Improving public healthcare in Namibia through clinical governance: A systemic review

A DISSERTATION SUBMITTED IN FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE

OF

MASTER OF SCIENCE IN HEALTHCARE MANAGEMENT

OF

UNICAF UNIVERSITY ZAMBIA

BY

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R2002D10423665

APRIL 2022

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ABBREVIATIONS

CG	Clinical Governance
MoHHS	Ministry of Health and Social Services
NHPF	National Health Policy Framework
PHC	Primary Healthcare
PPI	Patient and Public Involvement
QI	Quality Improvement
THE	Total Health Expenditure
UHC	Universal Health Coverage

Abstract

Introduction: The Namibian government through the Ministry of Health and Social Services has been working to improve the health status of its population. Considering the change in disease burden, availability of resources and collaboration between stakeholders, the goal is to make health service upgrades to best serve the population at large. Health service upgrades require systematic joining of strategies to improve the quality of care provided by public healthcare institutions. The introduction of clinical governance will allow for the establishment of necessary structures to implement standards and ensuring that they are met. Key areas addressed by clinical governance are strategic planning, leadership, staff training and education, patient involvement and organizational structure and management.

Methods: A systemic review was conducted, and articles were retrieved from databases for this review. The articles were published between January 2000 to March 2022 and the Prisma checklist was used to extract and organize the data with inclusion criteria. Duplicate articles were removed, and further analysis of article titles and abstracts was done to remove irrelevant articles. Finally, only articles relating to clinical governance were included in the review.

Results: Nine articles directly focused on clinical governance while the remaining seven addressed key areas of clinical governance. The findings were grouped into two main categories 1) barriers to clinical governance 2) strategies for clinical governance implementation.

Conclusion: Patient centered care and consumer satisfaction should be the driving force for every healthcare institution and public healthcare systems at large. Necessary measures and active steps need to be taken to ensure the best quality service is provided to individual patients. Healthcare systems managers should develop suited frameworks that can be adapted locally up to facility level.

Keywords: Namibia, Public health, Clinical Governance, Patient and Public Involvement, Quality Improvement and Healthcare Management

Introduction

Orientation of study

It is the obligation of state to provide safe and quality healthcare for the Namibian population. Although there is access to basic healthcare in the country as up to 76% of the population live within a 10 km radius of a healthcare centre, there has been recurrent outcries of poor healthcare provision from communities (Christians, 2020). The Ministry of Health and Social Services (MoHSS) is a custodian in providing healthcare services and aims to continue improving healthcare quality after the country's independence. However, this remains conceptually and operationally vague according to the National Health Policy Framework 2010 – 2020 (MoHSS, 2010). Considering the approach of focusing on hospital care, the safety and quality of healthcare have an impact on clinical outcomes and patient satisfaction (Hut-Mossel et al., 2017). Public healthcare facilities throughout the country have these persisting problems:

Shortage of healthcare personnel

Prolonged waiting hours at public healthcare facilities is a long-standing problem in the sub-Saharan region and Namibia is no exception with less than one healthcare personnel per a thousand in comparison to Europe that has ten per a thousand (Maphumulo & Bhengu, 2019). There are far less personnel in the public sector compared to the private and public sector as more than 70% of the doctors and a little less than 50% of registered nurses are employed in the private sector which caters for 18% of the population (MoHSS, 2017). Due to the workload in public healthcare facilities personnel often experience burnout rendering poor service (Christians, 2020).

Poor infrastructure and hygiene

An Article in the Namibian Sun (13,03,2017) the MoHSS reported an inadequate number of health facilities and poor condition of the existing facilities. Hospital beds are at 100% occupation and the 6 % budget cut is making it difficult to address the issue of insufficient infrastructure. In addition, due to the condition of Primary Healthcare (PHC) patients often overcrowd referral hospitals. The overcrowding of emergency departments has led to patients experience complications while waiting and deaths have been recorded in the emergency room (ER). There is poor disease control and prevention due to poor maintenance of public facilities (Nevhutalu, 2016).

