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A space where governance meets humanity-where stories of purpose, discipline and leadership reminds us that systems change begins with how we focus our attention each day.

• Governance
• Sustainability
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HOW THIS PLAYS OUT ACROSS THE ISSUE

SPOTLIGHT

STEWARDSHIP AS GOVERNANCE DISCIPLINE

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VOLUME 11 | 2026

EDITOR'S NOTE

Intergenerational Stewardship:

Governing for People Who Are Not Yet in the Room

The Fourth Archetype

Volume 8 introduced the Weaver.

The Weaver integrates. They hold analytical precision, African governance wisdom, and behavioural intelligence together under pressure, and they do not allow any one of those disciplines to dominate at the expense of the others. That was the archetype Volume 8 built.

Volume 9 introduced the Author.

The Author does not adopt standards. They create them. They understand that legitimacy requires authorship — that an institution measured against a framework it did not design will, eventually, be found wanting not by the framework but by itself.

Volume 10 introduced the Challenger.

The Challenger asks the question that power would prefer remain unasked. They possess Permission, Independence, Capability, Conviction, and Reach. Without them, even authored standards become documents.

Volume 11 introduces the fourth archetype.

The Steward.

The Steward is the leader who governs for people not yet present. Where the Weaver integrates, the Author creates, and the Challenger questions,

> *"Good clinicians save individual lives. Strong institutions save populations."* — Dr Sipho Kabane

the Steward holds. They hold the institution against the pressure to optimise for the present at the cost of the future. They govern in the knowledge that their most important stakeholders cannot yet speak in the room where decisions are being made.

Dr Sipho Kabane has spent four decades inside health system governance in South Africa. He has served as a clinician in the public sector, as a private practitioner, as Head of Department in two provinces, as CEO of the Council for Medical Schemes, and on the boards of PEPFAR, SANBS, Anova, and the Engineering Council of South Africa. His career has moved through almost every layer of a system that is simultaneously one of the most sophisticated and one of the most inequitable on the continent. What makes his contribution to this volume distinctive is not the range of roles. It is what that range reveals: that the most durable things built by any leader are not programmes or policies, but people, institutions, and governance traditions.

> *"Did I leave the institution stronger, more ethical, more capable and more equitable than I found it?"* — Dr Sipho Kabane

That question is the Steward's North Star. It reorients governance from the personal to the institutional, from the present to the future, from achievement to inheritance.

Volume 12 will synthesise the four archetypes into a framework. Before that synthesis, Volume 11 ensures the fourth archetype is fully built.

Enjoy Volume 11

Katlego Mojela

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FEATURE

LEADERSHIP IS CONCERNED WITH SOLVING TODAY'S PROBLEMS.

Stewardship is concerned with ensuring that future generations inherit institutions that are stronger than those we inherited ourselves.

— Dr Sipho Kabane

Former CEO, Council for Medical Schemes · Board Member, PEPFAR, SANBS, ECSA

FOUR DECADES, ONE QUESTION

A Conversation with Dr Sipho Kabane

Dr Sipho Kabane began his career as a medical officer at St Helena Gold Mine in Welkom in 1986. In the four decades since, he has moved through every layer of South Africa's health system: public sector clinical practice, private practice, provincial health leadership in the Free State and Limpopo, national regulatory leadership as CEO of the Council for Medical Schemes, and board service on PEPFAR, SANBS, Anova, and the Engineering Council of South Africa. He currently advises PEPFAR and mentors the next generation of health system leaders.

What follows is not a policy analysis. It is a practitioner's account of what four decades inside a health system teaches about governance, resilience, trust, stewardship, and the question that should define every leader's tenure.

This conversation is drawn from written responses. Views expressed are Dr Sipho Kabane's professional opinions in his personal capacity.

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Section 1 — System, not institution

QA1 The view from every level

You have worked across almost every layer of South Africa's health system — from clinical practice to provincial leadership to national regulation. What does that vantage point reveal about the system that is invisible from within any single layer?

That is a fascinating question because one of the privileges of my career has been the opportunity to view the South African health system from almost every level — from consulting with individual patients in a GP practice in Welkom, to managing provincial health systems, to regulating the medical schemes industry nationally. What becomes apparent from that vantage point is that many of the problems we experience are not isolated failures within individual institutions; they are symptoms of a fragmented system. When you sit in one part of the system, it is easy to believe that the problem lies somewhere else. Clinicians may blame administrators, administrators may blame politicians, funders may blame providers, and patients often blame everyone. When you have worked across all these layers, you begin to see that the incentives, funding flows, governance arrangements and accountability mechanisms are often poorly aligned. As a young doctor in the public sector, I witnessed extraordinary dedication from healthcare professionals working under difficult conditions — staff shortages, ageing infrastructure, equipment failures and medicine stock-outs. Those experiences taught me that good clinical skills alone cannot compensate indefinitely for systemic weaknesses. Leading provincial health departments and later regulating the medical schemes environment revealed another important lesson: health systems are fundamentally governance systems. Countries do not achieve better health outcomes simply because they spend more money; they achieve them because they align policy, financing, management, accountability and service delivery toward common objectives. The unique insight from having worked across these levels is that South Africa does not suffer from a shortage of expertise or commitment. We have excellent clinicians, capable managers, innovative private-sector players and sophisticated regulators. Our greatest challenge is connecting these strengths into a coherent system where incentives are aligned and where every participant is working toward the same goal: improving the health and wellbeing of the population. That perspective has shaped my leadership philosophy. Effective health system leaders must be bilingual — they must understand both the language of public health and the language of economics; both the realities of patients and the realities of institutions. Without that dual understanding, it becomes difficult to design solutions that are both equitable and sustainable.

