Ideal Clinic Realisation and Maintenance

Human Resources for Health

Lab Report
November 2014
Executive summary and status of work

- The public primary healthcare system in South Africa is currently ridden by several issues:
  - There is a **personnel shortage of both clinical and non-clinical staff** ranging from 3% to 84% of missing input: there are currently 46,000 vacancies in the human resources nationwide database
  - This shortfall is further accentuated by a **sub optimal distribution of the existing resources**: it is likely that a redistribution of staff will reduce this shortage, allowing for an optimization of the current budget
  - Going forward, the **shortage is only likely to increase** given:
    - a **higher demand** from the requirements of the Ideal Clinic delivery model
    - **low numbers of health** and clinical studies graduates (~1,200 doctors graduate each year)
- The already constrained resources are even more challenged by a **mismatch of the existing capabilities and workload** and a poor management of training schedules
- The above mentioned issues arise in **an environment that fails to incentivize the desired behavior**, which leads to:
  - an overall lack of motivation
  - high attrition rates (35% attrition rate for pharmacists in Gauteng)
Contents

- Context and case for change
- Aspirations
- Issues and root causes
- Solutions and Initiatives
The South African health system covers over 50 million people across 9 provinces and is attended to by over 100,000 nurses and doctors.

- **USD 7.4bn** in government funding in 2014
- ~3,100 public health clinics
- ~64,000 nurses
- ~40,000 doctors

An estimated 80% of doctors and nurses work in the private sector.

**CONTEXT AND CASE FOR CHANGE**

1 Doctors and nurses comprise all those registered with Health Professions Council South Africa and South African Nursing Council. It is estimated that less than half work in the public sector, the remainder are in private practice.

CONTEXT AND CASE FOR CHANGE

21% of clinics have no manager

41% of South African health workers are actively seeking employment elsewhere

47% of clinics had no visits from doctors

79% of clinics have no information management staff

On average, it takes 4.5 months to fill a post in the public service

Nearly 30% of surveyed nurses have engaged in moonlighting

Nurse vacancy rates go as high as 68%

SOURCE: National health facilities baseline audit, 2012; Blaaw, Global Health Action, 2013; Prof. Rispel, Study on nurses moonlighting, 2014; SA institute of race relations 2013; DPSA, Report to parliamentary committee 2010
These issues can be articulated along three main areas of focus

<table>
<thead>
<tr>
<th>1. Supply &amp; demand</th>
<th>Currently, the system faces a current shortage of personnel accentuated by a suboptimal distribution of existing resources</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>This shortage is only likely to increase given:</td>
</tr>
<tr>
<td></td>
<td>– the requirements of the Ideal Clinic service delivery model</td>
</tr>
<tr>
<td></td>
<td>– low numbers of health and clinical studies graduates</td>
</tr>
</tbody>
</table>

| 2. Capabilities & skill set | The already constrained resources are even more challenged by a mismatch of the existing capabilities and the workload |

| 3. Incentives & behavior | The above mentioned issues are amplified by an environment that fails in incentivizing the desired behavior, which leads to: |
|                        |   – an overall lack of motivation                                                                                                   |
|                        |   – high attrition rates                                                                                                                                                      |
|                        | These undermine the system even further, transforming it into a vicious circle                                                       |
Although ~70% of South Africans depend on public health, only 35% of the country’s human resources are public.

**Distribution of patients, health professionals**

<table>
<thead>
<tr>
<th>Percentage of patients, health specialists</th>
<th>Patients</th>
<th>Human Resources for Health</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>30%</td>
<td>70%</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

**… are particularly constrained**

<table>
<thead>
<tr>
<th>Health profession</th>
<th>Private sector</th>
<th>Public sector</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>30</td>
<td>70</td>
<td>100</td>
</tr>
<tr>
<td>Dentists</td>
<td>10</td>
<td>90</td>
<td>100</td>
</tr>
<tr>
<td>Professional nurses</td>
<td>40</td>
<td>60</td>
<td>100</td>
</tr>
<tr>
<td>Enrolled nurses</td>
<td>50</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>10</td>
<td>90</td>
<td>100</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>20</td>
<td>80</td>
<td>100</td>
</tr>
<tr>
<td>Psychologists</td>
<td>5</td>
<td>95</td>
<td>100</td>
</tr>
</tbody>
</table>

SOURCE: SA Health Review 2008, HST
This leads to some critical staff shortages in primary health clinics

### Availability of staff at 3,075 clinics across South Africa

<table>
<thead>
<tr>
<th>Service</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility manager present</td>
<td>79</td>
<td>21</td>
</tr>
<tr>
<td>Visit from doctor</td>
<td>53</td>
<td>47</td>
</tr>
<tr>
<td>Professional nurse present</td>
<td>97</td>
<td>3</td>
</tr>
<tr>
<td>Input from a pharmacist/equivalent</td>
<td>16</td>
<td>84</td>
</tr>
<tr>
<td>Lay counselors present</td>
<td>89</td>
<td>11</td>
</tr>
<tr>
<td>Administration support present</td>
<td>43</td>
<td>57</td>
</tr>
<tr>
<td>Information management staff present</td>
<td>21</td>
<td>79</td>
</tr>
</tbody>
</table>

**Key insights**

- Lack of administrative and information management staff increases nursing staff’s workload
- Presence and effectiveness of facility manager identified as key success criteria for IDCs needs urgent attention
- Shortage of pharmacists also critical

**Source:** National Health Facilities Baseline Audit 2012
The shortages in the system are due both to a lack of professionals … (1/2)

A pilot assessment with the WISN tool was conducted in over 90 facilities to estimate the real requirements in terms of human resources.

### Distribution of pharmacy assistants across 63 primary healthcare clinics assessed with the WISN tool – No. of Pharmacy assistants

<table>
<thead>
<tr>
<th></th>
<th>Staff requirements according to WISN</th>
<th>Existing staff</th>
<th>Real shortfall</th>
<th>Shortfall in understaffed facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of Pharmacy assistants</td>
<td>85</td>
<td>13</td>
<td>72</td>
<td>72</td>
</tr>
</tbody>
</table>

The total demand according to WISN could be underestimated given that it is based on headcount: it does not take into account the unattended patients at the clinic.

The current shortfall in understaffed facilities is equal to the difference between the requirements of the current service delivery model and the existing staff.

SOURCE: WISN assessment – 63 facilities
A pilot assessment with the WISN tool was conducted in over 90 facilities to estimate the real requirements in terms of human resources.

Distribution of Professional nurses\(^1\) across 63 primary healthcare clinics assessed with the WISN tool – No. of Professional nurses

<table>
<thead>
<tr>
<th>Staff requirements according to WISN</th>
<th>Existing staff</th>
<th>Real shortfall</th>
<th>Shortfall in understaffed facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>335</td>
<td>331</td>
<td>4</td>
<td>74</td>
</tr>
</tbody>
</table>

The total demand according to WISN could be underestimated given that it is based on headcount: it does not take into account the unattended patients at the clinic.

The current shortfall in understaffed facilities is over 1,000 times higher than the difference between the requirements of the current service delivery model and the existing staff.

\(^1\) The position “professional nurse” comprises: professional nurses, clinical nurse practitioners, public health nurses, and registered nurses.

SOURCE: WISN assessment – 63 facilities
## Distribution and requirements of staff across 63 primary healthcare facilities (1/3)

### CONTEXT AND CASE FOR CHANGE

<table>
<thead>
<tr>
<th>Cadres</th>
<th>Staff requirements according to WISN¹</th>
<th>Existing staff</th>
<th>Real shortage²</th>
<th>Shortage in understaffed facilities</th>
<th>Need for personnel³</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operational Manager⁴</td>
<td>64</td>
<td>35</td>
<td>28</td>
<td>28</td>
<td>100%</td>
</tr>
<tr>
<td>Health Promoter</td>
<td>16</td>
<td>13</td>
<td>3</td>
<td>7</td>
<td>43%</td>
</tr>
<tr>
<td>Medical Officer</td>
<td>19</td>
<td>10</td>
<td>9</td>
<td>13</td>
<td>69%</td>
</tr>
<tr>
<td>Enrolled Nurse</td>
<td>359</td>
<td>82</td>
<td>277</td>
<td>350</td>
<td>79%</td>
</tr>
<tr>
<td>Cleaner</td>
<td>137</td>
<td>59</td>
<td>78</td>
<td>82</td>
<td>95%</td>
</tr>
</tbody>
</table>

1 Personnel required according to the current delivery model of service packages as estimated per the WISN tool
2 Shortage calculated as staff requirements according to WISN minus existing staff
3 Real shortage/shortage in understaffed facilities
4 Working hypothesis of one operational manager per clinic – to be revised

**SOURCE:** WISN assessment of 71 primary healthcare clinics
# CONTEXT AND CASE FOR CHANGE

## Distribution and requirements of staff across 63 primary healthcare facilities (1/3)

<table>
<thead>
<tr>
<th>Cadres</th>
<th>Staff requirements according to WISN¹</th>
<th>Existing staff</th>
<th>Real shortage²</th>
<th>Shortage in understaffed facilities</th>
<th>Need for personnel³</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lay counselor</td>
<td>63</td>
<td>41</td>
<td>22</td>
<td>48</td>
<td>46%</td>
</tr>
<tr>
<td>Admin Clerk</td>
<td>101</td>
<td>44</td>
<td>57</td>
<td>92</td>
<td>62%</td>
</tr>
<tr>
<td>Data capturer</td>
<td>106</td>
<td>19</td>
<td>87</td>
<td>101</td>
<td>86%</td>
</tr>
<tr>
<td>Groundsman</td>
<td>70</td>
<td>27</td>
<td>43</td>
<td>56</td>
<td>76%</td>
</tr>
</tbody>
</table>

¹ Personnel required according to the current delivery model of service packages as estimated per the WISN tool
² Shortage calculated as staff requirements according to WISN minus existing staff
³ Real shortage/shortage in understaffed facilities

SOURCE: WISN assessment of 71 primary healthcare clinics
In order to extrapolate the results from the pilot WISN assessment to the 3,507 primary healthcare clinics nationwide and size the gap between supply and demand, the following methodology was used:

<table>
<thead>
<tr>
<th>What we did</th>
<th>What we did not do</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td>□</td>
</tr>
<tr>
<td>Identify workload per facility (2012 data for 3,093 facilities)</td>
<td>△ Conduct a WISN assessment of all 3,507 facilities</td>
</tr>
<tr>
<td>✓</td>
<td>□</td>
</tr>
<tr>
<td>Determine the facility requirements for clinic, per cadre, according to the norm, for 11 cadres</td>
<td>△ Estimate burden of disease per clinic</td>
</tr>
<tr>
<td>✓</td>
<td>□</td>
</tr>
<tr>
<td>Estimate total system’s requirements for 3,093 clinics and prorate for 3,507 clinics</td>
<td>△ Verify the existing staff with all 3,507 facilities</td>
</tr>
<tr>
<td>✓</td>
<td>□</td>
</tr>
<tr>
<td>Determine the estimated lack of staff (based on statistics on shortages from the 2012 baseline)</td>
<td>△ Assess the amount of existing staff based on PERSAL</td>
</tr>
<tr>
<td>✓</td>
<td>□</td>
</tr>
<tr>
<td>Determine the “real shortage” of staff (total demand minus existing staff)</td>
<td></td>
</tr>
</tbody>
</table>
To meet current demands and achieve Ideal Clinic status for the 3,507 primary healthcare facilities, additional human resources are necessary.

<table>
<thead>
<tr>
<th>Cadres</th>
<th>PHC needs¹</th>
<th>Lack of staff²</th>
<th>Gap to current delivery model³ (⁺/- 20% range)</th>
<th>Gap to ideal clinic delivery model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operational Managers</td>
<td>3,400</td>
<td>21%</td>
<td>550 - 850</td>
<td></td>
</tr>
<tr>
<td>Medical Officer</td>
<td>1,700</td>
<td>47%</td>
<td>650 - 960</td>
<td></td>
</tr>
<tr>
<td>Professional Nurses</td>
<td>17,200</td>
<td>3%</td>
<td>400 - 600</td>
<td></td>
</tr>
<tr>
<td>Pharmacist’s Assistant</td>
<td>6,800</td>
<td>84%</td>
<td>4,500 – 6,800</td>
<td></td>
</tr>
<tr>
<td>Lay Counsellors</td>
<td>6,800</td>
<td>11%</td>
<td>600 - 900</td>
<td></td>
</tr>
<tr>
<td>Data Capturer</td>
<td>10,350</td>
<td>79%</td>
<td>6,500 – 9,800</td>
<td></td>
</tr>
<tr>
<td>Administrative Clerk</td>
<td>10,350</td>
<td>57%</td>
<td>4,700 – 7,000</td>
<td></td>
</tr>
</tbody>
</table>

1 Nationwide PHC needs for cadres with defined WISN ratios extrapolated on the basis of available information on headcount and opening hours for 3,093 facilities; 2 Lack of staff based on National Baseline Audit, assumed homogeneous throughout clinics; 3 Gap to current delivery model according to lack of staff and estimated PHC needs (+/- 20% range)

**PLEASE NOTE**
- This information is based on existing data, the quality of which is sub optimal and could be enhanced.
- The Human Resources for Health workstream strongly advises to perform, and fast-track, a nationwide WISN assessment to have an accurate depiction of the system’s needs.

**SOURCE:** WISN norms, Headcount/Opening hours of 3,093 facilities (2012), National Health Facilities Baseline Audit (2012)
Despite increases across provinces, medical doctors remain scarcer in rural provinces.

The shortage is especially important along the rural urban divide:

- Although numbers have been increasing across provinces, medical doctors are still more scarce in rural provinces than in urban provinces.
- This could mirror difficulties in retaining staff deployed to those areas.

