District Management Study

A National Summary Report

A review of structures, competencies and training interventions to strengthen district management in the national health system of South Africa

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We hope that the time invested by those mentioned above will be rewarded through experiencing change stemming from their involvement in the project and their sharing information about district health management in the country.

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Clarification of Terminology

In this study the terms District and Municipality (or Metro District and Metro Municipality) have been used to refer to and differentiate between the health delivery structures funded by and reporting to the provincial Department of Health and those funded by and reporting to the Local Government Municipal structures.

The term 'provincialisation' is used to describe the process of transferring Municipal clinics to the provincial structures following the National Health Council's 2005 resolution reversing the MinMec[1] 2001 decision that Primary Health Care (PHC) services would fall under Local Government.

Note: Quotations in italics in the text are verbatim records.

[1] MinMEC is now the National Health Council (NHC)

Acronyms

AD	Assistant Director
APH	Associated Psychiatric Hospitals
CEO	Chief Executive Officer
CHC	Community Health Centre
CSC	Corporate Service Centre
DD	Deputy Director
DHC	District Health Council
DHIS	District Health Information System
DHS	District Health System
DM	District Manager
DM	District Municipality
DMT	District Management Team
DoH	Department of Health
DPSA	Department of Public Service and Administration
EC	Eastern Cape Province
EHS	Environmental Health Services
EMRS	Emergency Medical Rescue Services
FGD	Focus Group Discussion
FS	Free State Province
GP	Gauteng Province
HR	Human Resources
HRM	Human Resource Management
IDP	Integrated Development Plan
IT	Intermediate Technology
KZN	KwaZulu Natal Province
LP	Limpopo Province
M&E	Monitoring and Evaluation
MC&WH	Mother, Child and Women's Health
MHS	Municipal Health Services
MinMEC	National Minister of Health and Members for Health of provincial Executive Councils
MP	Mpumalanga Province
MPH	Masters in Public Health
NC	Northern Cape Province
NDHSC	National District Health Systems Committee
NDoH	National Department of Health
NGO	Non-governmental Organisation
NW	North West Province
OSD	Occupational Specific Dispensation
PHC	Primary Health Care
PMDS	Performance Management and Development System
QRS	Quarterly Reporting System
RTC	Regional Training Centre
SAHR	South African Health Review
SCM	Supply Chain Management
SDI	Service Delivery Innovation
SLA	Service Level Agreement
SMS	Senior Management Services
STP	Service Transformation Plan
TB	Tuberculosis
UWC	University of the Western Cape
WC	Western Cape Province
WHO	World Health Organisation

Executive Summary

International evidence reveals that the lack of management capacity impacts on the ability of health systems to deliver effective health care. Information on managers and district management structures within the South African health system is, however, limited and this has prevented and inhibited managerial workforce planning, monitoring and development.

A national assessment of existing district management structures, competencies and current training programmes was undertaken in order to inform a national strategy and plan to strengthen district management capacity to ensure effective delivery of primary health care in South Africa. The study took place under the auspices of the national Department of Health's National District Health System Committee and was funded by Atlantic Philanthropies.

Phase One of the project (i) describes the district management establishment throughout South Africa, (ii) reviews competencies appropriate to district health management teams and (iii) reviews information on training and other capacity development initiatives targeted at district managers in order to develop a national database of training interventions and to make recommendations on training programmes.

Phase Two of the project is the implementation of a strengthening strategy. It is to be put out on tender in an independent process.

Recommendations are presented under each of the three sections, followed by a proposed strategy for implementing the recommendations to strengthen the district health system.

The strategy comprises five parts:
1. Recommital to the district health system
2. Establish criteria for a well-functioning district health system
3. Conduct initial (baseline) national evaluation
4. Conduct initial (baseline) evaluation for provinces
5. Support to provinces initiating District Health System strengthening initiatives

1. Introduction

International evidence reveals that the lack of management capacity impacts on the ability of health systems to deliver effective health care. Information on managers and district management structures within the South African health system is, however, limited and this has prevented and inhibited managerial workforce planning, monitoring and development. The last formal national evaluation of health management training was undertaken almost a decade ago and reported in the 1998 South Africa Health Review (Schaay et al., 1998).