> *"South Africa does not suffer from a shortage of expertise or commitment. Our greatest challenge is connecting these strengths into a coherent system where incentives are aligned."*
>
> — Dr Sipho Kabane

QA2 The coping system and the resilient system

You led health departments in both the Free State and Limpopo. What did those two provinces teach you about what makes a health system resilient — not just functional under pressure, but capable of sustaining performance across time?

Serving as Head of Department in both the Free State and Limpopo taught me one of the most important lessons in health system governance: resilience is not determined by the amount of resources a system has, but by its ability to continue delivering essential services despite shocks, uncertainty and leadership changes. On paper, the two provinces were very different. Limpopo served a larger, predominantly rural population dispersed across vast geographic areas, with significant challenges in attracting and retaining specialist skills. The Free State had a smaller and more urbanised population, a more established tertiary platform, and the advantage of an operational medical school. Yet despite these differences, I observed something that fundamentally changed my understanding of health systems. Provinces with fewer resources can sometimes perform better than better-resourced provinces if their governance systems are stronger. Conversely, provinces with significant assets can deteriorate rapidly when accountability, leadership and institutional discipline break down. When I arrived in Limpopo, the department was under Section 100 administration because of severe governance failures, financial mismanagement and weak accountability mechanisms. The challenge was not simply a shortage of money or personnel. The deeper problem was that the systems that convert resources into health outcomes had become compromised. That experience taught me that a health system that is merely coping relies heavily on heroic individuals. It survives because committed managers, clinicians and frontline staff work around broken processes every day. The system functions despite itself. A structurally resilient health system is fundamentally different. It is characterised by strong institutions rather than strong personalities. It has reliable procurement systems, sound financial controls, effective supply chains, competent leadership, robust clinical governance and clear accountability. It continues to perform even when there are political transitions, fiscal pressures or leadership changes because the underlying systems are strong. One of the most important insights I gained is that resilience is largely invisible during stable periods. It only becomes apparent during a crisis. A resilient system absorbs shocks and adapts. A coping system becomes overwhelmed and begins to fail. The lesson from both provinces was that sustainable improvement in healthcare is not achieved through isolated interventions or emergency responses. It is achieved by building institutions that can consistently deliver quality care regardless of who occupies leadership positions at any given time.

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> *"Resilience is not determined by the amount of resources a system has, but by its ability to continue delivering essential services despite shocks, uncertainty and leadership changes."*
> — Dr Sipho Kabane

Section 2 — Regulation, trust, and the fault line

QA3 Standing at the fault line

You served as CEO of the Council for Medical Schemes — a regulator positioned between private sector sustainability and the obligation to protect beneficiaries. What does that position teach about what regulation is actually for?

Regulating the medical schemes industry was one of the most intellectually challenging and emotionally complex roles of my career because it placed me at the centre of one of South Africa's greatest health policy paradoxes. On the one hand, I was regulating a sector that delivers some of the highest-quality healthcare services on the African continent. The private health sector is well-resourced, technologically advanced and home to many of the country's most skilled healthcare professionals. It provides access to world-class care for millions of beneficiaries. On the other hand, it serves a relatively small proportion of the population while consuming a disproportionately large share of the country's healthcare resources. As a regulator, you are constantly confronted by the reality that excellence and inequity can coexist in the same system. Very quickly, I realised that the regulator occupies a uniquely lonely position. You are expected to be independent when powerful interests would prefer you to be accommodating. You are expected to be fair when competing stakeholders have fundamentally different expectations of fairness. And you are expected to make decisions that may be unpopular today but necessary for the long-term protection of members. The most important lesson I learned is that regulation is ultimately not about controlling institutions; it is about safeguarding public trust. The Medical Schemes Act gives the regulator a clear mandate to protect beneficiaries, and that mandate must remain the North Star regardless of commercial pressures, political debates or industry resistance. So what did it feel like? It felt like standing at the fault line between market forces and social justice. It was often uncomfortable, occasionally contentious, but always purposeful. Because at its core, the role was not about regulating schemes — it was about protecting people who depend on those schemes when they are most vulnerable.

> *"Regulation is ultimately not about controlling institutions; it is about safeguarding public trust."*
> — Dr Sipho Kabane

QA4 What trust actually costs

Public trust in health institutions is often discussed as a communications challenge. From your experience, what is it actually? And what does losing it cost — in ways that never appear on a balance sheet?

Public trust is perhaps the most valuable asset a health institution possesses because healthcare ultimately depends on a relationship of confidence between citizens and the system that serves them. People do not need to understand the intricacies of health financing, procurement systems, workforce planning or governance structures. What they need to know is something much simpler: when they or their loved ones need care, the system will be there, it will be competent, and it will treat them with dignity. A health institution begins to lose trust when there is a persistent gap between what people reasonably expect and what they consistently experience. One isolated incident may create concern, but trust is usually eroded when failures become predictable and recurrent. Medicine shortages, long waiting times, staff shortages, equipment failures, poor communication, financial mismanagement and visible leadership failures all send a message to the public that the institution is no longer reliably fulfilling its social contract. The most profound cost, however, is measured in lives rather than finances. Delayed diagnoses, treatment interruptions, preventable complications and avoidable deaths are often the hidden consequences of institutional mistrust. Those costs cannot be fully quantified in monetary terms. The difficult reality is that trust can be destroyed very quickly but rebuilt only slowly. Rebuilding trust requires more than promises, communication campaigns or leadership changes. Communities judge institutions by what they consistently do, not by what they say. Trust returns when people repeatedly experience reliable services, respectful treatment, competent leadership and visible accountability over time. One of the most important lessons I have learned is that public trust should never be viewed as a by-product of good healthcare. It is itself a critical health system resource. Just as health systems need medicines, infrastructure and skilled professionals, they also need public trust. Without it, even the best-designed policies struggle to achieve their intended outcomes.