**Medical doctors by province in public system 2008 - 2012**

**Doctors per 100,000 people**

**Source:** RUDASA
CONTEXT AND CASE FOR CHANGE

Managers lack the numerical competencies necessary for an effective administration of facilities

<table>
<thead>
<tr>
<th>Right and wrong answers from managers in calculation exercises</th>
<th>Percentage of total sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunization coverage</td>
<td>247</td>
</tr>
<tr>
<td>Clinic patient load</td>
<td>385</td>
</tr>
<tr>
<td>Annualized PHC utilization rate</td>
<td>121</td>
</tr>
<tr>
<td>Percentage and proportion</td>
<td>188</td>
</tr>
<tr>
<td>Interpretation of line graph</td>
<td>171</td>
</tr>
<tr>
<td>Interpretation of multiple bar graph</td>
<td>145</td>
</tr>
<tr>
<td>Interpretation of incomplete graph</td>
<td>155</td>
</tr>
<tr>
<td>Right answer</td>
<td>47</td>
</tr>
<tr>
<td>Wrong answer</td>
<td>18</td>
</tr>
<tr>
<td>Right answer</td>
<td>74</td>
</tr>
<tr>
<td>Wrong answer</td>
<td>60</td>
</tr>
<tr>
<td>Right answer</td>
<td>64</td>
</tr>
<tr>
<td>Wrong answer</td>
<td>69</td>
</tr>
<tr>
<td>Right answer</td>
<td>67</td>
</tr>
</tbody>
</table>

On average, less than half of the managers were able to calculate ratios and interpret graphs that would empower them for better administration of the facilities

SOURCE: HST - HSR Unit and Change Management Group
CONTECT AND CASE FOR CHANGE

Staff shortages appear to be a drain on both the facility managers and other staff members

“We’re very short staffed. Our cleaner is on leave so the municipality sent people but I have no control over them”

“I tell my nurses to hang in there…They’re overworked because we’re so short staffed”

“Two of my nurses are currently off on training so it puts a strain on the rest of the team”

SOURCE: Interviews at the facilities, Lean operations diagnostic, team analysis
# CONTEXT AND CASE FOR CHANGE

These challenges were made apparent by the reality on the ground. Insights and quotes from clinic visits.

<table>
<thead>
<tr>
<th>Description</th>
<th>Implications (problem)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinics can be over or understaffed</strong></td>
<td>▪ Staffing is not matched up to workload/demand</td>
</tr>
<tr>
<td>▪ Staffing is more or less the same yet the workload is different (i.e., one clinic sees twice as many patients)</td>
<td>“We need more nurses”</td>
</tr>
<tr>
<td><strong>Communication structures are inefficient</strong></td>
<td>▪ Clinic managers cannot optimize decisions due to missing information</td>
</tr>
<tr>
<td>▪ There is no clear communication line between clinic managers and central level</td>
<td>▪ There are no feedback mechanism on quality of information (and thus no way to improve information)</td>
</tr>
<tr>
<td>“Ask us how to run the clinic instead of imposing”</td>
<td>▪ Work conditions are not the same amongst workers performing the same tasks</td>
</tr>
<tr>
<td><strong>System fragmentation hinders best management practices</strong></td>
<td>▪ Clinic managers do not have full control of staff which undermines leadership</td>
</tr>
<tr>
<td>▪ The nurses can be employed by either the municipality or the province but report to a municipality employed clinic manger</td>
<td>▪ There are inconsistencies in policy application and operations (PMDS, discipline, etc.)</td>
</tr>
<tr>
<td>▪ Provincialization of municipal clinics has not been completed</td>
<td>▪ There is lack of proper HR planning and budgeting.</td>
</tr>
<tr>
<td>▪ Absence of an approved organogram</td>
<td></td>
</tr>
</tbody>
</table>

“I do not know” (answer given by staff member when asked about the clinic’s organogram)
**CONTEXT AND CASE FOR CHANGE**

**These challenges were made apparent by the reality on the ground**

Insights and quotes from clinic visits

<table>
<thead>
<tr>
<th>Description</th>
<th>Implications (problem)</th>
</tr>
</thead>
</table>
| **Skill mix is not always optimal**                                      | • Absence of pharmacist assistant  
• Pharmaceutical services are performed by clinic managers                   |
| **Trainings are not need-driven**                                       | • Professional nurses are overloaded with pharmaceutical services hindering service delivery |
| • Formal training is arranged by the central office                     | • Training requirements are not addressed as per institutional need.                   |
| **Continuity of external contracts is not ensured**                   | • Clinics rely on contract workers for support services (e.g. for security personnel) |
| • Continuity of the services beyond the contract periods is uncertain which may compromise service delivery due to an increase in workload |
| • Safety of staff and clients at risk when security personnel not resourced |
With patients being redirected from public hospitals into clinics to move towards a culture of prevention...

As demand is being redirected from hospitals into the primary healthcare facilities, the public sector’s resources will be further and further stressed.

SOURCE: StatsSA general Household Survey 2013 – Health
...and the implementation of the Ideal Clinic model of services delivery, it becomes critical to optimize the management of human resources in the primary healthcare system.

### Human resources requirements: current delivery model versus Ideal Clinic delivery model

<table>
<thead>
<tr>
<th>Nb. of health workers</th>
<th>Current service delivery model</th>
<th>Ideal clinic service delivery model</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- The model of service delivery designed for the Ideal Clinic realization and maintenance will drive the existing demand up.
- This means that the number of posts to be filled will increase between 2014 and 2018.
Contents

- Context and case for change
  - Aspirations
    - Issues and root causes
    - Solutions and Initiatives
ASPIRATIONS

The Human Resources for Health workstream aspires to optimize human resources in the primary health care...

ØPHC  PHC

Secondary & tertiary care

NDoH

Provinces

District

Sub-District

District Clinical Specialist Teams

“CHCs”

CHCs

“PHCs”

Clinics

WBOTS

Facility based services

Community based services

Governance structures

Service delivery structures

Communication lines

Scope of the HRHWS
... by focusing its efforts around the three main areas identified

<table>
<thead>
<tr>
<th>Aspiration</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Supply &amp; demand</strong></td>
<td>• Nb. of facilities at norm</td>
</tr>
<tr>
<td>▪ Matching supply of health professionals to demand</td>
<td>— 100% by 2018/2019</td>
</tr>
<tr>
<td>▪ Balancing existing resources in the service delivery platform</td>
<td>• Coordination of all partner efforts by 2018/2019</td>
</tr>
<tr>
<td>▪ Increasing productivity</td>
<td></td>
</tr>
<tr>
<td>▪ Coordinating partner efforts through the NHI</td>
<td></td>
</tr>
<tr>
<td><strong>Capabilities &amp; skill set</strong></td>
<td>• Nb. of properly skilled workers</td>
</tr>
<tr>
<td>▪ Ensuring that all workers have the skills to effectively deliver required services</td>
<td>— 100% by 2018/2019</td>
</tr>
<tr>
<td><strong>Incentives &amp; behavior</strong></td>
<td>• Increase staff satisfaction</td>
</tr>
<tr>
<td>▪ Transforming the public Primary Healthcare System into the employer of choice</td>
<td>• Increase retention rates</td>
</tr>
<tr>
<td></td>
<td>• Attract new employees</td>
</tr>
<tr>
<td></td>
<td>• Improve patient experience</td>
</tr>
</tbody>
</table>
To ensure that no patient goes home unattended we can pull several levers

- By pulling all the possible levers, the potential shortfall narrows
...and drive our health workers to perform at their best

- By taking a system wide approach to implement change management we will be able to sustain improved performance over time.

- Role-modeling: “I see superiors, peers and subordinates behaving in the new way”
- Fostering understanding and conviction: “I know what is expected of me – I agree with it, and it is meaningful”
- Developing talent and skills: “I have the skills and competencies to behave in the new way”
- Reinforcing with formal mechanisms: “The structures, processes and systems reinforce the change in behavior I am being asked to make”

ASPIRATIONS
The Human Resources for Health workstream will ensure that...

- No patient goes home unattended due to a lack of staff
- No employee feels that going the extra mile is not worthwhile
- No post will remain vacant due to inefficient recruitment processes
- No clinical professional is overburdened with administrative tasks
- All workers are engaged and ready to perform at their best
Contents

- Context and case for change
- Aspirations
  - **Issues and root causes**
    - Supply & Demand
    - Capabilities & skill sets
    - Behaviour & incentives
- Solutions and Initiatives
### ISSUES AND ROOT CAUSES

**The primary healthcare system is crippled by specific HR issues**

<table>
<thead>
<tr>
<th>Supply &amp; demand</th>
<th>Issues</th>
<th>Root causes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>We do not have enough people</td>
<td>▪ There are currently ~46,000 vacancies in the primary healthcare system</td>
</tr>
<tr>
<td></td>
<td>We are not distributing them optimally</td>
<td>▪ We are not being efficient</td>
</tr>
<tr>
<td></td>
<td>▪ ~80% of the facilities are either understaffed or overstuffed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>We are not preparing for the future</td>
<td>▪ Top down HR planning does not make the most of frontline input: managers are not empowered as decision makers in the system</td>
</tr>
<tr>
<td></td>
<td>▪ There is a mismatch between the health profession students and the growth of the demand for clinical services</td>
<td>▪ We are not coordinating our efforts as the information flows from clinic to district, but not the other way around</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Capabilities &amp; skill set</th>
<th>Issues</th>
<th>Root causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are not training on the right topics at the right time</td>
<td>▪ Health workers are fleeing rural areas</td>
<td></td>
</tr>
<tr>
<td>▪ Facility managers are performing poorly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Orientation and induction are not systematically provided</td>
<td>▪ Health professionals are not prepared to face rural conditions or leadership roles</td>
<td></td>
</tr>
<tr>
<td>▪ Trainings are not optimally scheduled</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Incentives &amp; behavior</th>
<th>Issues</th>
<th>Root causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are not walking the talk</td>
<td>▪ Professional etiquette (uniforms, politeness, etc.) is not observed</td>
<td></td>
</tr>
<tr>
<td>▪ Workers do not always benefit from Employee Wellness Packages</td>
<td>▪ Management is stalling important policy approval due to inefficient processes</td>
<td></td>
</tr>
<tr>
<td>We are not promoting the desired behavior</td>
<td>▪ 41% of health workers are actively seeking employment elsewhere</td>
<td></td>
</tr>
<tr>
<td>▪ Nearly 30% of nurses have engaged in moonlighting</td>
<td>▪ Moreover, it is perceived as irrelevant and is not role modeled across the organization: we are not enhancing the sense of responsibility or belonging</td>
<td></td>
</tr>
<tr>
<td>▪ PMDS are poorly implemented</td>
<td>▪ There are no consequences for non-compliance with professional etiquette or other undesired behavior</td>
<td></td>
</tr>
</tbody>
</table>
Contents

- Context and case for change
- Aspirations
- Issues and root causes
  - Supply & Demand
    - Capabilities & skill sets
    - Behaviour & incentives
- Solutions and Initiatives
The inequitable distribution of personnel translates into high variability in productivity levels across clinics.

### ISSUES AND ROOT CAUSES - SUPPLY AND DEMAND

The inequitable distribution of personnel translates into high variability in productivity levels across clinics.

#### Average consultation

<table>
<thead>
<tr>
<th>Doctors</th>
<th>Clinic A</th>
<th>Clinic B</th>
<th>Clinic C</th>
<th>Clinic D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minutes</td>
<td>12</td>
<td>10</td>
<td>9</td>
<td>12</td>
</tr>
</tbody>
</table>

#### Average patients seen PD

<table>
<thead>
<tr>
<th>Doctors</th>
<th>Clinic A</th>
<th>Clinic B</th>
<th>Clinic C</th>
<th>Clinic D</th>
</tr>
</thead>
<tbody>
<tr>
<td># of patients</td>
<td>30</td>
<td>38</td>
<td>40</td>
<td>30</td>
</tr>
</tbody>
</table>

#### Insights

- Poor capacity planning has resulted in inconsistent productivity
- Patients in overburdened clinics have below average face time with doctors and nurses
- Quality of care may be compromised by overstretching practitioners capacity

---

1 Based on OPE

SOURCE: Gauteng Health QA, team analysis, Lean Operations diagnostic
ISSUES AND ROOT CAUSES - SUPPLY AND DEMAND

For example, the shortage of pharmacy assistants translates into high variability of workload across clinics

<table>
<thead>
<tr>
<th>Clinic</th>
<th># of Pharmacy assistants FTE’s</th>
<th>Average consultation Minutes</th>
<th>Total patients seen Number of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic A</td>
<td>1</td>
<td>3</td>
<td>120</td>
</tr>
<tr>
<td>Clinic B</td>
<td>1</td>
<td>10</td>
<td>36</td>
</tr>
<tr>
<td>Clinic C</td>
<td>1</td>
<td>3</td>
<td>120</td>
</tr>
<tr>
<td>Clinic D</td>
<td>3</td>
<td>5</td>
<td>72</td>
</tr>
</tbody>
</table>

Insights

- According to the 2012 baseline audit, only 16% of clinics had input from a pharmacist
  - Pharmacists at Clinics B and D appear to be under-utilized
  - Pharmacists in Clinics A and C are seeing >35 patients per day above the average

1 Excludes General Workers deployed to Pharmacy

SOURCE: Gauteng Health QA, Diagnostic on lean operations, team analysis
ISSUES AND ROOT CAUSES - SUPPLY AND DEMAND

Recruitment processes are slow and inefficient

Identify the need to fill a post and prepare the request
Identify funds for advertising and filling of the posts
Identify the approval and availability of posts in the st
If there are no posts approved, request for the creation
Receive the request and compile a submission to be approv
Forward the approved document to Line/Programme Managers
Identify shotlisting and interview panel members and conf
Prepare a submission for approval to advertise the post,
Receive the approval, prepare the advert and place an adv
Receive and register application forms
Profile application forms
Shortlisting
Interview identified candidates through the utilisation o
Screening of the recommended candidates
Prepare submission for approval of the appointment of the
Prepare appointment letters for successful candidates and
Inform successful and unsuccessful candidates interviewed
Receive response from the appointed candidate and Inform
Prepare logistics such as office, office furniture and eq
The appointed candidate assume duty on the agreed date an
Line/Programme Manager receive the candidate and orientat

Total

It could take close to 4.5 months for a worker to be at the clinic

SOURCE: Lab analysis, questionnaire
Efforts from partners are not always best coordinated

Currently the efforts from group of developmental partners, the NDoH and Provinces and Districts are not optimally coordinated, which might lead to a duplication of efforts.

Coordinating the efforts of all parties involved in the provision of primary healthcare services in South Africa, would render the delivery of services more efficient and cost-effective.

SOURCE: Lab analysis
Contents

- Context and case for change
- Aspirations
- **Issues and root causes**
  - Supply & Demand
  - **Capabilities & skill sets**
  - Behaviour & incentives
- Solutions and Initiatives
ISSUES AND ROOT CAUSES – CAPABILITIES & SKILL SETS

Training is not provided systematically...