The key competencies required by district managers were subsequently defined by the National Department of Health in 2002 (Asia, 2002). There has, however, been limited use of the competencies as a framework for developing training course content and with the proliferation of courses offered to health managers there is concern about both the content and quality of many of the courses. Currently there is a need to expand this body of knowledge in the areas of district structures and management competencies. The database of health management training opportunities also needs updating.

As part of Phase One of the study this project describes, firstly, the district management establishment throughout South Africa, both in terms of functional models of district management, as well as the number, levels and staffing of district management posts. Secondly, information on training and other capacity development initiatives targeted at district managers is reviewed in order to develop a national database of training interventions and to make recommendations on training programmes and capacity development needs.

Phase Two of the project is implementation of a strengthening strategy. This is separate from the current Phase One and will reportedly be put out on tender in an independent process.

This report presents the findings of the study that was conducted over a period of four months from April to July in the selected districts in the nine provinces.

2. Aim of study

The aim of the study is to undertake a national assessment of existing district management structures, competencies and current training programmes in order to inform a national strategy and plan to strengthen district management capacity to ensure effective delivery of primary health care in South Africa.

Objectives

- To conduct a rapid review of existing district management structures.
- To conduct a rapid review of required district management competencies.
- To assess training programmes and other interventions designed to strengthen district management competencies and performance.
- To facilitate the development of a national district management strengthening strategy for South Africa.

3. Methodology

The research type conducted is Health Systems Research. The study design was observational, descriptive and cross-sectional. It used qualitative research methodology to review current district management structures, capacity and training interventions. The assessment coverage of the study included all nine provinces in South Africa and two health districts per province were selected as the sample. The study population included district managers and district management teams from the two sample health districts in each province and the data was primarily collected by means of a Focus Group Discussion (FGD) with the District Management Team (DMT) in the one district and a face-to-face or telephonic interview with the District Manager (DM) in the other.

Selection criteria for sample districts required that the district must have a management structure in place. Through purposive sampling the metro district or, otherwise, the district surrounding the capital city or town was selected. Random sampling was, thereafter, used to identify the second district from those remaining or, where there is more than one metro district (as in Gauteng Province), to select one of the three.

The findings from both districts, once verified at district level, are combined into a provincial report. Individual district contributions to the provincial report are meant to be anonymous, although in practice recognition of the source is sometimes inevitable. The district reports, treated by the project researchers as confidential documents, are intended to provide useful material for subsequent district strengthening activities. The provincial report was improved and validated by all district managers and provincial role-players, either through direct feedback at a provincial report-back workshop or through written comments on a circulated draft report.

All provincial reports were summarised into a national report containing recommendations towards a national plan of action for strengthening district management. Work-shopping of the proposals is recommended to achieve an agreed national plan.

4. Data collection

The data collection methods for the study included:

1. A desktop review of district management structures and existing training programmes targeting district management teams.
2. A literature and document review of:
    - Existing national and international district management competency frameworks to inform the selection of proposed competencies to be reviewed in the study.
    - The development of the district management structure in the country.
3. Focus group discussions with district health management teams to review specific areas with respect to district structures, competencies and training interventions.
4. Completion of a competency rating scale by district management teams.
5. An interview with the District Manager from each sample district.

Qualitative data was analysed thematically while the quantitative data (obtained from the administration of the competency rating tool) was captured in Microsoft Excel and analysed.

5. Results

5.1 Structures

> In 1994 we joined the government with an explicit goal of developing a unified National Health System that is organised at national, provincial and local levels, with active participation of the private sector, NGOs and communities. Central to this goal is the development of a ***district health system***. A well-functioning national health system is built on a well integrated and co-ordinated district health system that brings quality and affordable comprehensive health care closer to communities.
>
> The establishment of the district health system ……. promises to bring numerous advantages …… (including) greater ability to meet the health care needs of communities; greater efficiency through decentralized management and the use of efficient management systems; greater participation and involvement by communities in their own health and health care; and intersectoral collaboration to ensure that such sectors as education, water and sanitation, safety and security impact positively on the health status of communities.
>
> The importance of this publication …. [lies] …. in the belief that effective managers are a fundamental part of reconstructing the South African health system and delivering better health care to all South Africans.
>
> Extracts from the Preface of the Handbook for District Managers (July 1998) by Dr O Shishana (Director-General, Dept of Health, Pretoria)

5.1.1 Effectiveness of current structure for delivery of district health services

The need for a district management team is based on the decision made by national government to establish health districts in line with legislation and functions in terms of the National Health Act. Health districts are aligned to the three tiers of government to fulfil their role and function in line with the delivery of health services within a defined geographic area.