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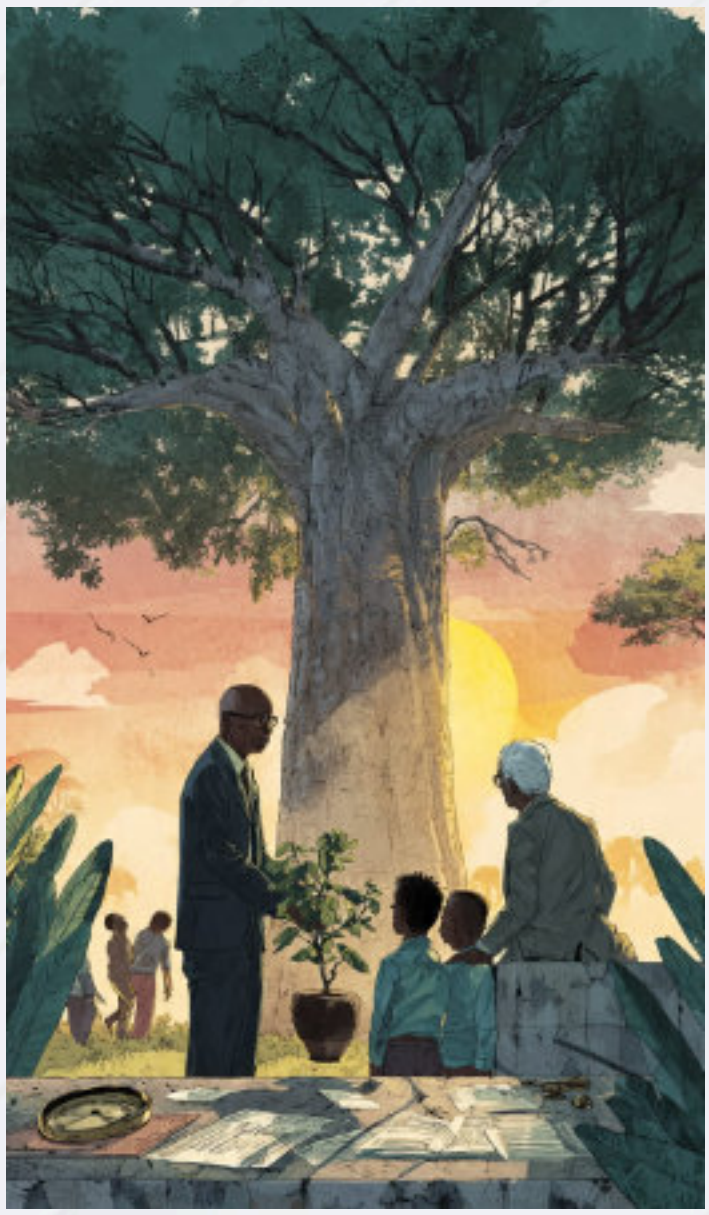
> *"Public trust should never be viewed as a by-product of good healthcare. It is itself a critical health system resource."* — Dr Sipho Kabane

Section 3 — NHI and the institutional project

QA5 The governance risk inside the reform

The National Health Insurance is the most ambitious governance reform in democratic South Africa. Where is the greatest governance risk — and what does success actually require?

The National Health Insurance represents perhaps the most ambitious governance and financing reform attempted in democratic South Africa. Its objective is both noble and necessary: to progressively realise universal health coverage by ensuring that all South Africans have access to quality healthcare services without suffering financial hardship. The debate about NHI often focuses on funding, but in my view the more fundamental question is institutional capability. Health reforms do not succeed because legislation is enacted; they succeed because institutions have the capacity, credibility and discipline to implement that legislation consistently over time. The NHI requires several institutional capabilities that currently exist only partially within the South African health system. Firstly, it requires a level of governance maturity and accountability that is not yet uniformly present across the health sector. A national purchaser responsible for managing very large financial flows must operate with exceptional transparency, independence and oversight. Public confidence will depend not only on what the institution does, but on whether citizens and stakeholders trust how decisions are made. The greatest governance risk, in my view, lies in the gap between policy ambition and implementation capacity. South Africa has historically been strong at policy development. Our challenge has often been translating policy intent into institutional execution. If the pace of implementation exceeds the ability of institutions to build the necessary governance, financial management and operational capabilities, the system may experience declining public confidence before the benefits of reform become visible. A third risk is the erosion of stakeholder trust. Major reforms of this scale require broad societal support. Sustainable reform is rarely achieved through legal authority alone; it is achieved through institutional legitimacy and public trust. Ultimately, I believe the success or failure of the NHI will not be determined by the policy itself. The policy objective is widely shared. The determining factor will be whether South Africa can build and sustain the institutions capable of implementing that objective effectively, transparently and accountably over the next decade and beyond. The lesson from health systems around the world is that universal health coverage is not primarily a financing project; it is an institutional project. The countries that succeed are those that invest as much in governance, accountability and implementation capability as they do in funding mechanisms.



> *"Universal health coverage is not primarily a financing project; it is an institutional project."*
> — Dr Sipho Kabane

QA6 What effective boards actually do

You have served on boards across PEPFAR, SANBS, Anova, and ECSA. What separates an effective board from a compliant one?