Equipment and resource shortages

According to Manyisa and Van Aswegen (2017) the deficiency of skilled personnel and administrative setup unfavourably affects the quality of healthcare provided by institutions. State doctors experience backlog due to the lack of equipment in hospitals delaying some patients awaiting treatment (Zere et al., 2007, Maphumulo & Bhengu, 2019). Another cause in delay of treatment is poor health record keeping. Sometimes records are lost or missing, and patients are made to wait or given incorrect diagnosis leading to death in some instances.

Management crisis

Another key element that has led to unsatisfactory service delivery in healthcare is poor leadership and inadequate management as many managers lack vision and clear philosophy (Carney, 2009, Pillay-van Wyk et al., 2016). According to Coovadia et al., (2009) the placement of inexperienced managers in senior positions has exacerbated the crisis. Twala (2014) explains further that though the government aimed to remove discrimination and promote equality but this was characterized by favoritsm instead of skills and competence. In addition, poor service delivery is intensified by the tolerance for poor management performance, misconduct and the lack of monitoring strategies

(Siddle, 2011). Managers often apply for promotion because of their length of service and the desire of a better pay rather motivation to improve service delivery. Promotion of unskilled managers creates a gap between management quality and clinical outcome (Pillay, 2010).

Clinical governance

Governance allows for a systemic control and directing of organizations and is equally a pivotal predicator of economic and social growth and overall development. Management of resources in a population for its wellbeing include governance of health systems which is an area that is frequently overlooked. Management of clinical care in healthcare facilities is often referred to as clinical governance (CG) (Scally & Donaldson, 1998). The term was first coined in 1997 as a framework by England's department of health to enable National Health Service (NHS) organizations to continuously enhance the quality of the services they offer and uphold a high standard of care while fostering an environment that ensures excellent clinical care (Department of Health,1998). Therefore, the mechanism set in place held healthcare organizations liable for the safety, quality and efficacy of healthcare services given to patients (British Journal of Healthcare Assistants,2013). The CG paradigm has seven pillars i.e. clinical effectiveness, risk management, clinical audit, patient and public involvement, staff management, education and training and information utilization. In addition, these seven pillars are based on five essential corner stones that are: leadership, system awareness, ownership, communication and teamwork (Heyrani et al., 2012). The main aim of a healthcare system is to provide equitable health for population at large, enabling them to participate in socio-political and economic communities with adequate health (Beyrami et al.,2014, WHO, 2018).