<table>
<thead>
<tr>
<th>Province 1</th>
<th>Province 2</th>
<th>Province 3</th>
<th>Province 4</th>
<th>Province 5</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>60%</td>
<td>57%</td>
<td>46%</td>
<td>42%</td>
<td>35%</td>
<td>32%</td>
</tr>
<tr>
<td>43%</td>
<td>44%</td>
<td>25%</td>
<td>32%</td>
<td>27%</td>
<td>24%</td>
</tr>
<tr>
<td>11%</td>
<td>7%</td>
<td>6%</td>
<td>12%</td>
<td>11%</td>
<td>15%</td>
</tr>
<tr>
<td>4%</td>
<td>12%</td>
<td>4%</td>
<td>2%</td>
<td>6%</td>
<td>1%</td>
</tr>
<tr>
<td>2%</td>
<td>2%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>4%</td>
</tr>
<tr>
<td>2%</td>
<td>0%</td>
<td>1%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>4%</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>2%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Nearly half of the managers interviewed had not attended a training session in the past five years

SOURCE: HST - HSR Unit and Change Management Group
ISSUES AND ROOT CAUSES – CAPABILITIES & SKILL SETS

... and when it does if actually affects the good functioning of the facility: the lack of frontline input from management prevents a smooth and effective training process

<table>
<thead>
<tr>
<th>Staff log in Clinic C</th>
</tr>
</thead>
</table>

- **Three of ten nurses** were off-site on training or campaigns for week in question
- **Majority of training conducted at district level** – limited scope for training to be moved to lower peak times of the day

SOURCE: Clinic staff logs, interviews, Lean Operations diagnostic
Contents

- Context and case for change
- Aspirations
- **Issues and root causes**
  - Supply & Demand
  - Capabilities & skill sets
  - **Behaviour & incentives**
- Solutions and Initiatives
In addition to the personnel shortages, the existing staff does not benefit from a working environment conducting to the best outcomes.

**Sources of frustration related to HR issues**

- **Lack of communication and role modeling**
  - Clinic staff becomes ‘frustrated’ and ‘confused’, feels lack of ownership over new processes: “like if I came to your house and re-arranged your furniture”
  - Clinic staff unsure if executing on changes correctly

- **Burden of non-medical work**
  - Medical staff becomes demoralized (particularly when forced to do jobs like cleaning), feels this takes them away from patient care

- **Lack of tangible benefit for doing well**
  - Little evidence of reward for “going the extra mile” leaves nurses demoralized and disincentivized

**Impact on medical staff**

- Clinic staff becomes ‘frustrated’ and ‘confused’, feels lack of ownership over new processes: “like if I came to your house and re-arranged your furniture”
- Clinic staff unsure if executing on changes correctly
- Medical staff becomes demoralized (particularly when forced to do jobs like cleaning), feels this takes them away from patient care
- Little evidence of reward for “going the extra mile” leaves nurses demoralized and disincentivized

**Root causes**

- Lack of ‘change story’ from NDoH
- Lack of buy-in from clinic managers
- Disconnect between provincial and national support systems
- No feedback or validation from those issuing changes
- Vacancies in administrative roles
- Poor accountability in areas like reception
- Poor management skills amongst administrative team leaders
- Lack of evidence based KPIs (not tracked at individual level)
- Inconsistent PDMS scores, which are highly subjective
- Sporadic bonus payouts

**Source of risk when nurses practice beyond limit of their licenses (e.g., acting for pharmacist)**

SOURCE: Client focus groups, team analysis, Lean Operations diagnostic
ISSUES AND ROOT CAUSES – BEHAVIOUR AND INCENTIVES

The primary healthcare public system suffers from high attrition rates, especially in rural areas.

Despite a difference in attrition rates throughout the provinces, the incentive package is homogenous nationwide.

SOURCE: TBD
The performance management and development system is not rigorously implemented

The uniformly high (versus bell-shaped) scores of a facility reveal that the PMDS is not being rigorously implemented

Sample of scores for medical staff within one facility
Score out of 100

- Medical Officer: Not done on a regular basis
- Nurse practitioner 1: 78
- Nurse practitioner 2: 78
- Nurse practitioner 3: 76
- Nurse practitioner 4: 75
- Nurse practitioner 5: 75
- Nurse practitioner 6: 75
- Nurse practitioner 7: 73
- Nurse practitioner 8: 73
- Nurse practitioner 9: 72
- Nursing assistant: 76
- Professional Nurse 1: 78
- Professional Nurse 2: 72
- Professional Nurse 3: 60
- Professional Nurse 4: Scores not available
- Professional Nurse 5: Scores not available

Discrepancy between impressions of clinic managers and medical staff:

Clinic manager: “There is a benefit to high performers. Nurses with high PDMS scores get promoted”
Nurses: “Your evaluation isn’t linked to promotion. It’s not fact based, it depends on who is doing it – it’s hard to prove that you gone the extra mile and move from a three to a four”

Doctors are not evaluated regularly and there is little tangible incentive to perform well:

Doctor: “No one does [performance management] for me – the professor never comes here… I do the best I can for patients, there is no bonus”

KPIs aren’t always under influence of nurses:

Nurse: “If you’re on TB [rotation], what you do now will only show in a year; you can’t show progress when you’re evaluated”

SOURCE: PDMS data from Gauteng Health QA, nurse focus groups, team analysis, Lean Operations diagnostic
Contents

▪ Context and case for change
▪ Aspirations
▪ Issues and root causes
▪ Solutions and Initiatives
  ▪ Initiative overview and prioritization
    ▪ Initiative details
    ▪ Budget of prioritized initiatives
    ▪ 1,000 feet plans
To ensure that no patient goes home unattended, and that our health workers are at their best, the workstream developed 14 initiatives which were prioritized into 3 categories:

**Breakthroughs “Must win”**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Ensure optimal redistribution of employees from overstaffed to understaffed facilities</td>
</tr>
<tr>
<td>2</td>
<td>Streamline recruitment process (no more than 3 months)</td>
</tr>
<tr>
<td>3</td>
<td>Contract GPs and other skills from the private sector</td>
</tr>
<tr>
<td>4</td>
<td>Identify and protect (ring-fence) funding for non-negotiable cadres</td>
</tr>
</tbody>
</table>

**Major delivery fixes “Effective execution”**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Ensure equitable implementation of community service policy to support under-resourced areas</td>
</tr>
<tr>
<td>6</td>
<td>#BringBackOurProfessionals: A campaign aimed at getting back into the primary health care system specific employees:</td>
</tr>
<tr>
<td></td>
<td>- South African health professionals working overseas</td>
</tr>
<tr>
<td></td>
<td>- Retired clinical employees</td>
</tr>
<tr>
<td>7</td>
<td>Empower facility managers through training and decentralization</td>
</tr>
<tr>
<td>8</td>
<td>Task shifting and task sharing</td>
</tr>
<tr>
<td>9</td>
<td>Upskilling of non-clinical staff: Provide basic emergency triage and customer focus training to all non-clinical employees</td>
</tr>
</tbody>
</table>

**“Business as usual”**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Get more health students in school and in the NDoH and expand state to state agreements to increase education capacity and recruit foreign professionals</td>
</tr>
<tr>
<td>11</td>
<td>#Walk the talk: campaign to secure adherence to the change management framework</td>
</tr>
<tr>
<td>12</td>
<td>The Health Academy: an institutional link between the NDoH and the DoE</td>
</tr>
<tr>
<td>13</td>
<td>Improve the Performance Management Systems</td>
</tr>
<tr>
<td>14</td>
<td>Ensure implementation of Employee Wellness Programs</td>
</tr>
</tbody>
</table>

SOURCE: Lab analysis
The workstream developed three feet implementation plans to drive breakthrough and major delivery fixes initiatives.

INITIATIVES OVERVIEW

- **Redistribute staff**
- **Contract clinical staff from private sector**
- **Lean and effective recruitment processes**
- **Ring fence funds to staff critical posts**
- **#BringBack Our Professionals**
- **Upskill non clinical staff**
- **Task shifting and sharing**
- **More effective community service policy**
- **Decentralise to facility managers**
- **Optimize staff distribution**
- **Increase productivity**
- **Leverage and coordinate PPP**
- **Retain more graduates**
- **Attract new employees**

- **Total demand**
- **Existing staff**
- **Potential shortfall**
- **Optimize staff distribution**
- **Increase productivity**
- **Leverage and coordinate PPP**
- **Retain more graduates**
- **Attract new employees**
- **Real shortfall**

Long term initiatives will increase the number of health professionals trained.
Contents

- Context and case for change
- Aspirations
- Issues and root causes

**Solutions and Initiatives**
- Initiative overview and prioritization
- **Initiative details**
  - **Breakthrough initiatives**
    - Major delivery fixes
    - Business as usual
  - Budget of prioritized initiatives
  - 1,000 feet plans
Optimal redistribution of employees

Objective: Develop an agreement that will ensure the optimal redistribution of employees from overstaffed to understaffed facilities

Case for change

Currently, the clinical staff is not evenly distributed throughout the country, there are ~6% under staff facilities while 26% of facilities is actually overstaffed, according to WISN standards. The divide is mostly articulated along urban vs. rural areas.

Initiative details/steps

1. Implement reallocation
   1. Assess 3,507 facilities according to WISN methodology to accurately determine number of overstaffed, understaffed facilities and number of employees potentially concerned
   2. Make business case for number of workers to be redistributed
   3. Formulate policy in concert with all relevant stakeholders
      1. Agree redistribution conditions with organized labor
      2. Mobilize resources required to implement redistribution
   4. Coordinate and implement policy

2. Design of enablers for sustainability of optimal allocation of staff
   1. Create IT tool to constantly report staffing levels and needs
   2. Coordinate with private partnerships to ensure optimal distribution of staff

Owner

- National Department of Health

Key stakeholders identified

- Provincial/Districts and Facility Managers for Health Departments
- Organized Labor
- Employees

Required resources

Investment (ZAR):
People:
Other resources:

Level of implementation

Clinics (PHCs and CHCs)
- Start date: 2015
- End Date: 2018

SOURCE: Lab analysis
### Redistributing the staff surplus will help alleviate existing shortages

Over 80% of the clinics are either over or understaffed by ~50% of their real needs.

#### Number of PHC facilities according to the need and availability of professional nurses

<table>
<thead>
<tr>
<th>Number of PHCs (% of total)</th>
<th>63 (100%)</th>
<th>11 (17%)</th>
<th>26 (41%)</th>
<th>26 (41%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existing staff</td>
<td>XX</td>
<td>XX</td>
<td>XX</td>
<td>XX%</td>
</tr>
<tr>
<td>WISN need</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff difference</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Redistribution steps and model

<table>
<thead>
<tr>
<th>Steps of redistribution</th>
<th>Estimated timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Assess all 3,507 facilities according to WISN¹ and estimate margins of error</td>
<td>2015</td>
</tr>
<tr>
<td>2. Define a comprehensive incentive package for concerned employees and assess related costs</td>
<td>2015 October – December</td>
</tr>
<tr>
<td>3. Determine policy in consultation with relevant stakeholders</td>
<td>2016 January – March</td>
</tr>
<tr>
<td>4. Design and roll out plan with input from bargaining council</td>
<td>2016 - 2017 March - July</td>
</tr>
</tbody>
</table>

1 Adjusted to the needs of the current service delivery model
2 Ratio calculated as (existing staff – WISN need) / WISN need
3 Adjusted to the needs of the new service delivery model

**Recommended approach**

- Country wide redistribution
  - Employees are redistributed across the country to better leverage the existing staff to fill existing vacancies
  - The compensation package for redeployed workers will be most expensive as incentives have to compensate for moving across provinces

- Province wide
  - Employees are redistributed only within their province: the optimization of the existing staff is lower
  - The compensation package for redeployed workers is smaller

- District wide
  - Employees are redistributed within their district: the level of optimization is lowest
  - The compensation package for redeployed workers is smallest

**Over 80% of the clinics are either over or understaffed by ~50% of their real needs**

<table>
<thead>
<tr>
<th>No. of PHCs</th>
<th>Understaffed</th>
<th>Adequate</th>
<th>Overstaffed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>202</td>
<td>25</td>
<td>132</td>
<td>335</td>
</tr>
<tr>
<td>0%</td>
<td>53%</td>
<td>-42%</td>
<td></td>
<td>-1%</td>
</tr>
</tbody>
</table>

We estimate that redistribution of 20% of the existing staff could alleviate shortages.

**Source:** WISN user manual and preliminary results, lab analysis
**The effectiveness of the staff redistribution will depend on the flexibility of the relocation process**

<table>
<thead>
<tr>
<th>Health workers in primary health care clinics</th>
<th>Redistribution hypothesis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total demand according to WISN could be underestimated given that it is based on headcount: therefore, it does not take into account the unattended patients at the clinic.</td>
<td></td>
</tr>
<tr>
<td>Employees are redistributed across the country to better leverage the existing staff to fill existing vacancies.</td>
<td></td>
</tr>
<tr>
<td>The compensation package for redeployed workers will be more expensive as incentives have to be larger to move beyond district/provinces.</td>
<td></td>
</tr>
<tr>
<td>Total demand</td>
<td>Existing staff</td>
</tr>
<tr>
<td>District</td>
<td>Province</td>
</tr>
</tbody>
</table>

**H₀: Country wide**
- Employees are redistributed only within the country to better leverage the existing staff to fill existing vacancies.
- The compensation package for redeployed workers will be more expensive as incentives have to be larger to move beyond the district/provinces.

**H₁: Province wide**
- Employees are redistributed only within their province.
- The compensation package for redeployed workers is smaller than in H₀.
- The level of optimization of the redistribution might be lesser.

**H₂: District wide**
- Employees are redistributed only within their district.
- The compensation package for redeployed workers is smallest.
- The level of optimization is also smaller than the previous options.

**SOURCE:** Lab analysis
Redistributing 20% of the professional nurses from the PHC clinics assessed with the WISN tool could help alleviate the staff shortage. The position “nurse” groups assistant nurse, clinical nurse practitioner, dispenser, enrolled nurse, professional nurse, public health nurse, registered nurse, staff nurse.

Distribution of professional nurses in 63 PHC clinics

- Total demand according to WISN could be underestimated given that it is based on headcount: therefore, it does not take into account the unattended patients at the clinic.

- Assumes the feasibility of a nationwide redistribution of nurses across the 70 assessed clinics.