Serving on boards across organisations as diverse as PEPFAR, SANBS, Anova and ECSA has reinforced a lesson that many people only learn after years of governance experience: compliance and governance are not the same thing. Many boards are procedurally compliant. They hold meetings on time, maintain registers of interests, approve policies, receive audit reports and satisfy statutory requirements. Those activities are important, but they do not necessarily make a board effective. An effective board creates value through the quality of its judgement rather than the quality of its paperwork. Firstly, effective boards possess the right mix of skills, experience and diversity of thought. Diversity is not simply about demographics; it is about bringing different perspectives into the

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room and creating an environment where those perspectives can be expressed openly and respectfully. The best decisions often emerge from constructive disagreement rather than unanimous consensus. Secondly, effective boards are intellectually curious. They do not merely accept management reports at face value. They ask difficult questions, probe assumptions, challenge emerging risks and seek evidence before making decisions. Healthy scepticism is one of the most valuable attributes a non-executive director can bring to a boardroom. Thirdly, effective boards remain relentlessly focused on purpose. Whether one is discussing blood safety, HIV programme outcomes, engineering standards or healthcare delivery, the most successful boards never lose sight of why the organisation exists and whom it serves. Perhaps the most important lesson I have learned is that board effectiveness is ultimately a matter of culture. The best boards create an environment where difficult issues can be raised early, uncomfortable truths can be discussed openly, and decisions are made in the long-term interests of the organisation rather than the short-term interests of individuals. That is why I often say that governance is not demonstrated by the documents a board approves; it is demonstrated by the quality of the conversations that take place around the board table. The difference between a compliant board and an effective board is that one focuses on processes, while the other focuses on outcomes, impact and stewardship.

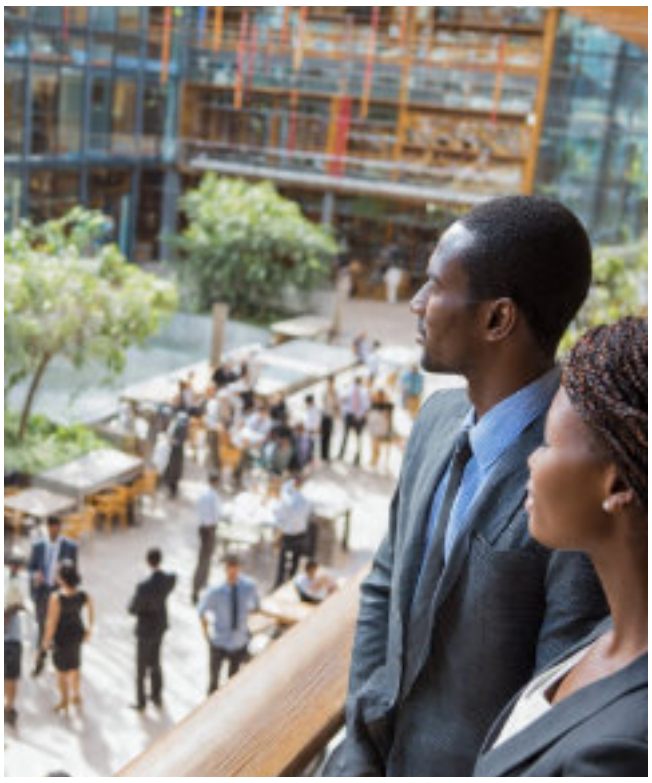
> ***"Governance is not demonstrated by the documents a board approves; it is demonstrated by the quality of the conversations that take place around the board table."***
>
> **— Dr Sipho Kabane**

Section 4 — Stewardship and inheritance

QA7 What lasts and what doesn't

Looking back across four decades, what have you built that has lasted — and what did the system fail to protect?

That question becomes more difficult to answer the longer one serves in the health system because with time one realises that very little of lasting value is built by individuals alone. When I reflect on what has lasted, I am less inclined to think about positions held and more inclined to think about people, systems and ideas. One legacy I am particularly proud of is the development of leadership capacity. Throughout my career I have invested heavily in coaching, mentoring and supporting younger professionals. Many individuals who were once junior managers, clinicians and administrators are now leaders in their own right. Leadership development has a multiplier effect because those individuals continue to influence institutions long after one's own tenure has ended. I am also proud of contributing to improvements in maternal health outcomes in the Free State through the use of data-driven decision-making, multidisciplinary review processes and strengthened emergency referral systems. Those interventions demonstrated that measurable improvements in health outcomes are possible when clinical and managerial leadership work together. Another contribution was my involvement in the development of quality standards that ultimately informed the standards used by the Office of Health Standards Compliance. While standards alone do not guarantee quality care, they create a common language of accountability and patient safety that continues to shape the health system today. However, the longer I have worked in health systems, the more I have come to appreciate that achievements are often less durable than we hope. Some improvements endured, while others proved vulnerable to leadership changes, shifting political priorities and institutional instability. That experience taught me a humbling lesson: sustainable reform requires strong institutions, not simply strong leaders. If there is one thing the system failed to protect, it was institutional integrity and, at times, the people committed to defending it. Too often dedicated professionals found themselves exposed to political interference, patronage networks, instability and corruption. The consequences extended far beyond individual careers. They affected workforce morale, delayed infrastructure renewal, weakened accountability and undermined public confidence in the health system. Looking back over four decades, I would therefore say that the most enduring things I helped build were not programmes or policies, but people, leadership capability and governance traditions. Those have the greatest chance of surviving changes in administrations, budgets and political cycles. And what did the system fail to protect? It failed, too often, to protect the institutions themselves from forces that gradually erode their integrity. Once that erosion begins, rebuilding trust, capability and performance becomes the work of a generation.



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> *"The most enduring things I helped build were not programmes or policies, but people, leadership capability and governance traditions."*
> **— Dr Sipho Kabane**

QA8 The discipline of stewardship

You have spoken about leadership and stewardship as different things. What does stewardship actually require as a governance discipline — and what does it demand of the leader who tries to practise it?