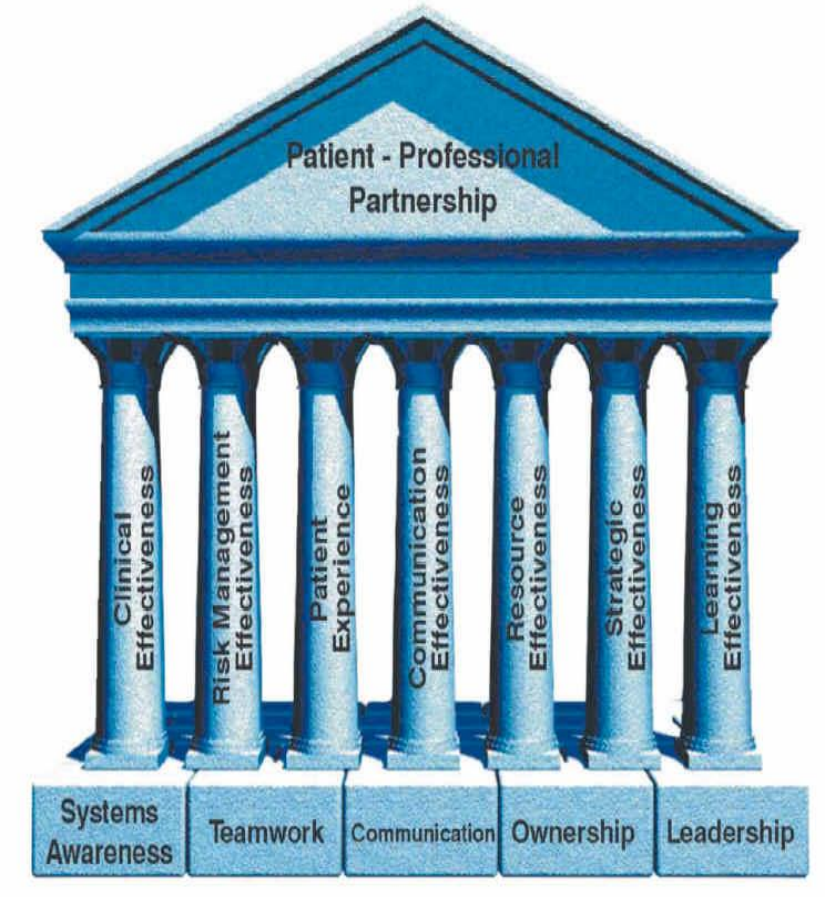

Figure 1 Pillars of clinical governance

Despite the increase in discussions about governance (Kaufman et al.,2005, Graham et al., 2003) the literature on clinical governance is still insignificant. It is important to note that CG appertains to the actions and ways embraced by a society at large and not only healthcare institution to organize itself in advocating and protecting the health of its population (Dodgson et al., 2002). The World Health Organization (2002) states that apart from funding, creating and managing resources, and service provision healthcare facilities should be reliable stewards. Stewardship ensures that governing bodies invest in the wellbeing of the population and are considerate of the trust and authenticity with which its actions are viewed by the citizens (Travis, 2001).

Rational

Of the limited data on CG only a small percentage discuss mechanisms designed for developing countries. The aim of this review article was to assess the design of the health systems and highlight how CG may improve healthcare at institutional level. Initially there will be a summary of the current concerns relating to the implementation of CG in the public health system. Second, the proposed healthcare system governance principles will be presented. The paper will conclude with the review and policy propositions of clinical governance can be explored.

Aims of the Study

The aim of this research is to provide an understanding of the effect of CG in public health sector and how strategic frameworks at grassroot level can assist some of the goals of the National Health Policy Framework (NHPF).

Objectives

The objectives of this research were:

- To determine what governing policies at national level, hinder the set-up of effective organizational structures in public healthcare facilities.
- To determine what factors contribute to the failure of implanting strategic plans in public healthcare facilities.
- To explore the interest of healthcare professionals' participation in improving healthcare.
- To investigate possible principles for the implementation CG in healthcare centres.

Methodology

In this systematic review, Prisma checklist was used to obtain and arrange the data. Relevant articles were extracted with various countries of publication and highlighting the implementation of clinical governance in PubMed databases [Table 1], Researchgate, Web of Science, ProQuest, and Google scholar search engine. The publication date was from January 2000 until March 31, 2022. Keywords such as MeSH terms and common keywords related to the topic under study were included Healthcare Systems, Clinical Governance, Organization, Patient and Public Involvement, Developing Countries, Quality Improvement and Healthcare Management.

Table 1 Search strategy 1

PubMed	ProQuest	Google Scholar
"clinical governance"[MeSH Terms] OR clinical governance[Text Word] [MeSH Terms] OR "quality improvement"[MeSH Terms] AND quality improvement[Text Word] [MeSH Terms] OR financial management[Text Word] "rural population"[MeSH Terms] OR rural population[Text Word] "developing countries"[MeSH Terms] OR developing countries[Text Word] public[All Fields] OR ("delivery of health care"[MeSH Terms] AND healthcare[Text Word]) "namibia"[MeSH Terms] OR namibia[Text Word]	Namibian healthcare Patient and Public involvement in quality improvement Health systems in developing countries	Clinical auditing Choosing strategies for change Continuous quality improvement

Table 2 Inclusion criteria 1

Inclusion criteria	**Exclusion criteria**
Articles written in English	Non-English articles
Government documents, gazettes, newspapers and press releases	Abstracts were excluded
Articles published from 2000 to date	Articles published before 2000
Articles that are relevant to the topic and question	Articles not relevant to research questions
Articles discussing healthcare systems governing problems	Governance non-related articles

All articles published in English were included. Articles that lacked full text and review articles were excluded. The PubMed search strategy is depicted in Table 1. Table 2 outlines the characteristics of the articles included in the study. These table contains the profile of the authors, country of study, year of publication, and the main findings. A total of 1648 articles were extracted of which 57 were duplicates and had to be removed. Afterward, the article's titles and abstracts were assessed according to the inclusion and exclusion criteria, removing unrelated articles. A total of 254 articles of them were excluded due to their irrelevance to clinical governance. Finally, 16 articles were included in this review and they were all qualitative studies. Figure 2 depicts the screening process including databases used and the inclusion criteria.

