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Abstract

This chapter explores how skills requirements have shifted over the past ten years in light of the introduction of the District Health System, what skills are now needed for successful, high-quality service delivery at district level, how the drain of skills is impacting on the health system, what progress we have made in ensuring that health workers, planners and managers, feel confident to render such services, and in which areas skills development needs to be strengthened.

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the **skills base** to implement the district health system

Introduction

> *"We need massively to improve the management, organisational, technical and other capacities of government so that it meets its objectives."*[1]

This statement by President Mbeki during his 2005 State of the Nation address points to the centrality which government assigns to skills and capacity. The President further announced that "by May, the Forum of SA Directors-General will submit to Cabinet a thorough review of the functioning of the government system as a whole, and make proposals particularly on the capacity of the implementing agents, skills and competence within the public service, alignment of planning and implementation, and issues pertaining to the mobilisation of the public service to speed up social transformation".

It is not surprising that ten years into our democracy the skills challenge is identified as a fundamental one. The last ten years have seen a dramatic restructuring of health services with the adoption of the District Health System (DHS) as a vehicle for delivery of the health care services. Comprehensiveness and integration, availability, affordability and access are guiding principles which characterise the objectives of the new health care system. The country's disease burden has changed dramatically, primarily due to the impact of the HIV and AIDS epidemic. New programmes have been introduced, such as the Integrated Nutrition Programme (INP). All of these have had far reaching implications for human resources and the skills required to render quality care. A new set of skills requirements.

When the DHS was introduced after 1994, an entirely new layer of health managers and professionals was introduced into the South African health system. The DHS requires mid-level management who oversee the implementation of district health services: district and sub-district managers and their teams, programme and facility managers. Commonly these mid-level managers are recruited from the various health care disciplines including nurses, doctors and environmental health officers. Yet, in their new positions they are required to design, plan and implement programmes, develop and manage budgets, analyse and utilise information and monitor outcomes.[2] This is an entirely new set of skills for which few staff was appropriately prepared.

In addition to management skills, there is also a need to develop skills required to implement new programmes such INP and the Integrated Management of Childhood Illnesses (IMCI). Specific new range of skills required include technical and public health skills.

Furthermore, the country's changing disease burden, including growing numbers suffering from diseases of lifestyle and, most prominently, the impact of the HIV and AIDS epidemic, demand a wide range of new skills from frontline providers, planners and managers. "In a short space of time, health workers and the health system have had to adapt to a completely new disease profile in which all other conditions are crowded by one crushing burden of fatal disease."[3]

Quite early on in the transformation process the government embarked on large-scale skills development and human resource development strategies, which have found expression in a range of legislative and policy documents (e.g., the South African Qualifications Authority (SAQA) Act 1995, the Skills Development Act, 1998 and the Skills Development Levies Act, 1999 and the Human Resource Development Strategy for South Africa) which have impacted on the health sector as a whole. Initiatives directed at enhancing skills within the health sector are discussed below.

Curriculum changes: new directions health personnel education

All strategy and policy documents since the early 1990 made the case for urgently revisiting and revising curricula for the training of health professionals to respond to new skills requirements. There have been moves towards restructuring health professions training. Most innovation has occurred in pockets, rather than in the mainstream. This applies in particular in the continuing education (CE) of health professionals, who have needed to acquire new skills fast in order to bring the DHS to implementation.

One such programme was the health management training initiative, which saw a proliferation of health management courses offered by educational institutions and within provinces in the 1990s.[4] Probably most prominent among these was the Department for International Development (DFID) funded Management Education Scheme by Open Learning (MESOL) programme, which, based on materials from the British Open University, trained mid-level health managers across the country in health services management in the late 1990s.

Another prominent programme has been the University of Cape Town's Oliver Tambo Fellowship Programme, an eighteen months post-graduate diploma for senior DoH and institutional managers which is in existence up to today. Similar programmes have been offered by the universities of Natal and the Witwatersrand.

A CE programme geared towards the strengthening of a wide range of public health skills among mid-level managers is the University of Western Cape's Summer and Winter School programme, which has seen about 7 000 participants attend its courses over the past 12 years.