One of the most important lessons I have learned over the course of four decades in healthcare is that leadership and stewardship are not the same thing. Leadership is often concerned with solving today's problems. Stewardship is concerned with ensuring that future generations inherit institutions that are stronger than those we inherited ourselves. Governing for that time horizon requires a very different set of disciplines. Firstly, it requires strategic patience. Modern governance often operates within political, budgetary and electoral cycles that reward immediate results. Yet many of the most important investments in health systems only produce measurable outcomes years later. Leaders must therefore have the discipline to invest in outcomes they may never personally witness. Secondly, it requires institutional thinking rather than individual thinking. Throughout my career I have observed that strong leaders can improve performance for a period, but only strong institutions can sustain performance across generations. Governing for the future means building systems, governance structures, accountability mechanisms and organisational cultures that survive changes in leadership and political administrations. Thirdly, it requires moral courage. Many decisions that are necessary for long-term sustainability are not always popular in the short term. Stewardship requires the willingness to make difficult decisions today in order to prevent greater harm tomorrow. Fourthly, it requires humility. One of the dangers of leadership is believing that we are building systems for our own legacy. In reality, we are temporary custodians of institutions that existed before us and should continue long after we are gone. The role of stewardship is not to leave monuments to ourselves but to leave institutions capable of serving future generations effectively. Perhaps most importantly, governing for future generations requires an unwavering commitment to equity. Every generation inherits the consequences of decisions made by the previous one. The inequalities that continue to characterise South African healthcare today did not emerge overnight; they are the result of decades of policy, funding and governance choices. This means that stewardship is ultimately an act of intergenerational justice. It asks us to consider not only the needs of current beneficiaries, but also our obligations to those who will depend on the health system long after we are gone. Looking back on my own journey — from serving mine workers in Welkom, to leading provincial health departments, regulating medical schemes, contributing to health standards, serving on national and international boards, and mentoring future leaders — I have come to believe that the most important question for any health leader is not, 'What did I achieve during my tenure?' but rather, 'Did I leave the institution stronger, more ethical, more capable and more equitable than I found it?' If every leader in healthcare were to govern with that question in mind, the children who are in nappies today would inherit a very different health system tomorrow.

> ***"Stewardship is ultimately an act of intergenerational justice. It asks us to consider not only the needs of current beneficiaries, but also our obligations to those who will depend on the institution long after we are gone."***
> **— Dr Sipho Kabane**

QA9 What the system doesn't teach

If you could go back and speak to the young medical officer who started at St Helena Gold Mine in 1986, what would you tell him that no training programme was likely to teach?

If I could go back and speak to the young medical officer who started working at St Helena Gold Mine in 1986, there is one thing I wish I had understood much earlier: health systems are ultimately shaped less by medicine than by institutions. As a young doctor, I believed that clinical excellence was the primary determinant of health outcomes. Over time, I came to understand that while good clinicians save individual lives, strong institutions save populations. The quality of governance, leadership, financing, accountability and organisational culture often has as much impact on health outcomes as clinical interventions themselves. I also wish I had understood earlier how difficult it is to create lasting change. In the early stages of one's career, there is a tendency to believe that evidence is sufficient to drive reform. Experience teaches otherwise. Evidence is essential, but health systems are also shaped by politics, incentives, competing interests, history and human behaviour. Good ideas do not automatically prevail because they are good ideas. They require coalitions, persistence, trust and leadership to become reality. Perhaps the most humbling lesson I learned is that leadership is not about having the right answers. It is about creating the conditions under which institutions can continue to find the right answers long after you have left. If there is one thing I would tell a young health system leader in South Africa today that no training programme is likely to teach them, it is this: Protect your integrity as fiercely as you protect your expertise. Most leadership programmes will teach strategy, finance, governance, quality improvement and management. Few will adequately prepare you for the moments when your values are tested. Yet those moments will define your career more than any qualification or technical skill. You will encounter pressure to compromise standards, to remain silent when you should speak, to prioritise expediency over principle, or to place personal advancement ahead of institutional interests. In

