the multifaceted leadership demands arising in a constantly shifting healthcare environment. This qualitative phenomenological inquiry was carried out with healthcare managers serving in the North West Province's Department of Health, specifically within the BPD and NMMD municipal areas. Focus group discussions—treated here as a broadened extension of standard interviewing [14]—were selected for their adaptability and analytical depth, since they deliver both descriptive accounts and interpretive insights, unlike in-depth interviews, which remain strictly interpretive. The intended study population comprised intentionally recruited staff from the NW Department of Health occupying key posts, including Head of Department, Deputy Director General, hospital Chief Executive Officers, Chief Directors, Directors, Clinical Managers, plus additional senior management service (SMS) roles at regional hospitals, district hospitals, and community health centers. A total of 68 employees stepped forward to join the project. Purposive sampling served to identify contributors from the public health domain based on their specialized contextual insight and relevance to answering the study's core questions. Information gathering comprised six focus group discussions (each with 6–10 participants) and eight in-depth interviews. FGDs served as

an expanded interviewing vehicle to spark conversation and uncover collective, organization-wide leadership viewpoints, while IDIs provided space for private reflection on individual stories and confidential institutional issues unlikely to emerge during group exchanges. Every focus group discussion lasted about 2 hours. The group meetings were designed to elicit participants' shared views on how management applied leadership across health system elements, inspired personnel, ranked priorities, enacted national policies, shared the strategic vision, and built leadership strength among local officials. All focus group discussions occurred from October to November 2022. A full discussion protocol for each FGD emerged from an intensive preparatory sequence that included an extensive scan of published material on healthcare leadership difficulties, trial runs of the discussion prompts, revisions drawn from pilot input, and final verification that each item matched the project's aims before the actual sessions. Central prompts used in the FGDs probed how management provided leadership across health system components, motivated staff, managed priority setting, implemented national policies, communicated the vision, and reinforced grassroots leadership. Each of the eight interviews zeroed in on the specific hurdles encountered in healthcare leadership and the impediments to delivering superior healthcare services. These sessions deliberately spotlighted top-tier personnel, such as clinical managers, district hospital chief executive officers, and community health center managers, to examine policy rollout within organizations, the influence of local oversight bodies, and resulting district-level health achievements.

Reflexivity and bracketing

The primary investigator had previously served as a Member of the Executive Council (MEC) for Health in the province; as a result, a personal reflective diary was kept, and regular memo writing continued throughout the project. Such reflexivity steps helped spot and suspend individual preconceptions, document the researcher's standpoint, and limit unintended influence, thereby improving the confirmability and overall dependability of the outcomes. Standard probe questions helped dismantle the central research question and scrutinize the collected responses. Microsoft Excel facilitated the structuring, tidying, and evaluation of all data. The investigator closely reviewed the material by producing preliminary codes, identifying emerging themes, reassessing them, and then naming and describing them based on content drawn from in-depth interviews, focus group discussions, and designated open codes [15]. At the same time, the person-by-person examination relied on "narrative analysis" [16], which traced every participant's standpoint so the investigator could see precisely how each unique account fed into the larger shared storyline. Analysis proceeded inductively, following Braun and Clarke's six-phase thematic analysis model (familiarisation, coding, theme development, review, definition, reporting). Early open codes arose from every transcript, were grouped into broader categories, and were progressively sharpened into dominant themes. Narrative analysis ran in parallel with thematic analysis to safeguard the participants' intimate significance and lived realities. To keep the emphasis firmly on lived-experience accounts, narrative analysis augmented the thematic steps by demonstrating how separate personal narratives built the unified group narrative. The lead researcher maintained analytic memos alongside reflexive journals to capture analytical choices, underlying assumptions, and emerging observations. Peer debriefing was conducted with an additional qualitative specialist to evaluate coding consistency, test the robustness of theme labels, and enhance the overall credibility of the conclusions.