Curriculum transformation in mainstream health professions education has been somewhat slower, although recent years have seen dramatic changes in some institutions. To what extent these new curricula are responsive to skills requirements and priority needs is not yet established. The Collaboration for Health Equity through Education and Research (CHEER) initiative, is presently in the process of assessing to what extent education programmes are responding to skills requirements in rural areas, using a peer review approach.[5] There is considerable agreement among stakeholders, however, that particularly post-graduate health professions education remains largely un-transformed, continuing to focus on the training of medical specialities.[6]

Review of scopes of practice

The Department of Health's Task Team on HRH, chaired by W. Pick[7] identified scopes of practice for the various health professions as one of the defining factors which circumscribe the skills available to health services by determining the range of services that can be provided by health workers practising in the various health care setting. One of the resolutions taken by the Task Team was that the scopes of practice for all health professionals should be revised so as to allow for the provision of services in line with the goals of PHC. Since 2001, progress in revising scopes of practice has been made in some areas.

Within the Nursing Profession, a revision of scopes of practise is presently under way, aimed at aligning the practice of nursing to the changes in the national health policy and the legislative framework and to present practice as it is acknowledged that nurses in different categories presently practice beyond the prescriptions of their scope. For instance, in the Northern Province nurses are being trained to perform circumcisions while in one district in KwaZulu-Natal nurses are trained to remove cataracts. While this is done to address issues of staff shortage most prevalent in rural areas, it also begins to demonstrate the need to define the scope of practice broadly such that it accommodates developing skills and competencies required to respond to changing local needs.

The proposed new scope moves towards providing a broad based scope which will permit all nurses to render services in line with their knowledge, skills and competencies. It also allows all nurses to be directly accountable for their acts and omissions. This will ensure that each category of nurse is enabled to practise independently within their scope.[8] In addition, the new scope of practice will inform the education and training of nurses required for such practice. This will assist in facilitating the development of a framework for a single unitary education pathway for nursing qualifications that is in line with the principles of the National Qualifications Framework. For more details see chapter seven in this Review.

New cadres of health providers

The replenishment of skills, particularly at community and primary care levels, through the introduction of new cadres of health professionals or para-professionals has been a topic of much debate since the early 1990s. In particular the introduction of a range of mid-level workers, the role of community based health workers and their relationship with the national health system have been much discussed. For more details see chapters 11, 12 and 13 in this Review.

Measures to improve retention

Efforts have been made to retain valuable skills in the country through the introduction of community service in most health professions and through the introduction of financial incentives via the rural and scarce skills allowances.

Community service

Despite the introduction of Community Service (CS) in 1998, staffing of the most rural hospitals remains a problem, and hospitals in remote rural areas remain without doctors, due to the fact that Community Service Professionals (CSPs) can, to a certain extent, choose the area of their placement. Reid[9] suggests a renewed look at strategies to attract and retain professionals in rural areas, including targeted recruitment of students from rural areas, and the much increased exposure of students to rural practice during their training.

Although many CSPs described their experience as positive with hindsight, few were willing to change their career plans based on the experience. However, "around 20% of CS doctors would voluntarily consider working in a rural or under-served area in the future, a cohort that could potentially fill the staffing needs of these hospitals, given the right incentives. However, only 13% of pharmacists and 6% of dentists shared these career plans".[9]

Skills gaps, attitudes, supervision and conditions of service have been identified as areas needing improvement.

New graduates "experience a disjuncture between the academic training expectations and the actual conditions in the public service", a disjuncture which is most keenly experienced by dentists.

Supervision has been found lacking particularly in rural areas where CS doctors may find themselves the only doctors in certain facilities. The lack of supervision aggravates the fact that many graduates lack appropriate skills. Not only do they find themselves often not knowing what to do, but also not knowing who to ask for assistance.

Reid found that all groups of CSPs expressed "dissatisfaction at the conditions of service in the public sector, but particularly the pharmacists, many of whom had exposure to the private sector during their internship".

Possibly as a result of the above, between 20 and 45% of CSPs expressed their intention to leave SA and seek work overseas following the completion of CS.

Reid concludes that "the factors that will attract health professionals to practice in under-served areas within SA are the same in principle as those that would encourage them to remain in the country. A thorough recruitment and retention plan is needed by the DoH, in order to prevent the ongoing loss of valuable human resources from the country, and at the same time provide the conditions that will support those who choose to work in circumstances that most prefer to avoid". This retention plan advocated by Reid has to centrally include attention to appropriate skills and careful support of CS professionals.