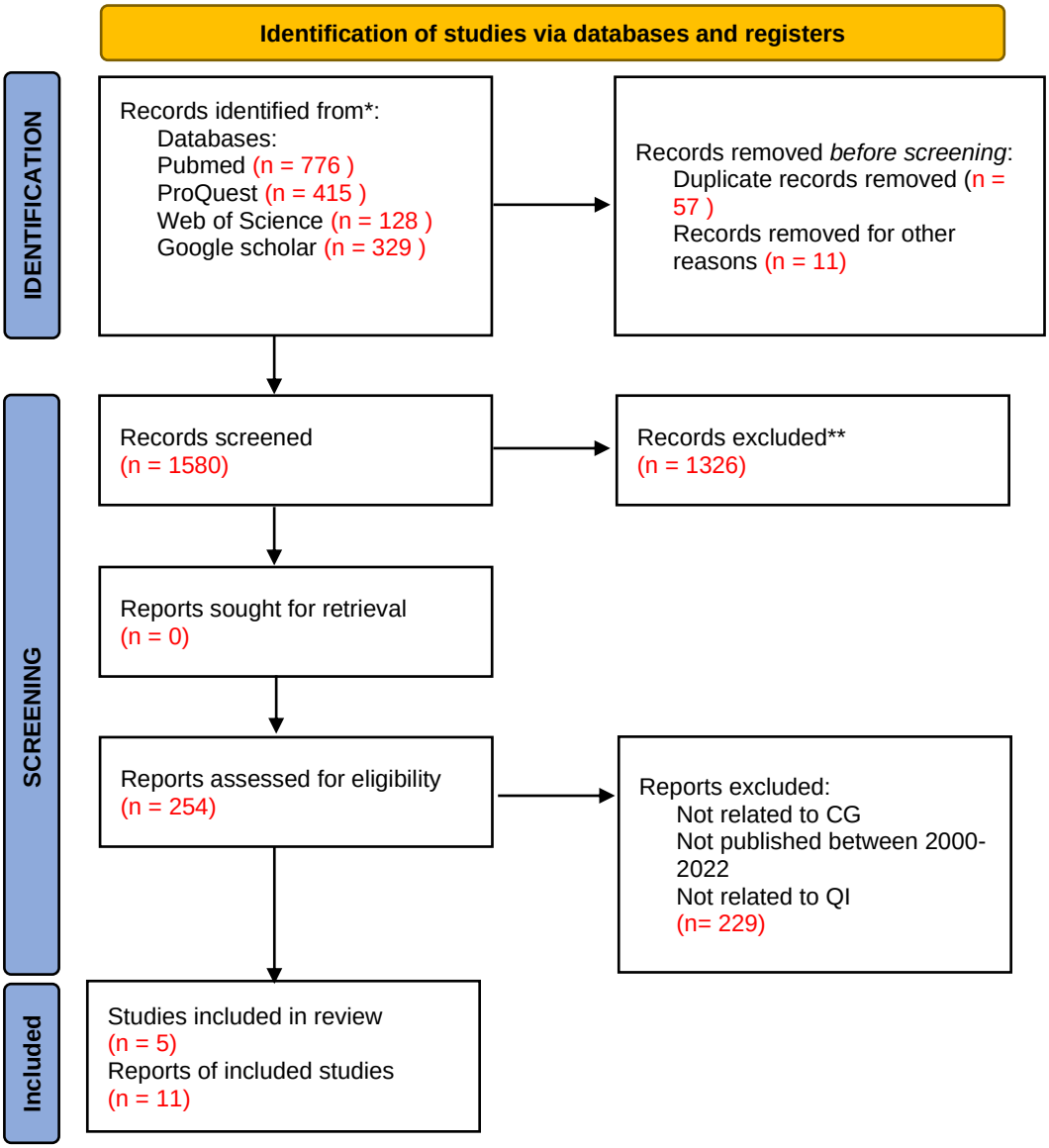

Figure 2 Study selection process

Table 3 Characteristics of articles 1

Authors	Design	Title	Key factors relating to CG	Objectives	CASP
Ghavamabad, L., Moghaddm A., Zaboli,R., Iran, 2021	A review	Establishing clinical governance model in primary health care: A systematic review	Resource management, Education organizational structure, Leadership, Barriers to CG implementation Leadership	To determine the principles and prerequisites necessary for CG implementation in primary healthcare	7/11
Veenstra G, Ahaus K, Welker G et al, Netherlands, 2016	A Delphi study	Rethinking clinical governance: healthcare professionals' views: a Delphi study	Ownership, Teamwork, Leadership, Communication	To explore the views of health personnel on CG Implementation	7/11
Gunst C, Mash RJ & Phillips LC. South Africa, 2021	A reflective study	A reflection on the practical implementation of the clinical governance framework in the Cape Winelands District of the Western Cape	Communication, Accountability, Compliance to standards, Operation strategies	To assess the practicality of CG implementation in Cape Wineland District in Western Cape	6/11
McCormick S, Wardrope J, Perez Avila C. UK, 2022	Analysis of effectiveness of established CG in St Jude hospital	Quality assurance, clinical governance, and a patient wants to die	Performance management, Incident reporting, Process measures and supervision	To determine if the implementation of CG can guarantee quality assuarance	6/11
Heyran A, Maleki M, Marnani AB et al., Iran, 2012	A systemic approach	Clinical governance implementation in a selected teaching emergency department: a systems approach	Systems approach to improving care	To examine if systems approach can facilitate CG implementation in a teaching emergency department	9/11
Halligan A & Donaldson l. UK, 2001	Analysis of how theoretical CG frameworks can be translated and introduced	Implementing clinical governance: turning vision into reality	Effective leadership, Planning for quality, Evidence based healthcare	To assess the practicality of clinical governance frameworks	7/11

Table 3 (Continued) Characteristics of articles