- Most impactful hypothesis: The real shortage would be within a range according to the flexibility (cf. previous page).

Percentage of current staff

1 The position “nurse” groups assistant nurse, clinical nurse practitioner, dispenser, enrolled nurse, professional nurse, public health nurse, registered nurse, staff nurse.

SOURCE: WISN assessment – 63 facilities
REDISTRIBUTION OF EMPLOYEES

Steps of the staff redistribution

- Assess 3,507 facilities according to WISN methodology to determine number of overstaffed, understaffed facilities and number of employees potentially concerned by a redistribution of staff
- Make business case for optimal number of workers to be redistributed
- Determine incentives package for relocation
- Formulate policy in consultation with all stakeholders
  - Consultation and agreement on redistribution conditions and incentive package with organised labour
  - Mobilise the financial and material resources required to implement redistribution
- Design roll out plan
  - Align with provincial Bargaining Council for better coordination and implementation
  - National Bargaining Council to develop the Resolution/Agreement that will result into Policy on Staff Relocation
- Redistribute concerned employees
  - Joint operation with provincial Bargaining Council and National Bargaining Council (for better coordination and implementation)

Remuneration and allowances must be maintained or increased. Rural Allowance should be widened to accommodate Enrolled Nurses and Pharmacist Assistants with post basic qualification

The clinics must be well resourced to promote a conducive working environment and be attractive to health personnel

Design enablers for sustainability of optimal allocation of staff
- Create IT tool to constantly report staffing levels through WISN going forward
- Coordinate with private partnerships to ensure optimal distribution of staff

SOURCE: Lab analysis
# Streamlining Recruitment Processes

## Objective: Streamline recruitment processes to 3 months

### Initiative concept/details/highlights
Currently, HRH recruitment is centralised and the function doesn’t lie with the Facility Manager.

The recruitment doesn’t include Facility Managers and Labour Organisations and not e-technology enabled but paper based which prolongs the process in terms of a high number of signatory levels.

### What the HR Lab would want to achieve

1. Allow the process of recruitment and appointment of HRH to be decentralised to the facility level.

2. Analyse the availability of posts as per WISN norms
   - Determine the norms set for the facility
   - Identify the workload per facility
   - Determine the facility benchmark norm for each cadre
   - Determine the variance between existing staff, and the facility norm

3. Analyse the gap in terms of scares skills shortage per facility needs through WISN process (i.e. non-negotiable staff)

4. Reduce the time period for filling identified and prioritised posts to shorten the recruitment process.

5. Improve HR appointment process through the implementation of e-technology

### Owner
- National Department of Health

### Key stakeholders identified
- Provincial Health departments
- Facility Managers
- Recruitment Agencies
- Organised labour
- Electronic & paper-based Media Houses
- Professional Bodies

### Required resources
- Investment (USD): Budget

### Implementation timeframe
- Start date: 2015
- End Date: 2018

### Key milestones
- 2015: Process Decentralisation
- 2018: Recruitment finalised within 3 months

SOURCE: Lab analysis
Objective: Streamline recruitment processes to 3 months

What the HR Lab would want to achieve

5. Use different ways of post advertisement including walk-in application process at facility level and

- Re-enforce the policy on direct appointment for incumbents with appropriate competencies in terms of facility needs.
- Head hunt appropriate incumbents through Professional Councils websites, University Career Centers, Recruitment Agencies within a month of identifying the need
- Advertise positions internally through intranet and externally through local, regional and national radios and newspapers, online, Professional Councils websites, University Career Centers, Recruitment Agencies, etc. Use media, e.g. local, regional and national newspaper and radio, recruitment agencies, intranet, internet, etc.

7. Interview identified candidates through the utilisation of Tele-communication or face to face.

8. Inform successful and unsuccessful candidates interviewed through e-mails, telephone, SMS, etc.

To ensure the recruitment and appointment of successful incumbents within three (3) months by 2018

Owner
- National Department of Health

Key stakeholders identified
- Provincial Health departments
- Facility Managers
- Recruitment Agencies
- Organised labour
- Electronic & paper-based Media Houses
- Professional Bodies

Required resources
- Investment (USD): Budget

Implementation timeframe
- Start date: 2015
- End Date: 2018

Key milestones
- 2015: Process Decentralisation
- 2018: Recruitment finalised within 3 months

SOURCE: Lab analysis
Streamlining recruitment processes down to 3 months will ensure that we actually hire the experienced employees and retain the students.

<table>
<thead>
<tr>
<th>Responsible</th>
<th>Working days</th>
</tr>
</thead>
<tbody>
<tr>
<td>District</td>
<td>Advertise the position</td>
</tr>
<tr>
<td></td>
<td>Shortlist candidates</td>
</tr>
<tr>
<td></td>
<td>Interview shortlisted candidates</td>
</tr>
<tr>
<td>Province HOD</td>
<td>Write submission</td>
</tr>
<tr>
<td>HOD</td>
<td>Accept submission</td>
</tr>
<tr>
<td>District</td>
<td>Give job offer to selected applicant</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
</tr>
</tbody>
</table>

- 6 out of 9 provinces already delegate appointments to the district level
- 64
- 3
- 4
- 10
- 5
- 4
- 90

Streamlining recruitment processes could be drastically reduced by:
- Standardizing ownership of the process at the district level
- Leveraging IT systems would enable a faster turnaround of applications
- Leveraging IT to bypass paper-based formats and expedite communication
- Decentralizing the recruitment processes, could significantly reduce the approval time for submissions
- Standards would have to be established to maintain quality of recruits
Contracting clinical staff for the most deprived areas will help to bridge the gap between supply and demand

**Objective:** Increase the number of healthcare professionals in the primary care public system by contracting private sector workers and coordinate the existing efforts from developmental partners so as to avoid duplication of tasks.

**Concept**

- According to the 2012 baseline audit of the PHC system, 84% of clinics did not receive any input from pharmacists & pharmacist assistants and 47% of clinics did not have visits from doctors.
- By leveraging the human resources from the private sector we can partially address the shortage of critical skills.

**Steps**

In order to leverage private sector resources, the following steps will have to be taken:

- **Conduct a pilot to leverage private GPs and refine best practices**
  - Assess the number of private GPs required and specific skill mix
  - Optimize contracting guidelines (standardize fees, consultation hours) and syndicate with developmental partners
  - Ensure completion and monitoring of pilot in NHI districts
  - Evaluate pilot and incorporate findings onto contracting strategy

- **Roll out pilot to allied health professions** (e.g. pharmacists)
  - Assess the number of private professionals required per profession
  - Engage with developmental partners to contract the required staff

All 3,500 clinics should have:
- Visits from doctors
- Pharmacy assistants

**Owner**
- NDOH - HR

**Key stakeholders identified**
- Professional Organizations & Unions

**Estimate of required resources**
- Financial resources (ZAR): GP’s R 388.00 p/h; Assistants 160K p/a
- Human resources: Doctors & pharmacists

**Level of implementation**
- Start date: 2015/2016

**SOURCE:** Lab analysis
3 Contracting private general practitioners and other health workers could be a fast way to address the scarcity in the PHC system

- **Almost 50% of the clinics in the country do not have doctor visits**
  - PHCs in the public service
    - Number of facilities, percentage
    - Total: 3,507
      - 100% input from doctor
      - 1,650 no input
      - 47%
    - Estimated need: ~650 - 960

- **Developing partners could assist in securing access to a GP for all South Africans**
  1. Fast track the current GP contracting pilot being conducted by the FPD
  2. Assess the number of private GPs required and specific skill mix for the remaining 43 non pilot districts
  3. Optimize the contracting guidelines (standardize fees, consultation hours) and syndicate with developmental partners
  4. Contract required number of GPs
  5. Extract best practices from findings of GP contracting and incorporate into strategy for other health professionals

1 Assuming a service package with one doctor per clinic

SOURCE: Lab analysis, IPAF, 2012 Baseline Assessment
3. By leveraging developmental partners to assist its contracting efforts, the NDoH can efficiently multiply its reach to health professionals.

- Mediating the contracting process entails coordinating the efforts of the developmental partners in order to ensure an equitable and efficient distribution of the human resources deployed.
- To increase efficiency and secure coverage of rural areas, an attractive incentive package has to be in place (e.g. accommodation package, transportation compensation).

SOURCE: Lab analysis
NON NEGOTIABLE STAFF FUNDING

4 Ensure Funds for non-negotiable staff

Objective: Ensure that 100% of the primary healthcare clinics have minimum non clinical staff to function adequately

Idea
- 21% of clinics have no manager
- Due to lack of funds posts were not filled
- Some of the posts were abolished as they were not filled for over a year
- Although filling of clinical post was prioritized above support staff but there were still clinical posts that could not be filled
- Some of the posts were abolished because they were unfunded
- On the other hand the system has “ghost workers” that are receiving a salary but are not working

Steps
- Clean up the Persal database and work towards linking it to the department of Home Affairs to keep it updated
- Identify existing vacant posts in the clinics
- Where there are no vacant posts request for funding and creation
- Cost the filling of posts
- Request the budget from treasury for creation and filling
- Appoint the minimum for every clinic for the Support staff
- Determine the number of staff according to the WISN staffing norms

Owner:
- District Managers

Key stakeholders identified:
- National and Provincial Treasury

Required resources
- Funds for the filling of posts including support staff
- People: Number of Security Guards
- Other resources: TBD

Level of implementation
- District and Province and Facility

Implementation timeframe
- Start date: 2014/11/31
- End Date: 2014/11/21
**NON NEGOTIABLE STAFF FUNDING**

4 It is necessary to ring fence the funding of 5 key support posts in clinics to ensure that the facilities will be fully functional to deliver health services.

<table>
<thead>
<tr>
<th>Facility Manager</th>
<th>Situation today</th>
<th>Minimum requirements per facility</th>
<th>Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>21% of clinics have no manager</td>
<td>1 manager for larger facilities</td>
<td>Up to 550-850</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Smaller PHCs can potentially share one manager</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pharmacist’s assistant</th>
<th>Situation today</th>
<th>Minimum requirements per facility</th>
<th>Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>84% of clinics lacked pharmacists</td>
<td>1 Pharmacist’s assistant or Pharmacy technician</td>
<td>4,500 to 6,800</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data capturer</th>
<th>Situation today</th>
<th>Minimum requirements per facility</th>
<th>Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>79% had no information staff</td>
<td>1 data capturing clerk</td>
<td>6,500 to 9,800</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Security officer and cleaner</th>
<th>Situation today</th>
<th>Minimum requirements per facility</th>
<th>Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>24% of the 63 facilities assessed through WISN had no cleaner</td>
<td>3 Security officers(^1) 1 Cleaner</td>
<td>14,000</td>
</tr>
</tbody>
</table>

**Proposed steps**

1. Clean up the PERSAL database and work towards linking it to the department of Home Affairs to keep updated.
2. Determine an accurate number of staff required according to results from a nationwide WISN assessment.
3. Identify existing vacant posts in the clinics and cost them.
4. Where there are no vacant posts request for funding and creation from Treasury.
5. Recruit and appoint the non-negotiable cadres for every clinic.

---

\(^1\) It is assumed that, by 2018, all security personnel will be either in-house or outsourced after the expiry of the current outsourcing contract.

### Ring-fencing will be enforced through directives at province and sub-district level

<table>
<thead>
<tr>
<th>Province</th>
<th>▪ CFO enforces that budget office is not allowed to shift away from non-negotiables during the financial year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-district</td>
<td>▪ Sub-district manager approves facility shifts only within non-negotiables or to non-negotiables</td>
</tr>
<tr>
<td>Facility</td>
<td>▪ Facility manager given full visibility on budget, and is allowed to shift funds but not from non-negotiable to other categories</td>
</tr>
</tbody>
</table>

Initiative also conducted by the Financial Management workstream

Ring-fencing implies that funds can be shifted to non-negotiables, but never away from non-negotiables

**Source:** Estimates of Provincial Revenue and Expenditure 2013 / 14 financial year
Persal clean up: remove "ghost workers" from payroll

Objective 1.
To ensure workforce productivity by cutting waste by eliminating ghost workers through persal clean-up and addressing absenteeism

What is the cause? 2.
Corrupt HRH officials
Low salaries received by the HRH.
Allowing dual employment to allow HRH to earn satisfactory income
Allowing continued presence of workers who have left the health sector or died on the books.
Allowing unauthorized absences and poor HR management practices

Who 3.
Ghost workers are individuals who are listed on the payroll but who do not exist, or who work only part time

Strategy – keep track of the HRH 7.
Regular audits, physical head counts, questionnaires, and reconciliation of different data sources could help to identify ghost workers and reduce the number of unauthorized absences. Audit results should be made available to the public. Affected institutions should be empowered to take corrective actions
Remuneration Policy review incl. RWOPS Electronic Payment System

Resources required/inputs 8.
Finance
Department/work-stream
Drafting enabling policies

How 4.
Allow whistle blowing
Review persal system to get rid of ghost workers
Better intelligence gathering

Consequence / impact 6.
Whistle blowing will lead to early warning signals
Intended consequence, improved performance
Consequence of job evaluation – raising the salary levels of lowest level HRH

Challenges 5.
~Eliminating ghost workers is a complex task and can be costly.
~Lack of law enforcement
Lack of availability/non-functional IT system –
Lack of intelligence gathering and lack of understanding of national situations to monitor progress or setbacks

SOURCE: Lab analysis
It is necessary to ring fence the funding of 5 key support posts in clinics to ensure that the facilities will be fully functional to deliver health services.

<table>
<thead>
<tr>
<th>Situation today</th>
<th>Minimum requirements</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Manager</td>
<td>• 21% of clinics have no manager</td>
<td>• The presence of the facility manager in the clinic ensures leadership at</td>
</tr>
<tr>
<td></td>
<td></td>
<td>facility level for the workforce to feel valued and supported</td>
</tr>
<tr>
<td>Pharmacy assistant</td>
<td>• 84% of clinics lacked input from pharmacists</td>
<td>• Shortage of dispensers</td>
</tr>
<tr>
<td>Data capturer</td>
<td>• 79 % had no information staff</td>
<td>• An insufficient number of data capturers compromises data integrity</td>
</tr>
<tr>
<td>Security officer and cleaner</td>
<td>• Patient Safety and Security has the lowest score</td>
<td>• This can lead to a poor understanding of the situation of the clinics,</td>
</tr>
<tr>
<td></td>
<td>in the rating by the National Health Baseline Audit</td>
<td>compromising in turn a sound HR planning strategy</td>
</tr>
<tr>
<td></td>
<td>• 1 data capturing clerk</td>
<td>• The safety and security of staff and patients are of utmost important</td>
</tr>
<tr>
<td></td>
<td>• 3 Security officers</td>
<td>for delivery of services</td>
</tr>
<tr>
<td></td>
<td>• 1 Cleaner</td>
<td></td>
</tr>
</tbody>
</table>

1 It is assumed that, by 2018, all security personnel will be either in-house or outsourced after the expiry of the current outsourcing contract.