Rural and scarce skills allowances

In 2003, the DoH introduced two measures to address inequities in the distribution of health personnel, the rural and scarce skills allowances. As Padarath et al.[10] point out, "it has also been contended that the introduction of these allowances will help to curb the alarming number of health professionals opting to work in other countries". It is too early at this stage to reliably gauge the effect of the allowances.

A very preliminary evaluation of 'the impact of the rural allowance (RA) for health workers' in KwaZulu-Natal by Reid[11] indicates that "prior to implementation around a third of health professionals (HPs) working in rural hospitals would be influenced to remain by a RA of at least R50 000 per annum", while "after implementation, the data are incomplete but could suggest that a minority is influenced by the new RA to change their short-term career plans".

One of the problems already identified, however, is that the allowances are not uniformly available to nurses working in rural and under-serviced areas.[10]

Furthermore, while incentives and compulsion may increase the pool of professionals in under-serviced areas, thus in some way resolving a quantitative aspect of capacity availability, they in no way resolve the qualitative aspect of capacity and the availability of appropriate skills of health workers.

Skills gaps

Despite the wide range of capacity developing and strengthening initiatives as outlined above, there is ample evidence that crucial skills in the public service in general and the health sector in particular continue to be lacking.

Lack of technical skills

There is growing evidence that technical / clinical skills are needed in a wide range of new and established areas. This need is most pronounced in the rapidly expanding area of HIV and AIDS prevention, treatment and care where clinical and management skills of frontline health workers are dramatically lacking, yet urgently required and needing massive training inputs and continuous support.[12,13]

The Interim Findings of the National PMTCT Pilot Sites[12] found that training and support for health workers in PMTCT sites was uneven. While "training and human capacity development is critical for the development of adequate staff competencies, morale and motivation", "many staff do not have a strong foundation of knowledge and skills in HIV and PHC". The report highlighted that the Programme engaged in very substantial training efforts, yet did not reach all staff involved in the programme. While skills development in these areas has been considerable in the past years, their conclusion remains true that "the sheer volume of training required at the pilot sites points to a major challenge should provinces expand the programme to new sites".

In facilities beyond the PMTCT sites the availability of knowledge and skills, as well as access to information, appears to be even more uneven. Modiba et al.[14] found that of a sample of 215 providers in PHC facilities in Gauteng more than half had received some training in HIV and AIDS, 40% had been trained in counselling, but only 10% had received training in the clinical aspects of HIV and AIDS and management. The study also found that "provider knowledge of the clinical illness associated with various stages of HIV was generally poor".

A rapid appraisal of primary level health services for HIV+ children at public sector clinics in South Africa[13] found that only 20% of a sample of 383 clinics had heard of the DoH guidelines for Managing HIV in Children, and only 10% reported using them. In the same study, 21% of clinics reported that they were assisting clients with accessing social assistance grants, pointing to further increases in workload not directly linked to clinical load.

The latest PHC facility survey points in the same direction. It found that large numbers of facility personnel were unable to correctly diagnose and manage common HIV related problems.[15] "In Mpumalanga and North West none of the professional nurses could correctly diagnose fungal oesophagitis, while in the North West and in the Western Cape none of the respondents could correctly treat the condition." This is despite the fact that all three provinces had a good coverage of available protocols. This finding seems to indicate a worrying discrepancy between policy and implementation, in particular, of the weakness or absence of mentorship and supportive supervision.

In addition to the training and support of existing staff, in particular the roll-out of ARVs will place a considerable extra burden on the system, requiring large numbers of additional staff. The Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment[16] stipulates that altogether close to 14 000 new staff members will have to be recruited by March 2008, about half of them lay counsellors and a third nurses. For more information read chapters 5 and 16 in this Review.

These staff will not only have to be recruited, but trained, inducted, supported and supervised.