Authors	Design	Title	Key factors relating to CG	Objectives	CASP
Braithwaite J & Travaglia JF Australia, 2008	Analysis of CG with reference to Australian and global healthcare	An overview of clinical governance policies, practices and initiatives.	Applying standards, Accreditation of staff, Auditing Patient safety, Clinical indications	To define CG and best possible practices to enable CG implementation	6/11
Siddiqia S, Masuda TI, Nishtarb S et al., Pakistan, 2019	An evaluation of health systems governance of public healthcare facilities in Pakistan	Framework for assessing governance of the health system in developing countries: Gateway to good governance	Healthcare systems dynamics, Role of stakeholders in clinical governance, Principles and framework assessing clinical governance	To present an assessment method for established healthcare government at both sub-national and national level	9/11
Hut-Mossel L, Welker G, Ahaus K & Gans R. Netherlands, 2017	Analysis of the clinical audit process	Understanding how and why audits work: protocol for a realist review of audit programmes to improve hospital care	Clinical audits, Quality improvement	To assess the process of clinical auditing and how it can be introduced to improve care	7/11
Tsofa B, Molyneux S & Goodman C. Kenya, 2016	A cross sectional study	Health sector operational planning and budgeting processes in Kenya-"never the twain shall meet"	Data use, Stewardship and coordination	To assess the correlation between planning and budgeting by Kenyan health sector	9/11
Herd G, Musaad S.A.M New Zealand,2019	A cross sectional study	Clinical governance and point-of-care testing at health provider level	Patient safety, Standards and guidelines, Evaluations and validations	To analyse CG and QA programs among healthcare facilities using POCT in New Zealand	7/11
King, J.C, Powell-Jackson, T et al., Tanzania, 2021	A cluster-randomized controlled trial	Effect of a multifaceted intervention to improve clinical quality of care through stepwise certification (SafeCare) in health-care facilities in Tanzania: a cluster-randomised controlled trial	Patient safety	To investigate the effect of multifaceted interventions in clinical care quality improvement	10/11