SOURCE: National Facilities Baseline audit (2012), Lab analysis
There are a number of vacancies in supporting roles (admin, maintenance and security)

<table>
<thead>
<tr>
<th></th>
<th>Admin/ general</th>
<th>Maintenance/ security</th>
<th>Nurses</th>
<th>Doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic A</td>
<td>1 vacancy (of 1 post)</td>
<td>1 vacancy (of 1 post)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinic B</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinic C</td>
<td>2 vacancies (of 2 posts)</td>
<td>2 vacancies (of 37 posts)</td>
<td></td>
<td>1 vacancy (of 3 posts)</td>
</tr>
<tr>
<td>Clinic D</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Insights**
- Shortages of administrative staff results in admin work being shifted to non-administrative staff

**SOURCE:** Gauteng Health QA, Lean Operations diagnostic, team analysis
Estimated financial resources that will have to be ring-fences to ensure full functionality of the 3,507 ideal clinics

<table>
<thead>
<tr>
<th>Staff</th>
<th>Goal By 2018 Number of extra employees (%)</th>
<th>Annual wage(^3) R’000</th>
<th>Total Cost Rm</th>
<th>2015-16 Rm</th>
<th>2016-17 Rm</th>
<th>2017-18 Rm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Manager(^1)</td>
<td>736 (21%)</td>
<td>350</td>
<td>260</td>
<td>87</td>
<td>87</td>
<td>87</td>
</tr>
<tr>
<td>Security Officer(^2)</td>
<td>10,500 (100%)</td>
<td>90</td>
<td>945</td>
<td>0(^2)</td>
<td>473</td>
<td>473</td>
</tr>
<tr>
<td>Pharmacist Assistant</td>
<td>2,950 (84%)</td>
<td>122</td>
<td>360</td>
<td>120</td>
<td>120</td>
<td>120</td>
</tr>
<tr>
<td>Data Capturer</td>
<td>2,800 (79%)</td>
<td>103</td>
<td>290</td>
<td>97</td>
<td>97</td>
<td>97</td>
</tr>
<tr>
<td>Cleaner</td>
<td>3,507 (100%)</td>
<td>87</td>
<td>305</td>
<td>0(^2)</td>
<td>152</td>
<td>152</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20,493</strong></td>
<td><strong>2,160</strong></td>
<td><strong>304</strong></td>
<td><strong>929</strong></td>
<td><strong>929</strong></td>
<td></td>
</tr>
</tbody>
</table>

NB: Figures might not add up given rounding of estimations
1 Working hypothesis to be refined: One facility manager per clinic
2 It is assumed that, by 2018, all security and cleaning personnel will be either in-house or outsourced after the expiry of the current outsourcing contract
3 Annual wages as stated in the COLA

SOURCE: Lab analysis
Initiative 4: Ring fencing funding for non-negotiable posts

All posts

- Negotiable
- Non-negotiable

Non-negotiable

- Vacant (B)
  - Funded
  - Non-funded (A)

Filled

KPI = A / B

SOURCE: Team analysis
Contents

▪ Context and case for change
▪ Aspirations
▪ Issues and root causes
▪ Solutions and Initiatives
  – Initiative overview and prioritization
  – Initiative details
    ▫ Breakthrough initiatives
    ▫ Major delivery fixes
      ▪ Business as usual
        – Budget of prioritized initiatives
        – 1,000 feet plans
An effective community health service policy

**Objective:** To develop a more effective community service policy to alleviate HRH shortage in under-served areas for optimal health outcome

<table>
<thead>
<tr>
<th>Initiative concept/details/highlights</th>
<th>Owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently there is no standardized policy in the country between the professions and between the provinces. The existing policies cannot effectively address the distribution of health professionals to the under-served areas. According to the HRH strategy, South Africa will need ~2,800 doctors and 3,160 professional nurses by 2015/16</td>
<td>Department of Health</td>
</tr>
</tbody>
</table>

**What the HR Lab would want to achieve**

- Find all existing policies
- Establish the current distribution of community Health Service professionals across the country
- Compare the policies to find gaps
- Obtain the original policy framework for the introduction of Community service to identify gaps in all existing policies
- Obtain literature on Community Services in other countries
- Prepare recommendations for the formulation of a standard community Health Service

To have an equitable/proportional distribution of all community service health professionals across the country by 2018

<table>
<thead>
<tr>
<th>Key stakeholders identified</th>
<th>Required resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provincial Health departments</td>
<td>Investment (USD): Budget</td>
</tr>
<tr>
<td>Health professionals statutory bodies; (SANC)</td>
<td></td>
</tr>
<tr>
<td>Organised labour</td>
<td></td>
</tr>
<tr>
<td>Nursing schools/colleges</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Implementation timeframe</th>
<th>Key milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start date:2015</td>
<td>2015: Policy formulation</td>
</tr>
<tr>
<td>End Date: 2018</td>
<td>2016: Policy implementation</td>
</tr>
</tbody>
</table>

SOURCE: Lab analysis
COMMUNITY SERVICE

Developing a more effective community service policy and practices will supply more clinical practitioners to rural areas

Community service professionals are not equitably distributed across provinces

<table>
<thead>
<tr>
<th>Province</th>
<th>No. of Community Service Professionals</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td>202</td>
</tr>
<tr>
<td>WC</td>
<td>154</td>
</tr>
<tr>
<td>FS</td>
<td>46</td>
</tr>
<tr>
<td>NC</td>
<td>76</td>
</tr>
<tr>
<td>LP</td>
<td>86</td>
</tr>
<tr>
<td>MP</td>
<td>105</td>
</tr>
<tr>
<td>KZN</td>
<td>176</td>
</tr>
<tr>
<td>NW</td>
<td>68</td>
</tr>
<tr>
<td>EC</td>
<td>138</td>
</tr>
</tbody>
</table>

No. of medical doctors per 100,000 inhabitants

<table>
<thead>
<tr>
<th>Province</th>
<th>No. of Medical Doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td>35</td>
</tr>
<tr>
<td>WC</td>
<td>35</td>
</tr>
<tr>
<td>FS</td>
<td>27</td>
</tr>
<tr>
<td>NC</td>
<td>39</td>
</tr>
<tr>
<td>LP</td>
<td>22</td>
</tr>
<tr>
<td>MP</td>
<td>23</td>
</tr>
<tr>
<td>KZN</td>
<td>34</td>
</tr>
<tr>
<td>NW</td>
<td>20</td>
</tr>
<tr>
<td>EC</td>
<td>25</td>
</tr>
</tbody>
</table>

- Some provinces are receiving fewer community service professionals than others despite having a lower ratio of medical doctors per 100,000 inhabitants

How we plan to achieve it

1. Review policy to:
   - Prioritize underserved areas when budgeting for community service posts
   - Distribute HRH (allocate according to facility needs and not individual preferences)

2. Create more placement posts in underserved areas

3. Incorporate incentives in the current policy to motivate community service professionals in underserved areas to accept a permanent position
   - Transport subsidy
   - Wi-Fi/internet
   - Flexi-hours
   - Training and conferences

**COMMUNITY SERVICE**

5. **There are best practices when it comes to drafting a sound community service policy**

| Good planning | Prospective and proactive planning around the 3 steps of the process is key for a successful program  
|              | ▪ Assignment  
|              | ▪ Placement  
|              | ▪ Fulfilment  
|              | The individuals should be trained in procedures relevant to working in a rural area |

| Transparency and clarity | ▪ A clear understanding of the rationale and requirements is key: health professionals need to have a clear understanding of the rationale for their assignment and a clear set of expectations  
|                          | ▪ Clarity of intent and consistency of implementation on the following are key:  
|                          |   – Rationale for the assignment  
|                          |   – Duration of assignment  
|                          |   – Decision making processes around the assignment  
|                          |   – Role of the host community in the selection process |

| Support | ▪ Benefits provided to the health worker must be clearly defined:  
|         |   – Pay  
|         |   – Housing  
|         |   – Continuing education  
|         |   – Clinical backup or supervision  
|         | ▪ Sending doctors to remote areas with little support may place doctors in the periphery, but the absence of assistance is likely to result in clinicians abandoning their site, or function ineffectively |

It is possible to benchmark off international best practices: In Norway each graduate is assigned a random number called in order. The graduate has six hours to choose a post location from those still available.\(^1\)

This system allows each graduate to know his/her chance of gaining a choice post location

---

\(^1\) Except under extreme circumstances (i.e. severe illness in the immediate family), no swapping of assigned locations is permitted

**SOURCE:** WHO - Compulsory service programmes for recruiting health workers in remote and rural areas: do they work?
Compulsory service programmes can be classified in three groups:

1. **Condition of service/state employment programme**
   - Federal or state (employment contract)
   - Country natives programme
   - International medical graduate programme

2. **Compulsory service with incentives**
   - Attached with financial and non-financial incentives
   - Before graduation programme as part of training requirement (rural placement to complete education)
   - After graduation programme (to be able to specialize)
   - Return of service (mandatory rural placement after graduation for provided educational financial support)
   - a. Educationally linked
   - b. Employment linked
   - c. Living-provisions linked
   - d. Bundled programmes

3. **Compulsory service without incentives**
   - With no attached financial or non-financial incentives and not due to condition of service
   - Licence to practice (public/private)
   - Career advancement
   - Housing allowance, car loan, children’s school, etc.
   - Combination of a, b or c

**SOURCE:** WHO - Compulsory service programmes for recruiting health workers in remote and rural areas: do they work?
Communit Service Policy Task Team

DG NDoH

Health Council

DDG PHC

DDG HR

Dir HRIS NDoH

GP

WC

NW

NC

EC

KZN

LP

MP

FS

NB: Each province will be represented by a Director of Human Resources Development.
Target groups for the new Community Service Policy

- Facility managers (3,507 managers)
- Human Resource Managers & staff (156 managers)
- PHC personnel (Clinical staff at 3,507 facilities)
- District Managers (Managers at 52 districts)
- Sub-District Managers (208 managers)

- Approximately ~11,000 people to be trained.
Proposed incentives for community service professionals in PHC facilities

- Accommodation
- Conference attendance
- Access to free Wi-Fi
- Indemnity insurance
- Flexible working hours
#BringBackOurHealthWorkers

**Objective:** Carrying out a communications campaign to recruit South African trained workers currently living abroad, retired health professionals and clinical workers outside the medical field back into the public health sector to help match the supply of clinical workers to the existing demand.

---

**Develop strategies to increase the return of health professionals who have left the profession**

**A. Quick wins to bring back professionals ASAP**

- Launch of the #BringBackOurHealthWorkers campaign
- Partner with International Marketing Council and the Homecoming Revolution campaign
- Communications campaign
- Time constrained financial incentives (tax exemption for a limited period)

**B. Implement NDoH Monitoring structure**

Implement a HR Observatory structure within NDoH to baseline and monitor continuously push & pull factors (Ensure Health Systems strengthening through an integrated HRM information management system in partnership with WHO by adopting HR Observatory system for use in SA with financial support from PEPFA and further support from DIRCO and Home Affairs to monitor migration patterns)

1. Carry out an accurate, detailed analysis of the current situation and needs
2. Refine mix of incentives based on determined needs (type and number of professionals and motivation of those professionals to leave)

---

**Owner**

- NDoH, Provincial Health Departments, District Offices

**Key stakeholders identified**

- DPSA, DoL, DIRCO, HA, DHET, WHO, SARS
- DIRCO, International Marketing Council
- Organised Labour
- Professional Councils
- Association of Retired Nurses

**Required resources**

- Funding to be made available to fill the 46000 vacant posts
- X one nurses unit costs per category

**Implementation timeframe**

- Start date: 2015
- End Date: 2018

**Key milestones**

- 2015/16: Launch international #BringBackOur HealthWorkers communications campaign
- 2015/16: Implement HR observatory unit to monitor trends, coordinate campaign leveraging WHO Observatory system

**SOURCE:** Lab analysis
Almost a third of South African trained doctors work outside the country, and of the ones in the country, 20% are outside the profession.

Doctors trained in South Africa working in OECD countries
Thousands of health workers, percentage

- Working in home country: 33.0 (73%)
- Working in OECD countries: 12.2 (27%)

General practitioners in South Africa per sector of practice
Percentage of health workers

- Public sector: 50%
- Private sector: 31%
- Unknown: 19%

1 Doctors - Australia, Canada, Finland, France, Germany, Portugal, United Kingdom, USA
In order to revert the flee of South African doctors from the country it is necessary to align the incentives with their drivers.

<table>
<thead>
<tr>
<th>Frequency of reason selection, %</th>
<th>Beyond reach of NDoH</th>
<th>Within reach of NDoH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial reasons</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Better job opportunities</td>
<td>79.3</td>
<td>86.2</td>
</tr>
<tr>
<td>High crime rate</td>
<td>75.9</td>
<td></td>
</tr>
<tr>
<td>Wanted to change immediate circumstances</td>
<td>58.6</td>
<td></td>
</tr>
<tr>
<td>Personally wanted to experience something new</td>
<td>58.6</td>
<td></td>
</tr>
<tr>
<td>Feeling of restlessness regardless of working conditions</td>
<td>55.2</td>
<td></td>
</tr>
<tr>
<td>Extended duty hours</td>
<td>55.2</td>
<td></td>
</tr>
<tr>
<td>High prevalence of HIV/AIDS</td>
<td>51.7</td>
<td></td>
</tr>
<tr>
<td>South Africans income tax system</td>
<td>51.7</td>
<td></td>
</tr>
<tr>
<td>Better schooling opportunities for children abroad</td>
<td>50.0</td>
<td></td>
</tr>
<tr>
<td>Dealing with business aspect of practice</td>
<td>48.3</td>
<td></td>
</tr>
<tr>
<td>On-call duties</td>
<td>46.4</td>
<td></td>
</tr>
<tr>
<td>Racial discrimination</td>
<td>44.8</td>
<td></td>
</tr>
<tr>
<td>Professional development</td>
<td>41.4</td>
<td></td>
</tr>
<tr>
<td>New dispensing laws</td>
<td>32.2</td>
<td></td>
</tr>
<tr>
<td>Meeting patient demands</td>
<td>31.0</td>
<td></td>
</tr>
<tr>
<td>Personal circumstances</td>
<td>20.7</td>
<td></td>
</tr>
<tr>
<td>Family abroad</td>
<td>17.9</td>
<td></td>
</tr>
</tbody>
</table>

The NDoH can actually have an impact on 9 out of the 18 reasons quoted.