Microsoft Excel served as the platform for cataloging and tracking codes, categories, and ongoing theme refinements. Credibility was further supported by drawing participants from differing ranks of authority and from various categories of facilities, supplemented by cross-checking data across both focus groups and individual interviews. Transferability benefited from purposive sampling spread over two of the four provincial districts, thereby reflecting a range of leadership environments. Ethical clearance was secured from the University of KwaZulu-Natal Biomedical Research Ethics Committee (BREC) under protocol reference number BREC 690/18. Access authorization was provided by the Department of Health in the North West Province. All participants received full details of the study objectives and supplied written informed consent. They were additionally told that any direct quotations appearing in future publications would remain anonymous where relevant. Every piece of data was applied exclusively to the goals of this investigation. The entire project followed the ethical standards set out in the Declaration of Helsinki.

Results and Discussion

Sociodemographic characteristics of participants

Sixty managers participated in the focus group discussion, and eight individuals took part in interviews. Half of the sample (36) were aged 11–12 and classified as middle management, whereas close to 40% (27) were junior managers. A bachelor's degree was the highest qualification for 53% (36) of the managers, while 7% (5) held postgraduate degrees. Female representation (53%) exceeded male representation (47%). Most participants (46%) were aged 46-55 years, followed by 38% aged 36-45 years. A total of 75% (51) had over five years of tenure in their current roles. More than half of the participants (53%) resided in the NMMD municipality **(Table 1)**.

Table 1. Sociodemographic profile of study participants.

Role of HCW (position)	Total		Key informant interviews		Focus group discussion	
	N	%	N	%	N	%
Level 9–10	27	39.71%	3	4.41%	24	35.29%
Level 11–12	34	50%	4	5.88%	30	44.12%
Level 13−14	7	10.29%	1	1.47%	6	8.82%
Total	68	100%	8	11.76%	60	88.24%
Highest degree attained						
Senior certificate	0	0%	0	0%	0	0%
National diploma	27	39.71%	3	4.41%	24	35.29%
Bachelor's degree	36	52.94%	4	5.88%	32	47.06%
Hons/PGDIP/Master's	5	7.35%	1	1.47%	4	5.88%
Total	68	100	8	11.76%	60	88.24%
Place of employment						
Provincial head office	7	10.29%	1	1.47%	6	8.82%
Bojanala Platinum District Municipality	25	36.77%	3	4.41%	22	32.35%
Ngaka modiri molema district municipality	36	52.94%	4	5.88%	32	47.06%
Total	68	100.00%	8	11.76%	60	88.24%
Duration of employment						
< 1 year	0	0	0	0	0	0
1–4 years	17	25%	0	0	17	25%
5–7 years	35	51.47%	6	8.82%	29	42.65%
> 10 years	16	23.53%	2	2.94%	14	20.59%
Total	68	100.00%	8	11.76%	60	88.24%
Age (years)						
25–35	6	8.82%	1	1.47%	5	7.35%
36–45	25	37.76%	2	2.94%	23	33.83%
46–55	31	45.59%	4	5.88%	28	41.18%
56 and above	5	7.35%	1	1.47%	4	5.88%
Total	68	100.00%	8	11.76%	60	88.24%
Gender						
Male	32	47.06%	5	7.35%	27	39.71%
Female	36	52.94%	3	4.41%	33	48.53%
Total	68	100.00%	8	11.76%	60	88.24

Results – focus group discussions and individual interviews

Findings from focus group discussions (FGDs) and in-depth interviews (IDIs) with purposely sampled public health workers exposed shortcomings in leadership, governance, and day-to-day operations. These results are grouped into five principal themes: (1) weak leadership empowerment, (2) poor performance management, (3) ineffective policy execution, (4) resource distribution and oversight, and (5) insufficient primary healthcare (PHC) infrastructure and governance **(Table 2)**.

Table 2. Healthcare leadership challenges in NW NMMD and BPD municipalities.

#	Leadership challenge	Description	Manifestation of the challenge
1	**Ineffective leadership (2)**	• Workforce morale is low, objectives lack clarity, and leaders struggle with self-management, prioritization, and communication, often avoiding conflict.	Senior-level managers frequently fail to demonstrate effective leadership across key components of the health system. The infrastructure within the North West Province is deteriorating, which staff observe daily, while accountability among colleagues remains limited.
2	**Lack of prioritization in healthcare service delivery goals (3)**	• All tasks are treated as equally important, resulting in no clear priorities. • Constant crisis management leads to staff burnout and a reactive working approach.	The health system is inherently complex, involving primary, secondary, and tertiary levels. Although frontline healthcare workers should be prioritized, all components are treated equally, contributing to ongoing systemic crises.
3	**Inadequate policy implementation**	• Insufficient dissemination and institutionalization of policies and training initiatives. • Absence of mechanisms to assess policy effectiveness. • Weak ownership and stewardship of policies.	Policies are intended to guide operational practices; however, frameworks such as Batho Pele are not consistently implemented, limiting their effectiveness in supporting high-quality, leadership-driven healthcare delivery.