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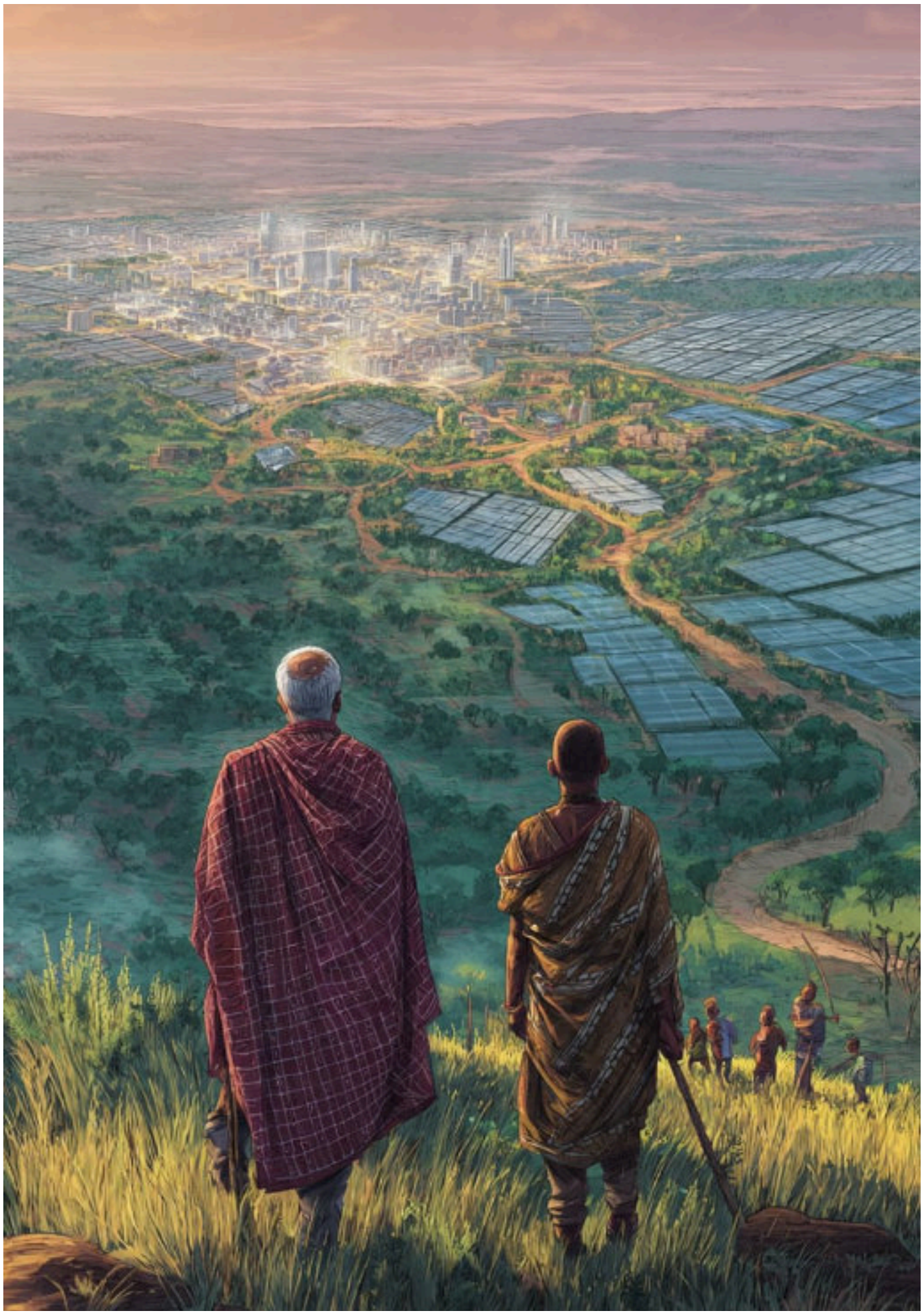
those moments, remember that credibility is a leader's most valuable asset. Once lost, it is extraordinarily difficult to recover. Finally, understand that your task is not simply to manage today's problems. Your task is to leave the institution stronger than you found it. If you focus on building capable people, strengthening governance, protecting public trust and advancing equity, your impact will extend far beyond your own tenure. Looking back now, I have come to believe that careers are measured not by the positions we hold, but by the institutions we strengthen and the people we prepare to lead after us.

> ***"Protect your integrity as fiercely as you protect your expertise."***
>
> **— Dr Sipho Kabane**



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CASE STUDY

THE COPING SYSTEM AND THE RESILIENT SYSTEM

Every organisation appears resilient until the people holding it together leave. That is the distinction Dr Kabane draws between a coping system and a resilient system, and it is one of the most practical governance frameworks to emerge from the *Rooted* series.

A coping system is not necessarily failing. From the outside, it may appear to be functioning well. Services continue to be delivered, reports are submitted on time, and key performance indicators remain within acceptable ranges. What remains hidden is the extraordinary effort required to sustain those outcomes. Dedicated individuals compensate every day for weak processes, poor controls, fragmented accountability, and ineffective governance. Performance is achieved despite the system rather than because of it.

The defining characteristic of a coping system is that its success is person-dependent. It relies on exceptional individuals who work around institutional weaknesses through experience, commitment, or sheer determination. When those individuals retire, resign, burn out, or are removed, performance declines rapidly because the capability never resided within the institution itself. It resided within the people.

A resilient system is fundamentally different. It performs because its underlying systems are strong. Roles, processes, governance structures, and organisational culture enable consistent performance regardless of who occupies leadership positions. Individuals remain important, but they strengthen the institution rather than becoming indispensable to it. The true difference between a coping system and a resilient system often becomes visible only during periods of disruption, leadership transition, or crisis.

A coping system survives because people work around broken processes every day. A resilient system performs because the underlying systems are strong. The difference only becomes visible during a crisis.

Section 100 and What It Reveals

The distinction becomes particularly clear when viewed through South Africa's experience with Section 100 interventions. Section 100 of the Constitution empowers the national government to intervene when a provincial administration cannot or does not fulfil its constitutional obligations. While the immediate trigger is often financial distress, irregular expenditure, procurement failures, or weak internal controls, these are rarely the root cause of institutional failure. They are usually its most visible symptoms.

As Dr Kabane's reflections demonstrate, financial collapse often reflects a much deeper institutional erosion. The systems responsible for converting resources into public outcomes—governance, accountability, procurement, leadership, and organisational culture—have gradually weakened until they can no longer perform their intended function. Money alone cannot compensate for institutional failure.

Recovery therefore requires far more than additional funding or revised policies. It requires rebuilding the governance architecture that enables resources to become outcomes: restoring accountability, strengthening systems, rebuilding trust, and re-establishing the institutional disciplines that sustain performance over time.