Key aspects of district structure, extracted from the provincial reports, are presented per province in Table 1. Each provinces' issues are grouped in the following three themes – organisation/structure, implementation and effectiveness. The content of the table is discussed further in the structure's discussion section.

Table 1: Key aspects of district structure and organogrammes, both prior to re-structuring and the envisaged new structure.

Eastern Cape	Organisation/structure • Hospital Clusters were created to facilitate an envisaged regional management approach with a Cluster CEO reporting to province. These are currently being de-clustered. Some clusters fall across district boundaries. Level 1 hospitals in the clusters will report to their respective Districts after de-clustering. • Specialised hospitals (e.g. TB and psychiatry) only recently (1st Sept 2008) moved from central to district control. • Province has been tasked with de-complexing the existing three Hospital Complexes (created to comprise tertiary complexes but with the dual aim of serving as Centres for regional Coordination) because this not in line with national policy. • PHC provincialisation process not fully implemented in non-Metro districts while Metro district appears in limbo between national policy and political opinion. Ex-"homeland" districts did not have municipality-run health services. • A key change in Districts is the split between Clinical and Corporate services. Implementation • Restructuring generally at an advanced stage of implementation, except for the Metro District where process is delayed awaiting political decisions on position of Metros. • Some sections of the re-structured district organogramme (e.g. hospitals and IT) not yet finalised. • District Hospitals (Level 1) generally reporting to DMs. • Other hospital structures still transitional and delaying stabilisation of the District operation. • With de-clustering the need for a "District Hospital Services Manager" (responsibilities previously managed by Cluster CEO) has become apparent in the district organogramme. • Need expressed for Public Health Manager and Clinical Manager as part of district structure. • Financial budgets inadequate to set up new structure according to organogramme. • District budgets adjusted at Provincial level without consultation or notification. • Corporate Services Centres are in place in six of the seven Districts – the seventh being the Metro. Effectiveness • Limited District input into designing new organogrammes. • Envisaged organogramme perceived as having the potential to serve district operational needs but the current incomplete implementation does not support effective service delivery. • Urgent need for single health service (i.e. one responsible authority) in districts, especially Metro. In the interim SLAs should emphasise the DMs position of responsibility and authority. • Need for district functions to be aligned with provincial operations.

Free State	Organisation/structure • Previous regional structures have been dissolved in favour of a district approach. • Province in transition in a re-structuring programme – in essence districts still functioning according to "old" district structure. • Questions arise about how Province sees District Health Services – DHS and PHC identified as separate provincial entities in new organogramme. • District Hospitals now part of district structure – regional, specialised and academic hospitals report to provincial level. Implementation • "Macro-structure" (top management and provincial level) implemented but "micro-structure" (districts and lower levels) awaiting MEC approval. • Provincial DHS Manager post created and filled – this has facilitated district operations. • New district structure includes Level 12 posts to support District Manager – previously only Level 9 posts that are not permitted to deputise for level 13 posts. Effectiveness • Confidence in restructuring process waning due to financial realities of implementing the plans – no provision in current budget for envisaged new posts. • Districts were part of restructuring process and are positive about the structures. • Verticalisation of DHS and Programme structures results in disjuncture at district level – splits the reporting lines. • Envisaged Level 12 DMT posts will allow deputising for DM without calling on Hospital CEOs. Previous Level 9 posts could not deputise. • Concern about tendency to centralise towards district level at cost to sub-districts – this in contrast to early intentions of DHS. • Concern about lack of revised structure at facility level.
Gauteng	Organisation/structure • Province busy decentralising from three regional structures to six districts. • Envisaged organogramme structured broadly into Clinical Services and Corporate Services. • District Hospitals reporting within District structure. • Regional and Specialised Hospitals being moved out of Region/District organogramme. Implementation • Organogramme currently available at District-level is not yet implemented and there is no indication that it is the officially approved organogramme for the district management teams. • District Directors (aka District Managers) in four of the six districts serving in acting capacity which impacts negatively on management of the districts – in terms of both continuity and accountability. Effectiveness • General reaction to the new structures positive. • Concern over lack of administrative support staff for senior district management posts. • Centralisation of sub-district administrative functions to district level (in those cases where it has occurred) is not viewed favourably.