4	**Weak governance structures (4,5)**	• Ineffective functioning of national, provincial, and district councils. • Underperforming hospital and clinic boards. • Ineffective health center committees. • Weak health councils.	Governance bodies are expected to provide oversight and accountability. The ongoing decline of the health system suggests that these structures are either ineffective or unable to fully execute their responsibilities.
5	**Deficient monitoring and evaluation systems (6)**	• Inaccurate or unreliable data. • Poorly designed data collection tools. • Weak monitoring and evaluation culture.	Effective health systems rely on monitoring and evaluation (M&E) to generate evidence for decision-making. However, the persistence of failing services and infrastructure indicates that available data are either insufficient or not effectively utilized.

Abbreviations: BPD = Bojanala Platinum District (BPD); M&E = Monitoring and Evaluation; NMMD = Ngaka Modiri Molema District; PHC = Primary health care; PMDS = Performance Management and Development System.

Limited leadership empowerment

Participants reported that local managers lacked independent decision-making power and frequently escalated even routine issues to the Provincial Department of Health's Head Office.

One respondent remarked,

Some local managers are not confident and hesitate to make decisions. This makes them ineffective leaders who must always seek approval from the Provincial Head Office for issues that should be handled locally. When the COVID-19 pandemic started, there was no direction from the Head Office, which created chaos at the local level. We had to figure things out on our own.

This overreliance on central authority produced delays and uncertainty, especially early in the pandemic.

Furthermore, participants noted a disconnect between knowing management theories and applying them in practice. As one person put it, "Many managers know the concepts but cannot put them into action." This theory–practice divide underscores the importance of building real-world experience and strengthening applied management skills.

Ineffective performance management

The performance management and development system (PMDS) was found to be poorly executed, undermining both operational effectiveness and healthcare quality. While participants understood that the PMDS was designed to assess and boost performance through quarterly and annual reviews, they observed that it rarely worked as intended.

The PMDS process involves evaluating public servants' work every three months and annually, which can result in promotions for high-performing staff.

One participant explained,

The PMDS influences operational plans, but staff need to feel valued and properly compensated to deliver high-quality care.

Participants also warned that training by itself was not a solution, stating,

We have discovered through costly mistakes that training alone cannot fix all our service quality issues. Delivering good healthcare requires far more resources than people typically realize. The harm caused by poor-quality healthcare to human lives cannot be measured. A positive work environment, with employees having a constructive attitude toward their jobs, will improve service delivery quality relative to established targets and priorities.

Weak policy implementation

Participants reported that policies were inconsistently applied, thereby reducing operational effectiveness. Healthcare policies intended to relieve strain on medical staff were frequently postponed or never carried out. One participant commented, "Healthcare policies often stall because of slow procedures or a complete lack of action."

Oversight entities, such as clinic committees and hospital boards, were found to be either missing or non-functional. One participant noted, "Clinic committees rarely convene, and while hospital boards do meet, their efforts are irregular, resulting in poor oversight and little community engagement." This inconsistent application of policies points to deeper systemic governance issues that undermine strong leadership.

Resource allocation and stewardship

Limited resources, worsened by budget cuts and weak financial oversight, remained a persistent challenge. Participants indicated that the Northwest Department of Health's (NWDoH) declining budget constrained workforce growth, leading to conflicts with unions. One participant stated,

A smaller budget means no new hires, and that creates friction with the unions.

Another participant added,

A weak economy, high unemployment, and unequal access to decent health facilities may breed unrest and resentment in poorer communities.

Furthermore, the COVID-19 pandemic stretched resource management to its limits. For oxygen machines and personal protective equipment (PPE), the administration provided only sufficient funding for what it considered top priorities starting in the 2020/2021 fiscal year.