This would create the opportunity of designing a wide incentive package tailored to the concerns of these professionals in order to bring back the South African health workers.

SOURCE: NDoH HRH Strategy, 2012
#BringBackOurProfessionals aspires to getting health workers back in the PHC system

Top 5 factors that drive South African GPs out of the country

<table>
<thead>
<tr>
<th>Factor</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial reasons</td>
<td>86%</td>
</tr>
<tr>
<td>Better job opportunities</td>
<td>79%</td>
</tr>
<tr>
<td>High crime rate</td>
<td>76%</td>
</tr>
<tr>
<td>Wanted to change immediate circumstances</td>
<td>59%</td>
</tr>
<tr>
<td>Personally wanted to experience something new</td>
<td>59%</td>
</tr>
</tbody>
</table>

No. of health professionals

- Professionals abroad: 6,844
- Retired professionals: 6,679

Incentives to get them back

- Communication campaign on South Africa’s need
- Revised financial incentives
- Improved work environment
- Flexible working arrangements (e.g. part time work, coaching focused tasks)
- Revised incentives for early retirees

1 Needs according to the current service delivery model: Total WISN need x lack of staff ratios
   Professional nurses: ~500, Pharmacy assistants: ~5,000, Doctors: ~700
SOURCE: HRH strategy plans (from professional councils), National Health Facilities Baseline Audit 2012, Lab analysis
#BringBackOurHealthWorkers will focus on communicating the reasons to join the PHC system and secure the incentives

<table>
<thead>
<tr>
<th>Description</th>
<th>Measures to undertake</th>
</tr>
</thead>
</table>
| ▪ Carry out an awareness campaign advocating the need for South African doctors to come back to the primary health care system  
  – Fact based communication (e.g. 47% of clinics had no doctor visits, improvement on working conditions)  
  – Patriotic resonance (e.g. communication based on patriotic duty)  
  – Incentives to join the PHC system (e.g. communication on tax exemption policy for returning workers from overseas) | ▪ Engage DIRCO & International Marketing Council (IMC) |
| ▪ A multi-benefits package in line with the concerns and ambitions of the health professionals that we want back in the system:  
  – Acknowledge and credit time spent working outside the country for returning health professionals and entry point salary is important  
  – Part-time employment for retired personnel  
  – Improved opportunities for professional development training | ▪ Secure cabinet approval  
 ▪ Syndicate with relevant stakeholders |

SOURCE: Lab analysis
# Empower managers through training and decentralisation of key responsibility

**Objective:** Empower facility managers on defined set of skills and competencies to empower them to better perform their current tasks and enable them to undertake higher responsibilities.

## Initiative concept/details/highlights:

Facility managers in clinics lack the required skills that are stipulated in the DPSA Leadership, Development and Management framework. This is further confirmed in the research conducted by the Health Systems Trust (HST). Facility managers need to be trained to do the required management tasks and before having any decentralization.

**Training**

The training would be based around the competencies identified by the HST (planning, budgeting, organising, communicating, leading and controlling, analysing, and community assessment, planning and implementation) to specifically enhance the following competencies:

- a. Project management
- b. Financial management
- c. Stakeholder management
- d. People management (HR)

All 3,507 facility managers will be equipped with leadership and management skills which will result in better planning, timeous appointments of staff and procurement of services and resources.

## Owner:

- South African Government
- Department of Health

## Key stakeholders identified:

- DPSA NSG
- HST
- DHET and training Institutions
- NGOs
- National school of Governance

## Required resources

- Funding
- Training materials

## Implementation timeframe

- Start date: 2014
- End Date: 2017

## Key milestones

- Training – 2015
- Decentralization of functions - 2016

*SOURCE: Lab analysis*
Training of facility managers is key to strengthen their engagement and empower them to secure leaner processes.

Self-assessment of facility managers
Average score in each component

- Budgeting (2.8)
- Planning (3.2)
- Leading and controlling (3.8)
- Organising (3.9)
- Analysing (3.2)
- Community assessment, planning and implementation (3.1)
- Communicating (3.7)

Facility managers scored
- better for organizing, leading and controlling and communicating
- worse on planning, budgeting, analyzing and community assessment, planning and implementation

Overall, clinic managers scored worse than other managers of the sample
- There was a tendency to overscore themselves, however, there is a linear relationship between the level of confidence and the scores

SOURCE: HST facility manager competency assessment, 2014; QUEST sub-scale
Empower facility managers through training and decentralization of key responsibilities

Managers will be trained around 4 key competencies

- Supply chain and infrastructure management
- Financial management
- Stakeholder management
- HR & staff management

A trained manager will, in turn be able to train his deputy facility manager in the team to improve patient experience.

The training could be delivered through various platforms:
- Mobile and online training
- In person/”classroom” (leveraging clinic accelerator teams that will be on the field)
- On the job

Decentralization support

Key processes will be decentralized to facility managers. To accompany this we will foster:

- **Transmission of knowledge** by informally appointing a deputy facility manager in the clinic to ensure transfer of knowledge
- **Sharing of best practices and enhanced sense of belonging** by creating a peer network for clinic managers to communicate and reach out in case of need

SOURCE: Lab analysis
Empower facility managers through training and decentralization of key responsibilities

Managers will be trained around 4 core competencies:

- Project management
- Financial management
- Stakeholder management
- People management

Decentralization and support:

- **Ensure transmission of knowledge**: Informal designation of a deputy facility manager to ensure knowledge transfer.
- **Decentralize powers**:
  - Selected financial decision making processes (i.e. managers will be involved at key points during the planning and budgeting cycle).
  - Selected HR functions:
    - Replacement of operational staff
    - Recruitment processes (receive and assess applications)
    - Monitor and use WISN tool
    - Deal with disciplinary issues
- **Share best practices and enhance sense of belonging**:
  - Create peer network for clinic managers to share best practices, and reach out in case of need.

**SOURCE**: Lab analysis
### Amend job descriptions

**Objective:** To review job descriptions in the facilities and sub-districts in order to ensure that the roles and responsibilities are clearly defined, the areas of accountability are identified and that the descriptions are flexible enough to allow for task shifting/sharing.

### Initiative concept/details/highlights:

- Eliminate inconsistency in the job profiles, skills requirement, roles and responsibilities and limit in scope of accountability.
- Detail job profiling for the following categories:
  - District manager
  - Sub district manager
  - Operational Managers (Facility manager, CHC Manager, PHC Manager)
  - Assistant Manager (for the facilities)
  - Program managers
  - Outreach team leader

- Establish job content per staff category
- Identification the gaps within the current work force and job load – as per WISN – in order to motivate for task shifting / task sharing.

### Owner:

- National Department of Health

### Key stakeholders identified:

- NDOH office of the DDG
- DPSA
- Organized Labor
- PPPS (HST)
- Organizational Design Unit

### Required resources

- **Investment (ZAR):**
- **Funding required to enlarge competency assessments & job profile study currently in progress by HST**

### Level of implementation

- District, Sub District & Facility Levels

### Implementation timeframe

- **Start date:** 2015
- **End date:** 2018

### SOURCE: Lab analysis
Enable task shifting for larger facilities and task sharing for smaller facilities

How we plan to implement it

1. Identify key tasks within:
   - Patient Care that could be delegated to Ward Based Outreach / junior clinical staff / volunteers
   - Administration that could be delegated to clerks, data capturers and other administrative
   - Management which could be delegated to team leaders

2. Identify cross-skilling opportunities

3. Get buy-in and agreement on assignment of tasks

4. Deliver training and build capabilities within group to whom tasks are transferred

Workers in bigger, more complex facilities could shift task from one another to specialize
Workers in smaller facilities with less services can share tasks
## Task Shifting

### Task transfer can increase face to face clinical care of doctors and nurses

**Key activities**
- Identify key tasks within:
  - Patient Care that could be delegated to Ward Based Outreach / junior clinical staff / volunteers
  - Administration that could be delegated to clerks / data capturers / general workers
  - Management which could be delegated to team leaders

- Identify cross-skilling opportunities
- Get buy-in and agreement on assignment of tasks
- Deliver training and build capabilities within group to whom tasks are transferred

**Prerequisites for success**
- Availability of baseline for performance indicators
- Strong clinic management and leadership
- Willingness from clinic staff to transfer and take on tasks
- Capacity within team for capability building
- Strong labour relations
- District support and involvement during and after implementation to ensure sustainability and roll out to other three clinics

**Outputs**
- **Physical outputs**
  - Revised role description
  - Potential increase in admin staff (e.g., data capturers)
- **Results**
  - Increase in amount of time spent with the patient by doctors and nurses
  - Increase in number of patients seen per day

**Performance indicators**
- Time spent on patient care by nurses
- Time spent on patient care by doctors
- Number of patients seen per day by nurses
- Number of patients seen per day by doctors

**Source:** Lab analysis, Lean Operations diagnostic
# Upskilling non-clinical staff

**Objective:** Non-clinical health workers should be trained on observing clinical emergencies and on customer care to increase productivity in clinics and sense of belonging to reduce attrition.

Provide induction and customer care training to non-clinical staff in facilities. The achieved impact will be:

- Coordination of staff within the clinic to improve patient experience and productivity
- Sense of belonging and responsibility, awareness of employees
- Ripple effect of promoting health within the community

## Steps

1. **Design training methodology and estimated total cost**
   - Determine the target group and number (~31,600)
     - Non clinical service flow line staff from 3,507 clinics will include:
       - security guards
       - grounds men,
       - queue marshals
       - admin clerks
       - datacapturers
   - Adapt NQF Level 2 framework course materials aiming at multi-skilling non-clinical staff (health care advocates) on basic health care and prioritizing emergencies such as (basic first aid/ basic life support, ability to observe the need for emergency assistance and ability to identify key symptoms of the burden of disease in the community)
   - Determine the schedules of training for all target workers
   - Identify the training institution and facilitators, preferably the proposed health academy
   - Syndicate with people running “Walk the talk” to ensure communication of “Health advocates Program” (i.e. basic induction sessions, posters, manager communication)
   - Determine sources of financing:
     - Contracting accredited service providers through the health academy/RTC;
     - Leveraging developmental partners (PPP)

2. **Implementing the trainings**
   - Pilot it in NHI ideal clinic districts
     - Plan enrolment
     - Secure monitoring (staff satisfaction, patient satisfaction)
   - Roll off

---

**Owner**

- NDoH – HR - HRD

**Key stakeholders identified**

- DOH (training needs assessed - target group and number confirmed)
- Accredited service providers (NGO/Private)

**Content**

- SAQA (NLRD- national learner record database)
- Quality councils (QCTO)
- Health & Welfare SETA

**Implementation**

- Districts
- Employees
- Organized labour

**Funding**

- Custodian of training (DHET)
- Developmental partners

**Required resources**

- R157 800 000 = R 5,000 x 31,600 (targeted staff)
- Venues for training and Transport (not included in the cost)

**Implementation timeframe**

- Start date: Jan 2015
- End Date: NA

SOURCE: Lab analysis
Training non-clinical facility workers will pave the way for a “health awareness” culture in South Africa

Providing basic health and customer focus training to over 31,000 non-clinical workers of the primary healthcare system would ripple into several spheres of influence:

<table>
<thead>
<tr>
<th>Individual worker</th>
<th>Staff</th>
<th>Facility</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raise awareness on health issues</td>
<td>Enhance the coordination between clinical and non-clinical staff driving productivity increases through fast-tracking</td>
<td>Improve approach to addressing the burden of disease, which contributes to an improved patient experience</td>
<td>Create ripples of awareness in the community: Health Advocates can recognize signs of alarm or emergency</td>
</tr>
<tr>
<td>Enhance sense of belonging, understanding how the pieces of the puzzle fit together</td>
<td>Ensure a better split of tasks</td>
<td>Promote healthier lifestyles</td>
<td></td>
</tr>
<tr>
<td>Develop sense of responsibility leading to delivering better service</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SOURCE: Lab analysis
The impact of this initiative would go beyond the primary care facilities as the trained staff bring the knowledge to their communities.

Over 30,000 non-clinical workers would be empowered

- Non clinical service flow line staff:
  - security guards
  - grounds men
  - queue marshals
  - admin clerks
  - Data capturers
  - all other non-clinical staff

- Provide basic health promotion training:
  - Ability to observe the need for emergency fast-tracking
  - Ability to identify key symptoms of the burden of disease in the community

- Provide customer care training

- The workers can progress in their trainings up to a NQF-Level 2. This enables them to qualify for further studies

- Estimated cost: ~ R160MM (R 5,000 X 31,600)
- Possible sources of financing:
  - Contracting accredited service providers
  - Leveraging developmental partners (PPP)

Assuming a potential area of influence of 5 people per non-clinical health worker, the initiative could ripple down to ~150,000 South Africans

1 Category levels ranging level one to five

SOURCE: Lab analysis, The National HIV Counselling and Testing campaign strategy
In order to optimize training of supporting staff, the training given will not be a full clinical training but will incorporate some elements of customer focus training.