HIV and AIDS however is not the only area where clinical or management skills are lacking. The National STI Initiative, for example, "set up in 1999 to develop 'model' district-based STI control programmes", found that clinical and management skills in STI care in clinics often fell short of standards, "resulting in many clients being incorrectly treated".[17] It was suggested that "training in STI clinical case management is still essential", and that "efforts to ensure that every primary level clinical provider knows and understands the syndromic case management protocols needs to continue".[17]

In another example, a review of the clinical management of severe malnutrition amongst children in rural hospitals found a lack of resources, as well as poor management and the use of outdated, inappropriate treatment practices, resulting in very high case fatality rates.[18] Using a participative action research approach, the team conducted training and developed case management protocols, concluding that, given the necessary training and support, "hospital staff, even in the most under-resourced areas, have the ability to identify and begin to rectify poor practices".

Furthermore, there are indications that poor relations between nurses and clients or, in extreme cases, even client abuse, partly have their roots in a perceived lack of appropriate skills. Jewkes et al.[19] found insecurity about

clinical roles, inadequate training and inadequate support and supervision to be an important contributing factor in occurrences of patient abuse. Lehmann and Zulu[20] reported that nurses reflected self-critically on poor relations with clients due to overwork and inadequate skills.

Influences on management capacity

The latest State of the Public Service Report[21] pointedly found that "our public service does not have enough skilled managerial staff", elaborating that "increased decentralisation and delegation of authority relating to human resource management to lower levels have in many instances overloaded managers."

Two recent studies investigating the impact of decentralisation in the health sector, have argued somewhat differently. One of them, a case study of health human resources in the Eastern Cape,[22] found that, while certain minor HR functions had been devolved to districts, many measures were temporary, as demarcation of districts and devolution remained incomplete. The other one, a study by the Local Government and Health Consortium (LGHC),[23] concluded that "management within the SA health sector remains quite centralised at national / provincial levels". This, the study found, is also the experience of those working within the health system. "People at every level, but particularly front line managers and providers, feel that they work in isolation from others at their own level, and face a top heavy and rigid management hierarchy that imposes multiple and often conflicting demands."

One effect of this perception by managers and providers is a certain degree of 'transformation fatigue'. In research conducted into the implementation of the INP Cape Town,[24] staff complained about management's inability to coordinate communication and activities between different departments and to prepare the ground for policy implementation. Staff voiced frustration with the fact that they bear the brunt of having to implement the new Nutrition Policy, without practical support or acknowledgement. They furthermore feel that policies are often not well thought through or they get abandoned halfway through the implementation process. This eventually leads to general disenchantment with the transformation process.

The same sentiment is well articulated in a quote by a facility manager interviewed by Leon et al.[25] "Because of all the change I am tired of change. Since 1994 these consistent changes. First it was the health policy they changed that, we had to get this primary health care, we are since then still in a changing phase because then it is this programme then it is that programme that's changing."

The LGHC study[23] concludes that so far health system transformation has focused on 'hardware' rather than 'software' issues.

> *"A key casualty of the hardware focus has been the limited attention given to human resource management. Personnel shortages require urgent action. Training more staff or offering financial or other material incentives are seldom enough by themselves to tackle either migration or the problem of poor staff morale. Other software needs include building trusting personal relationships and developing the associated skills of communication, negotiation, and people management (and allowing) room for innovation and creativity.... with local-level problem solving and bottom-up approaches to service delivery."*[23]

This probably contributes to the lack of management capacity in the health sector. Other reasons identified by the State of the Public Service Report, which specifically refers to the health sector:

> *"a) Public service professionals (such as doctors and nurses) are paid markedly less than in the private sector while environmental factors and working conditions are not conducive to the retention of such personnel in the public service. Recruitment, succession and career planning, employment equity, reward and recognition and employee relations are important factors that affect the supply of these vital skills.*
>
> *b) The public service recruits personnel from a variety of fields such as medicine, finance and development disciplines amongst others, in addition to the field of public administration. Despite various links between higher education institutions and governments there is still not enough strategic interaction between government and higher education over the supply of skilled personnel."*

The report emphasises that "building this cadre is a priority".

Slow implementation of 'Batho Pele'

The Human Resource strategy for the Public service, 2002-2006 notes that in addition to making people better at the role that they play in the developmental state, skills development becomes an important vehicle for transforming the less tangible aspects of the public servants – their

attitudes, their commitment and the manner in which they engage with people.