Supply chain inefficiencies made matters worse, with ongoing shortages of medications, especially for hypertension and diabetes, recognized as a recurring yearly issue.

A participant explained, Medicine shortages become more severe as the fiscal year ends because the budget runs out.

Some drugs are always in stock because they are rarely prescribed. But medications for long-term conditions like hypertension and diabetes are mostly unavailable. Managers at Community Health Centers say the new drug supply system has not yet helped, since even when they report low stock levels on time, deliveries still fail to arrive.

Additionally, poor upkeep of healthcare technology, such as broken machinery, interferes with service delivery. One participant noted, "If maintenance contracts were in place, equipment would work, but delays—like waiting for a patient's X-ray—leave professionals feeling frustrated." These findings highlight a strong need for better resource distribution and supply chain management.

Primary healthcare: Governance and service delivery inputs

Participants expressed concerns about the condition of PHC facilities, which lacked basic resources, including medicines and functioning equipment. This reduced patient trust, with one participant stating, "People avoid PHC facilities because they do not trust free services that are viewed as low-grade."

Our patients pay nothing, yet they go to other levels of care without referrals from primary care. They have little faith in the current primary healthcare system because it is so often underfunded that it lacks medicines, and essential equipment is broken.

Our patients seem to distrust free services. The belief is that free services are cheap and poor, meant only for the impoverished.

Weak governance structures further intensified these problems, with infrequent hospital board meetings and poor monitoring and evaluation (M&E) practices. One participant noted, "Regional governance is too weak to support localized M&E, and most actions agreed upon are never put into practice." Additionally, a failure to set clear priorities was evident, with one participant describing the system as "moving from one emergency to the next," which causes staff exhaustion and reactive management.

Table 2 summarizes the main challenges and impacts highlighted by participants.

This investigation revealed shortcomings in leadership, governance, and day-to-day management that hinder the provision of high-quality healthcare across two district municipalities in the North West (NW) province, South Africa. The issues uncovered—including insufficient leader empowerment, poorly functioning performance management, fragile policy enforcement, challenges in resource distribution and oversight, and weak PHC infrastructure—reflect deep systemic hurdles to effective leadership within the province's public health sector.

Although the five categories emerging from this work—leader empowerment, performance management, policy enforcement, resource stewardship, and infrastructure plus governance—are broadly recognized in international research, our results provide a locally specific understanding by showing how these difficulties take shape within South Africa's shifting district health system during the early stages of National Health Insurance (NHI) rollout. The North West Province offers a distinctive leadership environment shaped by prolonged centralization, financial constraints, corruption, favoritism, and inconsistent local decision-making authority. Recording the actual experiences of senior leaders operating at provincial, district, and facility levels provides timely evidence of how these systemic pressures are managed in practice. While these results confirm existing theoretical knowledge, they also guide real-world action by influencing decentralization strategies, performance management reforms, and governance strengthening in South Africa and in other low- and middle-income countries facing comparable health financing and structural changes.

Transformational leadership theory values empowerment, a clear vision, and the capacity to energize staff; however, those we spoke with reported restricted independence and limited scope to introduce changes. Complexity leadership theory values adaptability and spontaneous problem-solving within shifting systems; nevertheless, deeply embedded bureaucratic processes and rigid financial constraints often block such flexibility [17]. Systems leadership demands coordination across different stakeholders and levels of care; yet fragmented governance and uneven policy application prevent this integration [18]. These frictions indicate that while international leadership models are conceptually useful, they must be adapted to fit hierarchical, resource-scarce environments undergoing health reform, such as South Africa's shift toward NHI.

In Scandinavian systems, for example, Sweden, shared governance and protected time for leadership skill-building enable managers to act on their own authority while remaining answerable [1]. Uganda and Rwanda have effectively used performance-linked funding and decentralized accountability to encourage adaptive leadership within tight financial constraints [10]. South Africa's situation stands apart due to its heavily centralized past and the ongoing policy shift to NHI, meaning that such methods require careful local adjustment, including stronger financial supervision and leadership training linked to decentralization. Despite widespread recognition of these leadership deficits, several forces keep them alive: a deeply

rooted bureaucratic culture blocks adaptive behavior; performance management remains focused on rule-following rather than development; and leadership programs have not been woven into district-level career pathways.