<table>
<thead>
<tr>
<th>What it is</th>
<th>What it is not</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔ Training on the principles of Batho-Pele</td>
<td>✗ Patient care and clinical treatment</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Training on customer care to improve</td>
<td></td>
</tr>
<tr>
<td></td>
<td>✗ Patient counseling</td>
</tr>
<tr>
<td>▪ communication skills</td>
<td></td>
</tr>
<tr>
<td>▪ listening skills</td>
<td></td>
</tr>
<tr>
<td>▪ Compliance to etiquette</td>
<td></td>
</tr>
<tr>
<td></td>
<td>✗ Aditionnal tasks to existing ones</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Training on emergency triage to fast-track patients in case of urgency and understanding immediate patient needs</td>
<td></td>
</tr>
</tbody>
</table>

SOURCE: Lab analysis
Elements for training of non-clinical staff

- Focus on Batho Pele principles
- Tailor training courses to fit non-clinical staff
- Training to be provided in all 11 languages as needed by the trainees
- Face to face training with a facilitator
- Role playing training and clinic simulation
- Practical training
- Participants to be tested on knowledge and competences
- Participants to be given certificates of attendance and completion
- Participants to be given a take home manual after training (preferably on video or graphics depending on content)
Contents

- Context and case for change
- Aspirations
- Issues and root causes
- **Solutions and Initiatives**
  - Initiative overview and prioritization
  - **Initiative details**
    - Breakthrough initiatives
    - Major delivery fixes
    - **Business as usual**
      - Budget of prioritized initiatives
      - 1,000 feet plans
## Initiative: Retain more students

**Objective:** Increase the Medicine, pharmacy and nursing students intake to increase output of medical professionals

To ensure efficient HRH supply and conversion of health students to Public Service as an employer of choice

**Analysis**

- Use survey to understand final year students’ aspirations/plans
- Review bursary conditions to ensure conversion to public service on completion of the bursary holders’ studies.
- Track pipeline students on a regular basis

**Student financial support and communication to ensure health student uptake and conversion to Public service.**

- Get more students into NDoH careers via a revised bursary system and support during training period
- Communicate NDoH value proposition to students by advising that:
  - State be employer of choice
  - Duty to the country
  - Leverage role model and high profile workers
- Rural prioritization will assist when increasing number of student intake through revised bursary system

**Steps**

- Vigorously recruit school leaving students to follow health related studies as their field of choice
- Avoid potential dropouts through counselling, monitoring and financial support.
- Provide academic support to those who could not complete their studies within the required period.
- Increase number of graduates from disadvantaged areas and community service professionals serving in the Public Service after completion
- Increase commitment of professionals in the Public Service from current 50% to at least 80% of the total graduates per year

### Owner

- NDoH

### Key stakeholders identified:

- Accredited service providers (NGO/Private)
- SAQA (NLRD- national learner record data base)
- Quality councils (QCTO)
- Custodian of training (DHET)
- Health & Welfare SETA (funding)
- Department of Basic Education

### Required resources

- Infrastructure
- Funding

### Implementation timeframe

- Start date: January 2015
- End Date: January 2019

### Key milestones

SOURCE: Lab analysis
**Expand bilateral agreements between countries to recruit foreign workforce**

**Objective:** To increase the number of foreign workforce and optimize health services in the country

<table>
<thead>
<tr>
<th>Initiative concept/details/highlights</th>
<th>Owner</th>
</tr>
</thead>
</table>
| ▪ The current bilateral agreements are limited to fewer countries (Cuba and Tunisia) thus restraining the recruitment of Health Professionals apart from Medical Officers, however the country needs more Health Workers not limited to Medical Officers. Health professional such as Pharmacists and other Allied Health Professionals are in short supply and the extension of bilateral agreements to other countries will alleviate the problem. | ▪ South African Government  
▪ Department of Health |
| ▪ It is recommended that the country expands bilateral agreements to more countries and extend the agreement to include other Health Professionals in order to ensure the adequate supply of health professionals into the country. | |

The overall impact and target is to have more bilateral agreements with other countries in order to recruit an increased number of foreign health professionals work force into the country.

<table>
<thead>
<tr>
<th>Key stakeholders identified</th>
<th>Required resources</th>
</tr>
</thead>
</table>
| ▪ Provincial Health departments.  
▪ Foreign/Outside countries.  
▪ Xxx  
▪ xxx | ▪ Investment (USD): |

<table>
<thead>
<tr>
<th>Implementation timeframe</th>
<th>Key milestones</th>
</tr>
</thead>
</table>
| ▪ Start date:  
▪ End Date: | ▪ 2015: Negotiation with other countries.  
▪ 2016: Bilateral agreements. |

SOURCE: Lab analysis
The NDoH can accompany health student’s through their studies (e.g. providing financial support) to ensure conversion to the public service

- Get more people to enter pipeline, preferably from rural areas through bursary and quota systems
- Avoid potential dropouts – a high number of students do not graduate (dropout) or stay in the system longer than required—through counselling, monitoring and financial support
- NDoH target for doctors: 2,400 new doctors per year by 2014/15

1 Students enrolled to become pharmacists

SOURCE: Lab analysis
#WalkTheTalk

**Build awareness and engagement in the change process by having all members of the walk the Talk campaign for the Ideal Clinic Realization**

<table>
<thead>
<tr>
<th>Initiative concept/details/highlights</th>
<th>Owner:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carry out a communications campaign to build awareness and engagement in the change process by having all members of the walk the Talk campaign for the Ideal Clinic Realization</td>
<td>▪ National Department of Health</td>
</tr>
<tr>
<td>1. Ensure commitment to implementation</td>
<td></td>
</tr>
<tr>
<td>2. Ensure that the knowledge translation takes place</td>
<td></td>
</tr>
<tr>
<td>3. Carry out joint problem solving</td>
<td></td>
</tr>
<tr>
<td>4. Ensure continuous communication strategy from senior management</td>
<td></td>
</tr>
<tr>
<td>5. Establish informal coalition with other agents (stakeholders that will be to capacity building)</td>
<td></td>
</tr>
<tr>
<td>6. Celebrate successes – 1% performance incentive for best performing clinic</td>
<td></td>
</tr>
<tr>
<td>7. Role Modeling</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key stakeholders identified:</th>
<th>Required resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Provincial/Districts and Facility Managers for Health Departments</td>
<td>▪ People: Supply chain &amp; service delivery</td>
</tr>
<tr>
<td>▪ Organized Labour</td>
<td>▪ Other resources: Posters, digital messages at Provincial, District, Sub District offices and at Clinics; Facilitators, Venues for training, catering, transport;</td>
</tr>
<tr>
<td>▪ Employees</td>
<td>Total Uniform Costs per Nurse per annum: R2025 @ 131.770 Nurses = R266,834.250 country wide</td>
</tr>
<tr>
<td>▪ Civil society – NPOs, Community</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level of implementation</th>
<th>Implementation timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Clinic/sub-district/district/provincial/national?</td>
<td>▪ Start date:2015</td>
</tr>
<tr>
<td>▪ Community</td>
<td>▪ End Date:2018</td>
</tr>
</tbody>
</table>

SOURCE: Lab analysis
The prerequisites for change are generally lacking in most clinics.

**Core Framework**

**Personal choice**

- Role modeling: “… I see my leaders, colleagues, and staff behaving differently”
- Understanding and conviction: “… I understand what is being asked of me and it makes sense”

**Skills required for change**

- “… I have the skills and opportunities to behave in the new way”
- “… I see that our structures, processes, and systems support the changes I am being asked to make”

**Reinforcement mechanisms**

- Clinic staff have not been adequately trained in the ICDM
- Management do not understand what is expected of them in leadership

- Communication around new initiatives has been limited
- Staff are keen to implement change but are frustrated
- Changes need to be followed by change management process

*Source: Lab analysis*
Everyone, from the NDoH, to the personnel in the facilities and in the community needs to be engaged in the change management process.

**National**
Ministers: Health and Presidency
DG
Change drivers: DDG - PHC and Health outcomes

**Community**
Mayors, Ward councillors and other

**Province**
All MECs and HODs
Change drivers: NHI & PHC/DHS Chief Directors

**Facility**
Facility managers or facility change agents

**Districts**
PPTICRM

SOURCE: The Change management Plan Storyline Ms. N Jacobs, Lab analysis
Several elements from communication to performance management will have to be aligned in order for the employees to embrace the change.

<table>
<thead>
<tr>
<th>Ensure that the knowledge translation happens</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure that the knowledge translation takes place through:</td>
</tr>
<tr>
<td>- Mentorship &amp; coaching</td>
</tr>
<tr>
<td>- Continuous repetitive training programs at service delivery points</td>
</tr>
<tr>
<td>- Information sharing sessions</td>
</tr>
<tr>
<td>- Provincial workshops</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Carry out joint problem solving</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish data elements that will monitor the change progress</td>
</tr>
<tr>
<td>Monitor progress through feedback reports</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ensure continuous communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure continuous communication from senior management via:</td>
</tr>
<tr>
<td>- Newsletter publications – from Districts, Provincial offices, &amp; NDOH</td>
</tr>
<tr>
<td>- Digital messaging – at Provincial, District, Sub District &amp; Clinics</td>
</tr>
<tr>
<td>- Posters</td>
</tr>
<tr>
<td>- Emailing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Celebrate successes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assign performance-based incentives for best performing facilities</td>
</tr>
</tbody>
</table>

Impact of ensuring change
- Improved staff attitude and thus patient experience
- Increased staff satisfaction, retention rates, attraction rates
- Compliance to dress code
- Transparency of organograms and job descriptions

SOURCE: Lab analysis
Employees are likely to go through the stages of personal change.

- **Shock**: "This can't be happening to me!"
- **Denial**: "This is so unfair!"
- **Frustration**: "I can't do this!"
- **Depression**: "I got this!"
- **Exploration**: "Maybe..."
- **Acceptance**: "Might not be so bad"
- **Commitment**: "I got this!"

## Process of change

### UNFREEZE

**What needs to change?**
- Survey the current status;
- Understand why it needs to happen;
- Ensure senior management buy in;
- Stakeholder analysis + stakeholder management and other key persons.

### CHANGE

**Create a need for change**
- Have a vision and strategy;
- Communicate to all stakeholders with reasons why?
- Describe the benefits;
- Prepare everybody for the change;
- Dispel rumors;
- Answer any problems;
- Deal with any problems;
- Empower and involve everybody in the team;
- Identified quick wins.

**Signs of excepting change**
- A stable organizational structure or chart;
- Consistent job descriptions;
- Communication strategy in place;
- Institutionalization of the changes;
- Synchronization of daily activities;
- Confidence and comfort with the changes;

### RE FREEZE

( the Kurt Lewin Model )

1. **Anchor the changes into organization culture**
   - Identifying what supported the change
   - Identify barriers to change;

2. **Ensure the buy in to leadership;**
   - Document progress;
   - Establish a feedback system in the organization;
   - Adapt the organizational structure if necessary;

3. **Provide support and training.**

4. **Establish M&E Tools to monitor the progress.**

5. **Celebrate the success.**

---

**SOURCE:** The Change management Model, Kurt Lewin

---

![Change Ahead Sign](image-url)
**Objective:** To provide coordinated training to keep health professionals abreast of the latest information, clinical updates, policy and soft skills for other health care workers

**Structure**
- One main Centre – Health Centre for Excellence- which will have a training facility
- Convert the Regional Training Centre’s into Center’s of Excellence for skills training (52- one in each district)

**Model**
- Capacity Building
- Dissemination of education
- Synergies with education institutions
- Research center

**Implementation**
- Building
- Education staff
- Resourcing the building with a library and other material (guide on storage and departments)

**Monitoring and Evaluation**
- Assess the needs and strengthen the surveillance
- Evaluate real life effectiveness of the training programs

**Owner**
- NDoH
- Department of education

**Key stakeholders identified:**
- DOH & (private sector BPM) (training needs ass)
- NGO’S (train with/without funding)
- Universities/DHET(standards/
- Private Provider
- SAQA (NLRD- national learner record data base)
- Quality councils (QCTO/ CHE)
- Syndication- IS/SD/FIN)

**Required resources**
- Investment (ZAR):

**Implementation timeframe**
- Start date: Jan 2015
- End Date: April 2016

**Key milestones**
- Mr. Cook and Ms. Mbane input
- Dr Carter to Present
- Confirmation of RTC center
- Evidence of the model

SOURCE: Lab analysis
**Current situation**
- No well-coordinated training institution or central center in the country targets the non-clinical training staff
- Staffing skills component not meeting the needs of the sector
- Currently we have limited number of health professionals graduating and joining Public Service
- Student intake specifically from rural areas are low and most do not complete their studies
- Fewer graduates joined Public Service beyond their community service period

**Situation with Health Academy**
- There is specialist institution in the country that houses programmes under one roof that targets at a range of clinical staff professionals and non clinical staff that particularly focus on addressing the countries disease burden and other immediate training shortage demands
  - Appropriately skilled staff
- Better service
- Improved productivity
- Efficiency and effectiveness
- Increased retention
- Improved public image

SOURCE: Lab analysis
Facility managers can use the performance management cycle to monitor the performance of their employees.

**Phase 1- Planning March/April**

- “What is the employee expected to do this year?”

**Phase 2: Coaching (Ongoing**

- “How well is the employee doing?”

**Phase 3: Reviewing (End March**

- “How well has the employee done now that it is year end?”

**Phase 4: Rewarding (April**

- “What recognition will the employee get for outstanding performance?”

Develop formal performance improvement plan together with the employee

Provide support and training if necessary

SOURCE: Lab analysis
Should poor performance be identified, they will be given the tools to address it

1. **Poor performance is identified**
   - Inform employee of poor performance
   - Formal performance improvement plan is developed and agreed with the employee

2. **Performance has improved**
   - Performance is reviewed as per the performance improvement Plan
   - Has performance improved

3. **Performance has improved, however further action is required**
   - Continue with Performance improvement interventions.

4. **Performance has not improved**
   - Initiate disciplinary action.

   - Performance is reviewed as per the performance improvement Plan

   - Has performance improved

   - YES
     - No further action is required. Resume the Performance management cycle
   - NO
     - Initiate disciplinary action.

**SOURCE:** Lab analysis
Despite a satisfaction increase, it is necessary to ensure a series of employee wellness measures to transform the PHC system into the employer of choice.

The set of proposed initiatives will have an impact on employee wellness overall.

The set of proposed initiatives will have an impact on employee wellness overall.