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CASE STUDY

The Structural Resilience Framework

Drawing on Dr Kabane's experience and the broader governance themes explored throughout Rooted, structural resilience rests on six mutually reinforcing capabilities:

- Operational reliability: Procurement, financial management, supply chain, and information systems function consistently regardless of changes in leadership.
- Institutional accountability: Governance mechanisms hold individuals accountable for outcomes and stewardship, not merely compliance with prescribed processes.
- Distributed leadership capability: Leadership capacity is developed throughout the organisation rather than concentrated in a small number of exceptional individuals.
- Operational and quality governance: Clear standards, effective assurance, and escalation mechanisms identify and address problems before they become systemic failures.
- Organisational culture: An environment where difficult conversations are encouraged, emerging risks are surfaced early, and institutional learning is valued over protecting reputations.
- Governance traditions and institutional memory: Shared practices, values, and expectations that preserve organisational identity and guide decision-making long after individual leaders have departed.

The final capability is often the most neglected and the most difficult to restore once it has been lost. Governance traditions constitute an institution's memory. They preserve the habits, values, and behaviours that enable good governance to endure across generations of leadership. They ensure that difficult questions continue to be asked, that uncomfortable truths are protected rather than punished, and that long-term stewardship is valued above short-term convenience.

Ultimately, the true test of institutional resilience is succession. If performance deteriorates every time capable leaders leave, the institution has accumulated dependency rather than resilience. Sustainable governance exists when leadership can change without institutional purpose, integrity, or capability changing with it.

Dr Kabane's reflections point to a profound lesson: institutions rarely fail because they run out of money. They fail because they lose the governance traditions that once made sound decision-making routine. Rebuilding budgets may take a financial year. Rebuilding institutional character can take a generation.

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STEWARDSHIP AS GOVERNANCE DISCIPLINE

STEWARDSHIP AS GOVERNANCE DISCIPLINE

The four disciplines Dr Kabane names — and what they require

Dr Kabane identifies four disciplines that distinguish stewardship from leadership. They are worth examining individually, because each one describes a governance capacity that current institutional design rarely builds deliberately.

1. Strategic Patience

Modern governance is structured to reward short-term results. Political cycles are measured in years. Budget cycles are annual. Electoral mandates create pressure to demonstrate achievement within timeframes that are often incompatible with the timelines of genuine institutional investment.

The Steward operates within those cycles while refusing to be governed by them. They invest in outcomes they may never personally witness — training a specialist cohort, building primary healthcare infrastructure, implementing governance reforms whose benefits will only be visible a decade later.

Strategic patience is not passivity. It is the discipline of acting on long-horizon evidence in the face of short-horizon incentives. In a governance context, it requires an institutional mandate for long-term investment that is protected from electoral and budgetary volatility — what Dr Kabane implicitly describes in his analysis of the NHI as an institutional project rather than a funding mechanism.

2. Institutional Thinking

The Steward's most important contribution is not what they build during their tenure. It is what they leave behind that continues to build after they are gone.

Strong leaders can improve performance for a period. Only strong institutions can sustain performance across generations. The discipline of institutional thinking requires the Steward to systematically ask: am I solving this problem in a way that strengthens the institution's capacity to solve similar problems in the future? Or am I solving it in a way that makes the institution more dependent on me?

The distinction matters enormously. A leader who solves every problem personally produces a coping system. A leader who solves problems by building the systems, culture, and capability to solve them produces a resilient one.

3. Moral Courage

The decisions that define stewardship are rarely the popular ones. They are the decisions that impose short-term cost in exchange for long-term protection — decisions that are necessary precisely because they are inconvenient.

Dr Kabane's account of the regulatory role captures this precisely: the regulator occupies a uniquely lonely position. The Steward does too. They must be willing to say no to politically powerful interests, to absorb the short-term damage of unpopular decisions, and to take positions whose vindication may arrive long after they have left.

This is the governance discipline that Volume 10's Challenger performs at the institutional level. At the individual leadership level, it requires what Dr Kabane names directly: protecting your integrity as fiercely as you protect your expertise.

4. Humility

The Steward's fourth discipline is the most counterintuitive. It is the recognition that the institution does not belong to them.

They are, in Dr Kabane's formulation, temporary custodians of institutions that existed before them and should continue long after they are gone. The role is not to leave monuments. It is to leave the institution capable of serving future generations effectively.

This is where the baobab from Volume 9 finds its human expression. The baobab does not grow tall. It grows wide. It hollows as it matures — not through decay, but through the slow convergence of multiple stems into a shared space. The institution that achieves the continental standard does something analogous: it becomes a container for community capacity rather than a vessel for its own authority.

The Steward is the leader who builds that kind of institution. One that is larger than any individual who has served within it. One whose governance traditions outlast every administration, every budget cycle, and every political transition.

The most important question for any Steward is not, 'What did I achieve during my tenure?' It is: 'Did I leave the institution stronger, more ethical, more capable and more equitable than I found it?'

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THE STEWARDSHIP SCORECARD

Assessing institutional governance across time, not just position

The Bead & Blueprint has a single test: does the tool change how a practitioner thinks, or does it merely look elegant? The Stewardship Scorecard is designed to be used not during a tenure, but before one ends. It asks the questions that most governance frameworks never ask.

The Kgotla Connection

The Kgotla is the traditional community assembly of the Tswana people — a space of deliberation governed by a principle that Rooted has found nowhere better stated than in its traditional formulation: every voice may be heard, but the decision accounts for those who are not yet present.

The Kgotla's most distinctive governance feature is not its inclusivity but its temporal extension. Deliberation in the Kgotla does not account only for the interests of those who have gathered. It accounts for the interests of those who will gather next — for the community of the future that the community of the present is obligated to protect.

The Stewardship Scorecard is built on this logic. The most important question in any governance assessment is not how well the institution is performing today. It is whether the institution today is capable of performing tomorrow, after the people who built it are gone.