Table 3 (Continued) Characteristics of articles

Authors	Design	Title	Key factors relating to CG	Objectives	CASP
Mogakwe, J.L, Hafisa, A & Magobe, N.B.D. South Africa,2019	Cross sectional survey	Recommendations to facilitate managers' compliance with quality standards at primary health care clinics	Promoting internal communication, Education and training	To recommend compliance of management to quality standards in primary healthcare as a means to improve service delivery	8/11
Fardaza F.E., Safari, H., Habibi, F., Haghighi, F.A. & Rezapour, A. Iran, 2015	A descriptive cross-sectional study	Hospitals' readiness to implement clinical governance	Organizational structures	To assess the readiness of hospitals to introduce CG in Iran	8/11
Wishnia, J & Goudge, J. South Africa,2021	Qualitative case study	Strengthening public financial management in the healthcare sector: a qualitative case study from South Africa	Strategies to improve public financial management, Collaboration in public healthcare management	To identify areas of collaboration between financial managers, executives and healthcare personnel.	7/11
tTerzic-Supic et al., Serbia, 2015	Prospective study	Training hospital managers for strategic planning and management: a prospective study	Management training programs, the use of SWOT analysis to improve care	To assess the effects training has on healthcare managers with respect to strategic planning	9/11

Results

Sixteen articles were extracted (Table 3). Seven of these assessed the impact of clinical governance implementation on healthcare systems as a means of improving quality of service delivery. Three studies focused on equipping healthcare managers with planning and managerial skills to effectively govern healthcare institutions. Based on the literature reviewed in this review there are two major general groups, the first are requirements necessary to establish clinical governance (CG) the second are barriers hindering CG. The studies reveal that the main aim of CG is to allow for continuous improvement of quality healthcare by every individual involved in providing healthcare within an organization (Veenstra et al., 2016). Operational elements of CG included clinical auditing, risk management, patient involvement, training and education and evidence-based medicine (Balding, 2008, Bender, 2012, Nicholls et al, 2000, Travaglia, 2011). The above-mentioned elements were backed up by shared beliefs among the healthcare professionals such as leadership, teamwork, ownership, communication and systems awareness (Nicholls, 2000).

Leadership

Leadership was identified as essential to every organization as it gives clear directions on goals and vision throughout the structure of the organization. Effective leadership enables open and consistent communication to all staff regarding CG. Active communication promotes participation and motivates staff giving them purpose. In addition, efficient leadership promotes teamwork enabling an open and interactive environment and both principles and daily delivery of CG prevails as an intrinsic part of every clinical care service (Halligan & Donaldson, 2001). Leaders in all healthcare organizations need to understand CG and how collaboration and shared responsibilities will prove more productive than authoritarian perspective (Veenstra et al., 2016).

Teamwork

According to Halligan and Donaldson (2001) professionals in healthcare can contribute to improve healthcare whether collectively or on an individual bases. Understanding how interconnected healthcare systems are, multidisciplinary teamwork is a driving force to shared responsibility and good relationships (Veenstra et al., 2016). Regarding structural and organizational CG, teamwork is a pre-requisite as it allows for relevant infrastructure for research, dissemination of ideas, encouragement, role clarification and the monitoring of staff progress (Gharamabad et al.,2021).

Communication

An inherent part of communication in CG was indicated as the sharing of values and practice-based feedback with the aim of improving healthcare quality (Veenstra, et al., 2016). Generated data within an organization needs to be formatted so that stakeholders at various levels in the organization have credible and suitable reports to allow for timely decision making. When aiming at evidence-based healthcare it is important that the information shared is reliable, timely and clear to understand (Halligan & Donaldson, 2001).

Systems awareness

Systems approach is claimed to have emerged and evolved due to the unpredictability, increasing complexity and the diversity of problems in an organization such as a healthcare facility (Heyrani et al., 2012). Systems awareness incorporates the idea of understanding organizational structures and establishes evidence based long term goals. This means individuals throughout the organization participate in feedback loops that involve self-reflection, patient and public feedback and objective

expert insight (Reynolds, 2010). Furthermore, Kalim et al., (2006) and Braithwaite (2002) state that systems awareness is the premier mode to develop and established CG in various levels and healthcare settings.

Ownership

The Delphi study by Veenstra et al., 2016 concluded that ownership in CG requires active participation in the planning and execution of healthcare by healthcare professionals. This implies that individuals involved share responsibilities to ensure quality improvement within the healthcare system. Working environments that promote creativity and freedom of expression are essential for teamwork and active participation (Veenstra et al., 2016).