SOURCE: Western Cape Report, KZN report, National Core Standards
**Employee Wellness Programs**

**Objective:** Ensure that there is a management system in place to improve Employee Safety, Health and Wellness

<table>
<thead>
<tr>
<th>Develop management systems to improve employee safety, health and wellness with a view of ensuring job satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Steps</strong></td>
</tr>
<tr>
<td>▪ Conduct baseline staff satisfaction studies</td>
</tr>
<tr>
<td>▪ Determine the staffing requirements to implement Health and Wellness programs (psychologists, etc)</td>
</tr>
<tr>
<td>▪ Develop a strategy to improve staff satisfaction and employee morale</td>
</tr>
<tr>
<td>▪ Review DPSA policy framework on employee wellness</td>
</tr>
<tr>
<td>▪ Develop systems to improve workplace security and personal safety</td>
</tr>
<tr>
<td>▪ Introduce programs and systems to reduce the risk of contracting communicable diseases (e.g. TB)</td>
</tr>
<tr>
<td>▪ Re-launching a fitness campaign</td>
</tr>
</tbody>
</table>

**Owner:**
NDoH, Provincial Department of Health, District Management, Facility Managers

**Key stakeholders identified:**
- Organised Labour
- Professional Councils

**Required resources**
- Funding for proposed initiatives

**Implementation timeframe**
- Start date: 2015
- End Date: 2018

**Key milestones**
- Follow up on the staff satisfaction survey conducted in 2015

**SOURCE:** Lab analysis
Steps to roll out employee wellness programme

1. DPSA to issue directive on the implementation of EWP
2. Provinces to develop policies for EWP
3. Fund the EWP programme
4. Awareness campaign
5. Monitor and evaluate

SOURCE: Lab analysis
Contents

▪ Context and case for change
▪ Aspirations
▪ Issues and root causes
▪ **Solutions and Initiatives**
  – Initiative overview and prioritization
  – Initiative details
  – **Budget of prioritized initiatives**
  – 1,000 feet plans
## Detailed initiative budget – Human Resources for Health

Total additional budget, R thousands

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Redistribution of staff</td>
<td></td>
<td>R 4,280</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>R 4,280</td>
</tr>
<tr>
<td>3</td>
<td>Contracting clinical personnel</td>
<td></td>
<td>R 11,212</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>R 11,212</td>
<td></td>
<td></td>
<td>R 22,425</td>
</tr>
<tr>
<td>4</td>
<td>Ring fencing budget for non negotiables</td>
<td></td>
<td>R 6,243</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>R 6,243,100</td>
<td></td>
<td></td>
<td>R 12,486</td>
</tr>
<tr>
<td>5</td>
<td>Review community service policy</td>
<td>R 150</td>
<td>R 14,300</td>
<td>R 52</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>R 14,502</td>
</tr>
<tr>
<td>6</td>
<td>Bring back our workers campaign</td>
<td>R 62,060</td>
<td>R 48,120</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>R 18,144</td>
<td></td>
<td></td>
<td>R 128,324</td>
</tr>
<tr>
<td>7</td>
<td>Empower Managers</td>
<td>R 17,543</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>R 17,543</td>
</tr>
<tr>
<td>9</td>
<td>Upskill non-clinical staff</td>
<td>R 50</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>R 18,000</td>
<td></td>
<td></td>
<td>R 18,050</td>
</tr>
<tr>
<td></td>
<td>Filling the &quot;personnel gap&quot;</td>
<td>R 1,616,073</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>R 3,413,146</td>
<td></td>
<td></td>
<td>R 10,479,911</td>
</tr>
<tr>
<td></td>
<td></td>
<td>R 62,210</td>
<td>R 31,842</td>
<td>R 1,616,073</td>
<td>R 52,502</td>
<td>R 17,455</td>
<td>R 3,413,146</td>
<td>R 18,144</td>
<td>R 35,455,540</td>
<td>R 5,450,691</td>
<td>R 10,697,521</td>
</tr>
</tbody>
</table>

**Note:** Capex/Opex refers to Capital Expenditure/Operating Expenditure.
## Budget overview – Human Resources for Health

<table>
<thead>
<tr>
<th>Year</th>
<th>Personnel Opex/Capex</th>
<th>Training</th>
<th>Personnel</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015/16</td>
<td>1,710</td>
<td>32</td>
<td>1,616</td>
</tr>
<tr>
<td>2016/17</td>
<td>3,413</td>
<td>17</td>
<td>3,483</td>
</tr>
<tr>
<td>2017/18</td>
<td>5,451</td>
<td>35</td>
<td>5,504</td>
</tr>
</tbody>
</table>

**Total budget**

- **R million**: 10,480 (98.0%)
- **R million**: 133 (1.2%)
- **R million**: 85 (0.8%)
Contents

- Context and case for change
- Aspirations
- Issues and root causes

- **Solutions and Initiatives**
  - Initiative overview and prioritization
  - Initiative details
  - Budget of prioritized initiatives

- **1,000 feet plans**
Redistribution of employees from overstaffed to understaffed facilities

**Main activities**
- Implement WISN
- Measure of estimate for Staffing Need
- Consultation with affected employees and organized labor
- Determine the Staffing Needs per clinic (assess 3,507 facilities) according to WISN methodology
- Define and formulate the redistribution Policy with all stakeholders
- Mobilize the financial and material resources for human capital and infrastructure
- Engage stakeholders in redistribution/re-allocation of employees
- Coordinate and implement the policy with stakeholders

**Targets/milestones**
- Obtain clear understanding of the staffing needs within primary care level clinics
- Appointment of deputy managers
- Distribute the staff taking in account the ideal distribution of resources and in the smoother possible way

SOURCE: Lab analysis
**2 Streamline recruitment processes**

_1,000-feet plan_

**2015-2016**

- Develop a regulatory policy and framework to ensure quicker turnaround times and equitable processes
- Develop detailed recruitment plan with targets and align different areas within the HR department
- Head hunt through Professional Councils websites

**2016-2017**

- Build an online recruitment platform
- Advertise positions internally externally
- Implement e-technology for monitoring of pipeline volumes and enabling facility managers to have a say in recruitment issues

**2017-2018**

- Ensure and enforce continuous recruitment and appointment of incumbents within 3 months

**Main activities**

- Ensure basic utilization of e-technology enablement in the recruitment and appointment of personnel

**Targets/milestones**

- Ensure availability of e-technology infrastructure
- Ensure the utilisation of e-technology enablement in the recruitment and appointment of personnel

SOURCE: Lab analysis
3. Contracting GPs and other skills from the private sector

**Main activities**
- Assess the number of private GPs required and specific skill mix
- Optimize contracting guidelines (standardize fees, consultation hours) and syndicate with developmental partners
- Ensure completion and monitoring of pilot in NHI districts
- Evaluate pilot and incorporate findings onto contracting strategy
- Define and adapt contracting strategy based on pilot findings
- Assess the number of private professionals required per profession
- Engage with developmental partners to contract the required staff
- Recruit and contract local GP’s & pharmacists to be trained and employed in their home towns/local areas
- Leverage private sector resources on the remaining unsatisfied demand on primary care clinics
- Define attractive incentive packages to increase efficiency and secure coverage of rural areas

**Targets/milestones**
- Finish and evaluate first initiative pilot
- Roll out pilot to allied health professions
- Reduce the gap between offer and demand

SOURCE: Lab analysis
Ensure Funds for non-negotiable staff

Main activities

- Identify existing vacant posts in the clinics
- Where there are no vacant posts request for funding and creation; cost the filling of posts
- Request the budget from treasury for creation and filling
- Appoint the minimum for every clinic for the Support staff
- Determine the number of staff according to the WISN staffing norms

Targets/milestones

- Assure required budget for the long term implementation of the initiative
- Determine additional needs of personnel
- Ensure that 100% of the primary healthcare clinics have the minimum required staff to function adequately

SOURCE: Lab analysis
Community service

Main activities

- Review current policies on Community Service for all Health workers for the ideal clinic (SA)
- Review all International policies for health care workers required in the ideal clinic to benchmark aging them
- Establish a Community Service Policy Development Task Team
- Develop first draft policy on Community Service
- Consult internally (DOH) and externally (all other stakeholders)
- Develop final draft based on the consultation inputs from stakeholders.

Targets/milestones

- Cost the Draft Policy and develop the policy implementation and M&E tools
- Equitably distributed Health Workers on Community Service

Operational plan for the Community Service Policy developed and implemented

SOURCE: Lab analysis
# BringBackOurProfessionals

## 1,000 FEET PLAN

### #BringBackOurHealthWorkers

#### 2015-2016

- Launch of the #BringBackOurHealthWorkers campaign
- Partner with International Marketing Council
- Carry out an accurate, detailed analysis of the current situation and needs
- Refine mix of incentives based on determined needs (type and number of professionals and motivation of those professionals to leave)
- Start bringing professionals, quick wins to bring back professionals ASAP

#### 2016-2017

- Evaluate professional evolution, and define continuous goals for the team
- Define strategies for low penetrated segments

#### 2017-2018

- 2nd year evaluation to the professionals attracted

**SOURCE:** Lab analysis
Empower facility managers

Main activities

- Access key information from HST research
- Consider recommendations to be applied (DPSA)
- Approve organogram
- Access basic indicators and develop initiative’s baseline
- Appoint deputy facility managers in all clinics
- Develop adequate information systems that enable personnel to perform their functions correctly
- Create a forum for managers to share best practices
- Commitment within the lab to conclude the organogram/organizational structure at facility, sub district and district levels
- Follow-up existing facility managers to understand if proper training has been offered

Targets/milestones

- Training of 3,507 facility managers
- Ensure transmission of knowledge through deputy managers
- Secure continuous information flow
- Assess and train facility managers (continuously)

SOURCE: Lab analysis
2015-2016
- Review and revise current job descriptions
- Syndicate with unionized labour and reach consensus over new contracts
- Create title for “Job Deputy Manager” and related responsibilities (without creating additional post, “deputy facility manager is a title to ensure transfer of skills, not a function)

2016-2017
- Ensure that organograms in clinics countrywide have a skills mix that aligns with amended job profiles
- Monitor performance indicators

2017-2018
- Amendment and revision of all job profiles/functions
- 3,507 with upgraded job profiles

SOURCE: Lab analysis
Upskilling non clinical staff

Main activities

- Determine the target group and number (~31,600)
  - Non clinical service flow line staff from 3,507 clinics will include:
    - security guards
    - grounds men,
    - queue marshals
    - admin clerks
    - datacapturers
    - all other staff category levels ranging from level 1-5
- Identify training and estimated total cost
- Identify the service provider/s
- Enrolment of identified group

2015-2016

- Continuous monitoring of the application of customer care service principles through quality assurance processes. e.g customer care feedback tools
- Evaluation through self evaluation tests, focus groups, in-depth interviews etc,

2016-2017

- Continuous coaching and mentoring of the trained staff as per diseases burden and per clinic environment and set up needs

2017-2018

Targets/milestones

- Improved customer care, patient experience, image of the service points and health sector as a whole
- Maintenance of improved customer care
- Informed interventions

SOURCE: Lab analysis
Back-up
The Human Resources for Health workstream has addressed the following key questions:

<table>
<thead>
<tr>
<th>Key questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ How to quickly and effectively implement the WISN tool across the 3,507 clinics in order to optimize the staffing numbers and training needs?</td>
</tr>
<tr>
<td>▪ How to best utilize clinical associates in order to achieve optimal skill mix?</td>
</tr>
<tr>
<td>▪ How to ensure a sufficient supply of health professionals and prevent those in the pipeline from being lost to the South African health system? And how to best leverage private sector resources?</td>
</tr>
<tr>
<td>▪ How to ensure an equitable distribution and retention of clinicians in both rural and urban communities? And how to fast-track recruitment and ensure retention of non-clinical personnel in both rural and urban areas?</td>
</tr>
<tr>
<td>▪ How to empower facility managers to accurately identify skill gaps amongst employees and timely bridge them properly? How to empower district staff to optimize monitoring processes and planning?</td>
</tr>
<tr>
<td>▪ How to ensure that the roles and responsibilities of managers in both clinics and districts are clearly defined and uniform across the facilities? And how to ensure compliance to their tasks?</td>
</tr>
<tr>
<td>▪ How to build and sustain the required skills, in a timely manner, for all health workers to be able to properly perform their tasks?</td>
</tr>
<tr>
<td>▪ How to enable and train workers to properly deliver health services (e.g. all health workers with uniforms and name tags)?</td>
</tr>
<tr>
<td>▪ How to establish an effective framework to monitor and ensure a positive staff attitude? And how to ensure staff satisfaction?</td>
</tr>
<tr>
<td>▪ Determine whether to employ or outsource support services (security, cleaning, etc.) to ensure continuity of services. And how to ensure the effectiveness of the service from an HR perspective?</td>
</tr>
</tbody>
</table>

SOURCE: Lab analysis
Ideal Clinics will have 10 components which break down into 26 sub-components and 196 elements that detail the exact requirements

To qualify as an ideal clinic, a clinic must score 80% or higher in an OHSC inspection of these components

SOURCE: NDoH Ideal Clinic Status Realization Tool
To estimate the new service model demand, the 3,507 PHC have to be classified per their size and the service package delivered.

<table>
<thead>
<tr>
<th>Size (headcount)</th>
<th>Service package</th>
<th>Health Post</th>
<th>Mobile clinic</th>
<th>Satellite clinic</th>
<th>Clinic</th>
<th>CDC</th>
<th>CHC</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very small 8,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Small 8,001–40,000</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Medium 40,001–72,000</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Large 72,001–152,000</td>
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<td></td>
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<tr>
<td>Very large &gt; 152,001</td>
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<td></td>
</tr>
</tbody>
</table>

Total

SOURCE: Team analysis
### Organisation chart for each typology

**Cadre needed? – If so, how many HRH?**

<table>
<thead>
<tr>
<th>Clinical staff</th>
<th>Non Clinical</th>
<th>Core cadres</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Core cadres</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operational manager</td>
<td></td>
<td>Administrative officer</td>
</tr>
<tr>
<td>Professional nurse</td>
<td></td>
<td>Administrative clerk</td>
</tr>
<tr>
<td>Clinical associates</td>
<td></td>
<td>Data capturer</td>
</tr>
<tr>
<td>Staff nurse (Enrolled nurse)</td>
<td></td>
<td>Groundsman</td>
</tr>
<tr>
<td>Nursing assistant</td>
<td></td>
<td>Security guard</td>
</tr>
<tr>
<td>Dental therapist</td>
<td></td>
<td>Cleaner</td>
</tr>
<tr>
<td>Oral hygienist</td>
<td></td>
<td>Queue manager</td>
</tr>
<tr>
<td>Pharmacist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy assistants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy technician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lay counselors</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Visiting cadres</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health promoters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dieticians</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutritionist</td>
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<tr>
<td>Social worker</td>
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<td></td>
</tr>
<tr>
<td>Radiographer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physiotherapist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environmental health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist audio</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced midwife</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental assistant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lab (NHLS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical officer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Optometrist</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>