The Five Stewardship Questions

STEWARDSHIP QUESTION	WHAT IT IS ACTUALLY ASKING
Is this institution stronger than when this leader arrived?	Not just performing better in the short term — but structurally more capable, more accountable, and more equipped to sustain performance without depending on any single individual.
Can this institution perform if every current leader is replaced tomorrow?	Not a stress test of any individual leader, but of the governance architecture itself. Strong institutions continue. Coping systems collapse.
Are the decisions being made today serving people who are not yet in the room?	The intergenerational test. Does governance extend beyond current beneficiaries to future ones? Does infrastructure investment, workforce planning, and policy design account for the health system of 2045, not only 2026?
Are the people who protect institutional integrity being protected by the institution?	The most important governance failure Dr Kabane identifies: the system failed to protect the people committed to defending it. A Steward creates the institutional conditions under which speaking difficult truths carries safety, not risk.
What governance traditions is this institution building that will outlast its current leaders?	Traditions are institutional memory. The practices, expectations, and cultural norms that persist across administration changes. A coping system loses them when strong individuals leave. A resilient system embeds them.

The Stewardship Scorecard is not designed for annual governance reviews. It is designed for leadership transitions, strategic planning cycles, and institutional self-assessments. It asks the questions that most governance frameworks avoid: not whether the institution is doing well, but whether it is building the capacity to do well after the people who currently lead it are gone.

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• ACT • LISTEN • THINK •

THE DISCIPLINE OF INTERGENERATIONAL GOVERNANCE

THINK	LISTEN	ACT
• Ask: is this institution a coping system or a resilient system? What would happen to performance if every current leader were replaced tomorrow? • Ask: what governance traditions is this institution building? What practices, expectations, and cultural norms will outlast this generation of leaders? • Ask: are the decisions being made today serving the people who are not yet in the room? Who is not yet born who will depend on this institution? • Ask: are the people who protect institutional integrity being protected? Does speaking a difficult truth in this institution carry safety or risk? Ask: will this institution be stronger when I leave than when I arrived? That is the Steward's question.	••The Knowledge Project (Shane Parrish) – Episodes with Simon Sinek on legacy, leadership and long-term thinking. • a16z Podcast – Episodes on systems thinking, institutional resilience and decision-making under uncertainty. • The TED Radio Hour – Future of Leadership and The Long View episodes. • The McKinsey Podcast – Conversations on organisational resilience, leadership transitions and institutional capability. • The Long Now Foundation Podcast – Long-term thinking, civilisation, stewardship and governance across generations. • Donella Meadows – Thinking in Systems lectures and summaries. • Simon Sinek – Leaders Eat Last and The Infinite Game talks. • Margaret Heffernan – Dare to Disagree (TED Talk) on constructive dissent. • Peter Senge – Systems Thinking lectures on learning organisations. • Institute of Directors South Africa (IoDSA) webinars on governance and ethical leadership.	• Apply the Stewardship Scorecard to your institution: five questions, answered honestly, before the next leadership transition • Identify one governance tradition your institution has built that would survive if every current leader left. If you cannot name one, that is the work. • Identify one long-term investment your institution is not making because the return falls outside the current budget or electoral cycle. Name it. Advocate for it. • Identify one person in your institution who consistently protects institutional integrity at personal cost. Protect them. Write down the answer to Dr Kabane's question: did I leave this institution stronger, more ethical, more capable and more equitable than I found it? If you cannot answer yes, you still have work to do.

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WHAT'S ON OUR RADAR

UPCOMING FROM KM NALA ADVISORY

KM Nala 2026 Governance Outlook Launch — Volumes 5–11 presented as the foundational research arc. Volume 12 announced as the synthesis. Register at www.kmnala.co.za.

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ONGOING

BBBEE Paper Consultations
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VOLUME 12 PREVIEW

The Rooted Governance Framework

Four archetypes. One synthesis. A framework for African institutional excellence.

Volume 8 built the Weaver. Volume 9 built the Author. Volume 10 built the Challenger. Volume 11 builds the Steward. Volume 12 brings all four together into the Rooted Governance Framework — the first comprehensive African governance leadership model to emerge from this series.

The Rooted Governance Framework is not a checklist. It is a diagnostic: a way of asking, for any institution, which archetype is present, which is absent, and what the absence costs. Volume 12 will present the framework in full, supported by case studies from across the eleven volumes, and introduce the institutions and leaders that exemplify each archetype in the African governance context.

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CALL FOR CONTRIBUTORS

Got something to say?
CALL FOR CONTRIBUTORS

CONTRIBUTION CALL — VOLUME 12

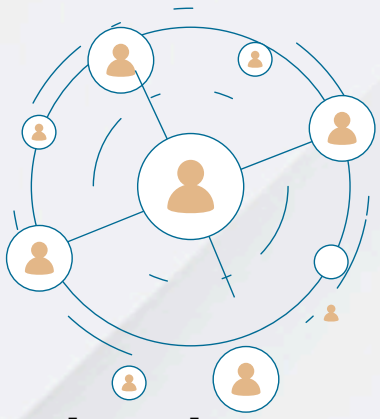
- Essays, case studies, and practitioner reflections on: the economics of institutional trust
- What governance failure actually costs in rand, dollar, and shilling terms
- Institutions that rebuilt trust after losing it

Submission deadline: 20 August 2026
info@kmnala.co.za
Length: 600–800 words | Include a 2-sentence bio

Careers are measured not by the positions we hold,
but by the institutions we strengthen
and the people we prepare to lead after us.

The children in nappies today
will inherit the institutions we build — or fail to build — now.

FINAL NOTES + STAY CONNECTED



“Leadership begins when we choose to act with purpose, not just power.” – KM Nala

How to connect

Let’s keep the conversation going:

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