Discussion

Challenges in implanting Clinical governance

Findings from various studies indicated that there are several barriers that hinder CG beginning with ambiguity of healthcare quality. CG is an initiative that emboldens adherence and enhancement of clinical care principles at every level of healthcare and the participation from patients, the public and stakeholders is required. According to Karassavidou et al., (2011) the presence of various studies on CG have not given enough understanding on the concept of CG. Healthcare professionals are found in a predicament that while trying to implement CG they need to develop policies and structures. Moreover, if the implementation of CG requires the reformation of essential areas of the healthcare systems and key aspects to the process of providing care then it becomes difficult because of the strongly imbedded social impediments relating to work environments and organizational operational practices (Bahrami et al.,2014). These presents a serious peril for clinical governance implementation ideas for as long as there is interference with established cultures and practices and there is a need to refocus on understanding healthcare quality conceptually (Kontch et al.,2008).

Four articles further reported on the rigidity of managerial structures, especially in public healthcare settings. Organizational structures in public healthcare systems are ranked, rigid and bureaucratic having a long standing inflexible way of working (Preker & Harding, 2003). Poor organizational structures have given way for improper dissemination of information, lack of feedback mechanisms and systemic learning. All the above are contrary to the effective establishment of clinical governance (Fardazar et al., 2012). According to Michel Crozier, a French sociologist, state organizations are stuck in a vicious cycle of inefficiency due to the disregard of strategies proposed by employee groups to improve service delivery within departments (Edwards & Saltman, 2017). Public healthcare institutions should develop policies based on status quo or strategic analysis such as SWOT analysis (strengths, weaknesses, opportunities and threats) (Terzic-Supic et al.,2015).

Siddiqu et al., (2009) states that the Ministry of Health in most developing countries is the main provider of health services despite the growth of private healthcare entities. Studies from developing countries in this review highlighted the poor or lack of engagement between stake holders in healthcare even up to managerial level. In addition, a study by Joshi and Moore (2004) discussed the unorthodox arrangements of organizations. Considering health in the holistic does not only relate to providing clinical care services and so other state ministries should deliver public services and set the necessary conditions to improve accountability of service providers (Bloom et al.,2008, Joshi & Moore, 2004, Saddiqu et al., 2009).

Strategies for Clinical Governance implementation

There are several core principles mentioned in all the studies reviewed regarding the successful implementation of CG. Below is a summary of commonly identified strategies:

Continuous improvement through education and accreditation

Knowledge explosion is evident in all disciplines and healthcare is no exception. Healthcare institutions should entrench lifelong learning as a cultural characteristic. It is necessary for individuals and organizations to keep up with the growing knowledge as it gives exposure to new practices, ideas and technologies that are essential to quality improvement up to the organizational level (Braithwaite &Travaglia,2008). In addition, executives need to make certain that clinical care is only delivered by qualified personnel who are consistently efficient (Victorian Managed Insurance Authority, 2007). Equally, healthcare organizations should provide the support needed for personnel to perform to the best of their ability. A study by Terzic-Supic et al. (2015) emphasized on the importance of strategic planning and management training for hospital managers to capacitate them for their role. In addition, training should be followed by evaluation as a diagnostic tool when reviewing training programs and assessing effectiveness. Furthermore, this should be evident in job execution (Collins, 2000 & Unger, 2003).

Performance management and clinical auditing

With the help of clinical indicators at various levels of healthcare and organizational wide indicators boards can map the performance of a specific department or the entire organization for a certain time frame ((Braithwaite &Travaglia,2008). Executives need to be aware of these indicators to assist in tracking organizational and clinical performance and progress. Furthermore, regular reviews need to be performed to assess if practices conform with the overall organizational mission. Performance management systems will evaluate the progress of the organization's aim with the goal of encouraging staff and promoting development rather than being punitive (Bourne et al., 2003, Australian Council for Safety and Quality in Healthcare, 2004).

The National Institute of Clinical Excellence (2002) defines clinical auditing as a quality improvement cyclic process that aims to improve healthcare outcomes through systematic evaluation of patient care compared explicit standards and implementing the necessary changes. Factors relating to the organizational structure, procedures, and outcomes of care are chosen and systematically appraised against explicit policies and standards. Where necessary, amendments are implemented throughout the organization from individual, department, or service level and continuous surveillance is used to corroborate improvement in care delivery."