These results also directly affect the quality of treatment provided to communities. Poor decentralization and weak managerial empowerment lead to slow decision-making, inadequate responses to local health needs, and low worker morale, all of which damage service reliability and consistency. A performance management system that prioritizes compliance over growth discourages new ideas and responsibility. Weak policy enforcement and fragmented governance worsen supply shortages and service gaps, while inefficient resource allocation reduces the availability of essential drugs, equipment, and trained personnel. Taken together, these elements drive patients to seek care elsewhere, erode public trust, and lower service quality—trends repeatedly observed in South Africa and other low- and middle-income countries. Within this broader health systems context, our findings highlight that improving district-level leadership is critical to raising service quality and achieving the aims of the National Health Insurance.

Against this background of deep-rooted centralization, evolving funding reforms, and the need to reshape established leadership models for a resource-limited, hierarchical setting, the real-world stories shared by district and facility managers show how these systemic pressures operate in practice. The following sections present and interpret the five themes drawn from the analysis.

Limited leadership empowerment

This study found that failures in healthcare governance structures negatively affect service delivery commitments outlined in the Department of Health's Patients' Rights Charter. Governance failures arise from excessive centralization, in which district managers send decision-making authority upward to provincial headquarters, reflecting inadequate leadership qualities such as taking responsibility, making firm choices, and showing initiative [3]. This over-centralization, paired with ineffective bureaucracy, creates delays in local decision-making, leading to healthcare system inefficiencies and worsening infrastructure. This finding agrees with international work, which stresses that empowered local leadership is necessary for health systems to be adaptive and resilient enough to respond quickly to emergencies [4].

Large differences exist between provinces in the financial and administrative powers delegated, with the NW province notably limiting district managers' freedom compared to provinces such as the Western Cape (WC) [19]. The scale of these differences becomes clear when looking at financial delegation limits. For example, the NW province allows delegations up to R200,000, whereas the Western Cape (WC) permits delegations up to R500,000. Other differences include the inability of NW district managers to fully handle and close out supply chain management matters or to make human resources appointment decisions at the district level.

Current thinking in healthcare leadership suggests that good leadership practices should include (a) leading with empathy, (b) spreading the vision, (c) bringing the team together, (d) shaping results, (e) analysing information, (f) linking the service across settings, (g) building skills in others, and (h) demanding accountability from others, as taught by the United Kingdom's National Health Service [5] through their Healthcare Leadership Model. A cited report from the Institute of Medicine [20] stresses that leadership is essential for reaching goals related to quality treatment and patient safety. That report states that for quality care to be achieved, leadership is expected from people at every level of an organization.

The Healthcare Leadership Model is designed to grow stronger leaders who adopt transformative ways of working. Other research argues that leadership must be both inclusive and flexible to respond to the quickly shifting healthcare environment [5].

One study that reviewed and synthesized existing research to build a comprehensive picture of healthcare leadership concludes that leadership development programs are vital for the ongoing improvement of healthcare capabilities [21].

Ineffective performance management

According to participants, the way the Performance Management and Development System (PMDS) operated across the municipalities under study was flawed, leading to staff frustration and reduced drive. These observations align with those from a qualitative investigation in Namibia's Kavango East Region, where ineffective PMDS operation was traced back to insufficient staff training, poor system architecture, and minimal managerial participation [6]. In a similar vein, research conducted in Dr. Kenneth Kaunda District, North West Province, found that nurses questioned whether the PMDS was fair and transparent, a sign of broader systemic leadership breakdowns [7]. These results indicate that for performance management systems to work, they need strong leadership support—such as proper training and reward strategies—to encourage a workplace culture where people take responsibility and stay engaged.

Weak policy implementation

This investigation found that policies were inconsistently enforced, with clinic committees and hospital boards meeting irregularly, leading to poor supervision and operational breakdowns. This aligns with a literature review that cited studies from Kenya, which revealed a disconnect between policy and implementation, despite the Abuja Declaration requiring greater

funding for the health sector [22]. The Kenyan study stressed that leadership is essential to ensuring policies are implemented, a point that also emerged in this study's observations of delayed or missing policy implementation [8]. The North West Province's difficulties point to a need for leadership that improves policy ownership and accountability, along with indicators that track whether implementation is actually working, rather than just ticking procedural boxes.