The latest State of the Public Service Report[21] indicates that the Batho Pele policy, introduced in 1997 to ensure a caring, high quality and accessible public service has in some areas only slowly taken root.

The reasons identified for this lack of a service culture range from a lack of understanding of the Batho Pele principles to burnout and skills shortages.

Nhlonipho[26] found that "certain departments are not familiar with Batho Pele principles and thus do very little towards the implementation of these. Senior managers believe that Batho Pele is more relevant to frontline and junior managers as they come in contact with customers more frequently. Junior personnel, on the other hand, argue that they cannot implement Batho Pele on their own, as they need the managers' support to create a conducive environment. This tug of war leaves Batho Pele with no permanent residence in affected departments." Within the health sector, while there are many health workers who work far beyond the call of duty, there are worrying incidents where clients rightfully complain about lack of service and inappropriate treatment. In an investigation into causes of maternal deaths in the Western Cape, Mbombo[27] found that the reasons cited by most participants for not attending antenatal care and for avoiding hospital delivery were associated with adverse poor interpersonal treatment they either experienced or expected.

In research investigating the impact of the HIV and AIDS epidemic had on health workers in Cape Town nurses spoke quite self-critically about their deteriorating relationships with clients:[20]

> *"Like any human being, you get tired, and become aggressive, we are like any human being, faced with dying people that you can not help, it's frustrating, and people say we are rude, that's it."*

Recommendations for developing a capacity building strategy

The need to make skills and capacity development in the public service a key priority has been identified throughout government, as indicated in the President's speech and the State of the Public Service Report.[21] What are the implications of this for the health sector? Where and how is intervention needed to strengthen the capacity and skills of personnel in the health sector? The DoH is presently in the process of discussing the 'Strategic Framework for Human Resources for Health Plan' in preparation of the HRH plan. No doubt, a comprehensive skills development strategy will be central to and shaped by this plan, including the following topics.

Rethinking education programmes

It was mentioned earlier that the development of an appropriate skills profile is directly and inextricably linked with the production (training) and CE of health personnel. While there have been numerous reforms and initiatives to address skills development, a number of agenda items are outstanding, which were highlighted prominently by the Health Sciences Working and Reference Group's submission to the National Commission on Higher Education and the DoHs HRH Task Team as well as the new National Health Act.

Rethinking Academic health complexes towards PHC

The National Health Act in paragraph 51 gives authority to the Minister to establish

"a) academic health complexes (AHCs), which may consist of one or more health establishments at all levels of the national health system, including peripheral facilities, and one or more educational institutions working together to educate and train health care personnel and to conduct research in health services; and

b) any coordinating committees that may be necessary in order to perform such functions as may be prescribed".

AHCs have existed for a long time as joint ventures between tertiary hospitals and medical and dental schools. The new AHCs, though, should incorporate all levels of care, opening new opportunities for rethinking the structure and content of health professions education. With the new legislation,

health sciences faculties, in conjunction with the departments of Health and Education, will now have to apply their minds as to how district hospitals, clinics and community-based settings can be developed as venues for learning in terms of structure, governance, funding and staffing. This presents an exciting opportunity for strengthening the base for skills development for DHS implementation. It could also provide the basis for strengthening the interface between the departments of Health and Education through joint decision making structures, thus improving communication between the planning and production aspects of skills development.[6]

Curriculum reform

Although all health sciences faculties in the country have engaged in substantial curriculum reforms over the years,[28,29] concern continues to be raised with regard to the appropriateness of skills of young graduates.

The re-definition of AHCs may well open up the opportunity to revisit the location, content and learning processes of health professions' education. It may also be worthwhile to revisit the recommendations made by the HRH Task Team, which included the setting up of a curriculum review committee, a comprehensive evaluation of training institutions and the establishment of monitoring processes to assess continuously the appropriateness of educational programmes. Of particular concern would be the preparedness of health professionals to practise in low-resource contexts as well as the restructuring of curricula to provide multiple entry and exit points.