Evidence based practices and information sharing

Evidence based medicine is defined as the diligent, clear and prudent usage of contemporary viable information to make decisions regarding the clinical care given to patients in healthcare systems (Blaber, 2018). Additionally, this exercise resolves to integrate individual clinical knowledge and the best existing external data from studies (Veenstra et al.2016). The balance of this practice is that if research evidence alone is applied then medical practice will be tyrannised and external evidence may not always prove appropriate or applicable. On the other hand, the absence of research evidence may become outdated to the detriment of patients (Abu-Baker et al.,2021). It is therefore imperative that executive boards ensure the availability of evidence for clinicians to remain updated on new developments in the discipline.

Healthcare systems generate a large amount of data but not all of it is aggregated into usable, valid and reliable information. According to Fowler et al., (2013) organizations aim to carry out evidence based practice will require that generated data should be converted into information that is accessible to departmental, divisional, organizational, executives and regional levels to make timely decisions. Technological advancements are equally necessary to facilitate in this regard as it makes information readily available such as Health Information Systems (HIS).

Resource management

Allocating and managing resources in the healthcare sector is highly influenced by the healthcare needs of a specific community. There are diverse facets to improve healthcare services and resource allocation and management is intrinsic to the process (Harris et al., 2017). Rigid budgets and inefficient management of resources proves to be a hurdle if the aim is to improve healthcare delivery at the grass roots (Mitton & Donaldson, 2003). Smoke (2015) and Andrew (2010) state that actions such as decentralization will allow for local decision making. In addition, budgeting with healthcare outcome targets in mind will provide a better perspective on healthcare expenditure goals and improve health care provision. Inaccurate budgeting leads to cashflow constraints and eventually planning redundancy. Human resource is another factor in resource management and maintaining a sufficient work force to facilitate the quality improvement and continuous functionality of the organization. It is not only necessary to have sufficient intakes but to retain healthcare workforce and especially in rural areas (Mbemba, 2016).

Public and patient involvement

The assessment of quality of healthcare can be best described by those who receive the care and this is where consumers feedback is most required. When conducting quality improvement (QI) projects patient and public involvement (PPI) is crucial because the stages that follow are built on what is being evaluated. Furthermore, PPI assists in guideline development and particularly relevant to ensure that these guidelines not only reflect on clinical care alone but the continuation of care for the chronically ill and service integration (Den Breejen et al., 20014). Han et al., (2013) and various other studies report on the prevalent assumption about patients' contribution being invaluable to the improvement of healthcare service provision. It is assumed that PPI may pose a threat by challenging cultural principles of healthcare organizations. Though it is a fairly new strategy in QI, public healthcare systems managers may explore PPI when conducting QI as part of clinical governance (Groener & Sunol, 2015).

Conclusion

The literature demonstrated that the effectiveness of healthcare systems depends on the entire governance of a country and not solely on the stewardship role of the public healthcare system, especially in developing countries. The suggested CG principles provided a set of guidelines whose operative factors permit evaluation and improvement. Another key area that was highlighted was the persistent misalignment between planning, policies and organizational execution and could be alleviated through contextualizing operational frameworks to fit respective healthcare settings. Clinical leadership and supportive culture will prove useful to CG in public healthcare organizations. CG implementation should be based on systemic reviews of organizational strengths and weaknesses, and the generated information is to be used in daily clinical practice to improve healthcare quality as a means of evidence based practice. Clinical governance will serve as a link between executive and clinical approaches to quality. The literature suggested that governing bodies such as

MoHSS need to consider reliable foundations of organizational structure this being inclusive of equipment, supporting specialties, staffing arrangement and staff training.
Further mixed method research needs to be conducted. The quantitative aspect of the study should assess the degree of CG implementation and the correlation of its implementation with anticipated outcomes. The qualitative research should investigate settings in which CG is implemented and its impact.

Endnotes

Acknowledgements
Ms Katjinaani would like to thank friends, family and colleagues for the support given.

Ethics approval
No ethical approval was necessary as no individual participants were involved for this review.

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