Resource allocation and stewardship

The NW province deals with severe resource shortages, compounded by weak financial oversight and broken supply chains. Financial constraints and procurement failures have become major obstacles to providing effective healthcare. Participants reported ongoing scarcities of critical medications for chronic illnesses like high blood pressure and diabetes, made worse by budget reductions and inefficient purchasing systems. This is consistent with other studies showing that Resource Allocation and Stewardship, when combined with financial constraints, strongly shape how chronic diseases are managed and the health outcomes [23, 24]. Neglecting to maintain essential medical equipment weakens service provision, indicating that maintenance contracts and monitoring mechanisms are insufficient.

Primary health care governance and service delivery inputs

The research revealed that poorly funded PHC facilities, together with fragile governance arrangements, lowered patient confidence and reduced service quality. Participants noted that people skipped PHC facilities because they viewed the care as low-grade, a problem intensified by irregular governance and feeble monitoring and evaluation (M&E). A cross-sectional study conducted in Ntungamo District, Uganda, found that how an M&E program is implemented within the health sector significantly affects the quality of healthcare service delivery. That study also found that although M&E should not be regarded as the sole factor guaranteeing an intervention's success, it does exert a moderate influence on healthcare service quality in Uganda [25]. A comparative study in Uganda and Rwanda that evaluated the strength of M&E systems using (i) policy; (ii) quality of indicators, data, and methods; (iii) organization; (iv) capacity; (v) participation by non-state actors; and (vi) M&E outputs concluded that the health sector M&E systems in both Rwanda and Uganda are somewhat disconnected, with some parts working well and others not [26]. This contrasts sharply with the M&E practices of the North West Province's Health Department, which are viewed as poorly executed.

Absence of prioritization in goal setting

Failing to set priorities in healthcare goal-setting has produced reactive management and worker exhaustion, with participants painting a picture of a system where "every task claims top importance, so none actually gets it." Comparative studies on how to set priorities in the health sector were undertaken in Sweden and Norway. Norway has a long record of open priority-setting in healthcare at the national level, whereas such openness does not exist at the municipal level, as in the NWP. Even though people recognize that priority-setting matters, there is skepticism and distrust between municipalities and the central government. This doubt and suspicion can be overcome by involving stakeholders and making decisions transparently, thereby enabling effective healthcare leadership [27]. In Sweden, priority-setting is used to achieve a fair and efficient distribution of scarce resources, employing a "refined approach." A study that assessed Swedish physicians' views on (I) how limited resources affect patient care; (II) clinical decision-making; and (III) the ethical framework and national guidelines for healthcare from the National Board of Health and Welfare concluded, among other things, that priority-setting offers one way to reach fair and open decision-making in clinical environments, with particular weight placed on the ethical foundation [28]. The NW province's healthcare system lacks organized priority-setting processes, underscoring the need for interventions to build transparent, inclusive, and evidence-based mechanisms rooted in an ethical foundation. This can be supported through healthcare leadership practices promoted by the NHS Leadership Model.

Limitations

Because the study focused on only two district municipalities and drew its sample entirely from senior management personnel, the findings may not be broadly generalizable. Moreover, the researcher's own position could have introduced some social desirability bias, so the results need careful interpretation. That said, the use of purposive sampling and triangulation through FGDs and IDIs strengthens the credibility of the findings within the specific context studied. Although this qualitative approach yields rich, context-specific insights, future work could incorporate quantitative methods to assess the frequency and severity of the identified leadership challenges and explore how they relate to health system performance indicators.

Conclusion

The results highlight systemic leadership failures that undermine the North West Province's health system, particularly in terms of care quality. While confirming well-known international leadership gaps, this study offers practical, locally specific

insights into how deeply rooted centralization, budget constraints, and NHI policy shifts influence leadership at the district level. It extends transformational, complexity, and systems leadership models by demonstrating how they must be adjusted to fit hierarchical, resource-poor settings. On a practical front, the findings recommend pushing decision-making authority downward with clear financial accountability, shifting to a performance management approach that prioritizes development rather than just compliance, and making ongoing leadership training a permanent part of district operations.

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