To give just one example provided by the HRH Task team:[7]

> *"When nursing students decide to leave the programme at the end of two years, they would not be penalised as they are now. They would leave as an 'enrolled nurse' and can return to complete the remaining two years. In the last two years, the focus of nursing education would be diagnosis and treatment of life threatening illness. Those completing the four years of training successfully will be registered as professional nurses."*

Developing large-scale continuing education programmes

Continuing education is an enormous challenge. The problem arises that once off training courses, often of short duration, do not suffice to impart the required knowledge and skills or to instil the desired confidence. The challenge is to develop comprehensive capacity development programmes which include:

- initial training;
- regular refresher training;
- on the job mentoring and coaching;
- experimenting with new structures, strategies and practices; and
- systematic and regular supervision.

Such programmes would allow for a guided acquisition of theory and practice as well as reflection of practice and development of new systems and practices.

Revival of 'Batho Pele'

The revival of Batho Pele Principles, as suggested by the President and the State of the Public Service Report is an important strategy. However, to be successful, we should take into account some of the lessons learnt in previous years.[26] Amongst the key elements for a successful re-vitalisation of the Batho Pele strategy Nhlonipho identifies

> *"the institutionalisation of Batho Pele principles at all levels of functioning in organisations", "instilling a culture of life-long learning", and "enabling ordinary people to do extraordinary things and rewarding them."*

Strengthening community-based and mid-level health workers

The introduction of new, mid-level cadres is another strategy to address personnel shortages, particularly in under-served areas. Dovlo[30] reports that "a number of countries have produced locally specific cadres of mid-level workers some of whom take on tasks usually carried out by the main health professions". Also see chapters 11 and 13 in this Review. However, in most cases the numbers supplied are too few to make a substantial difference for health care provision.

Given the urgency and increasing pressures on the health system and its personnel through the brain drain and HIV and AIDS, it seems judicious to support and drive the Ministerial initiative to establish and rapidly expand and strengthen community and mid-level health workers with the South African health system, particularly at community and primary levels. This requires the cooperation of all stakeholders, including, very importantly, professional bodies and the unions.

Strengthening support and supervision

Skills development goes hand in hand with management and support. Good support and supervision will vastly improve work satisfaction and ability to function productively.[18,19,24,31] Similarly good management, leadership and support contribute greatly to well-functioning service delivery, as shown by a number of authors.[18,19,32] Therefore it is recommended that leadership development be given priority on the national and provincial capacity development agenda.

Moreover, careful and regular supervision is increasingly being identified as a factor which impacts positively on the quality of service delivery. Kerry,[33] in his report on the improvement of child health in Thukela District, KwaZulu-Natal stresses the importance of ongoing supervision in supporting and enhancing training efforts. It is urgent that both provincial and local government health departments explore mechanisms to improve supervision of staff working at lower levels of the service and in rural areas. One such mechanism could entail incorporation of such supervisory duties into the contracts of professionals employed in provincial and regional tertiary and secondary level facilities.

Lastly, all evidence points to the fact that good management and leadership can boost staff morale, productivity and ultimately quality of care. A case may therefore be made to visit and revisit the numerous management development initiatives the country has seen since the early 1990s, to assess gaps and to develop or strengthen management and leadership development programmes at all levels of the system. In this assessment attention should particularly be paid to identifying which initiatives have proven most successful. Experience in numerous projects indicates that management development is most successful when it happens in the context of practice, e.g. within a programme or service. An assessment of management development initiatives should take account of these findings and recommendations.

Conclusion

Enormous strides have been made in strengthening the skills base in the past ten years. However, the health sector continues to face a great challenge in having to build the skills required for successful and comprehensive implementation of PHC and DHS.

To cope with the changing and increasing disease burden, staffing and skills mixes have to be revisited and reconfigured. This includes the particular role which can be played by different cadres of mid-level and community-based workers.

Although much effort has gone into skills development over the past years, appropriate training, coupled with support and supervision, remain crucial agenda items. The recognition is growing that skills development demands long-term and holistic approaches and that training requires substantial supportive scaffolding such as mentoring, coaching, and supervision. These supportive issues have not received enough attention in the past.

Limited management capacity is hindering successful policy implementation. It is almost self-evident that the complexity of the challenges posed requires a high quality of managers throughout the system. Although substantial resources have been poured into management training in the past decade, the results appear to have been disappointing. A revision of management development strategies, which looks to other sectors, including the private sector, for inspiration, has to be a priority.

Strengthening the skills base in the health sector will require innovation and creativity, thinking the impossible and making it possible.

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