KwaZulu-Natal	Organisation/structure • Province busy re-structuring organisational arrangements and implementing new District organogrammes. • Level 1 (District) and Level 2 (Regional) Hospitals now report to District structures. • EMRS, Forensic Services, EHS and Port Health Services are provincialised. • PHC Services are run through the Hospitals and not by the District. Implementation • Current district organogrammes being reviewed by Province. • PHC organisation structures not yet finalised by province. • Lower post levels of Hospital structures not yet finalised. • Financial implications of implementing envisaged district structures are beyond current budgets. Some districts would also need infrastructure (e.g. office space) adjustments to accommodate expanded management team. • No Hospitals' Director post in Metro District. • Contracts' Management Unit and Public Relations Officer needed in larger districts, especially Metro. Effectiveness • Envisaged district structure viewed as more supportive of district service delivery. • DMT members fulfilling dual roles detracts from effectiveness and results in role confusion. • Detachment of EMRS, EHS and Forensic Services from district operations experienced as impacting negatively on coordination of district services. • Staffing levels not in keeping with workload in Metro District. • Little uniformity between post-related responsibilities and skills mix between district hospitals.

Limpopo	Organisation/structure • District organogramme was finalised in 2004 and is the one still in use. • Limpopo Province has a very flat district management structure, with the District Manager exercising as very wide span of control. • Management and support services are centralised at district level with minimal management structure at sub-district level. Implementation • Current operating structure has District Managers at Level 12 with Deputy Managers between levels 9 and 11. • Rural districts experience difficulty in filling posts due to rural nature of the area. • District operational structures are not aligned with provincial operational structures (e.g. a single district programme manager for MCWH – a priority programme - must link with five different provincial-level programme managers). Effectiveness • The flat district structure is not considered effective and a proposal has been submitted for a review. • Many managers appointed to management positions are largely involved at operational level due to high vacancy rates in the field. • Inadequate office space (district staff occupy offices in different locations) impacts negatively on health service delivery in at least one district. • The lack of sub-district management posts means that one manager is responsible for managing and supervising the entire sub-district. • District Programme Managers are attracted to provincial positions as there are no career-pathing opportunities at District-level.
Mpumalanga	Organisation/structure • Current Districts' organogramme has been in implementation for five years, although province is initiating a process to have it revised. Implementation • District Directors appointed at level 13 with Deputy Directors (DD) at levels 11 and 12, and Assistant Directors (AD) at level 9. • Hospital CEOs are also part of the DMT, together with the above. • PHC Coordinators (ADs) are currently managing sub-districts and reporting to District PHC Coordinator (DD). • Some districts experience inadequate office space. Effectiveness • District organogramme is not considered to be aligned to the diversity experienced in districts. • DMTs noted the urgent need for fully functional sub-district structures, proposals for which have been put forward for the new organogramme. • Districts' do not have the capacity to deal with the "*avalanche of information requests*" from province, often the same information being requested from different quarters (i.e. poorly coordinated information collection processes). • District admin support not demonstrating required skills. • Filling of posts takes a tremendously long time.

Northern Cape	Organisation/structure • District Health Services in Northern Cape includes the total platform of PHC and District Hospital services. • The current district management structure is not in line with the proposed organogramme. The envisaged structure is split between Clinical Management and Corporate Services, but this is not yet being implemented. Implementation • District Managers are appointed as Deputy Directors (Level 11). • Other DMT Members are appointed at Level 8 - so they do not have the qualifications or experience to deputise for the DM. DM has to do all the "thinking work". • Some DMT members serve in contract posts funded by outside institutions. • The current structure (organogrammes, job descriptions, delegations) are not considered adequate to fulfil district management needs. Effectiveness • Unfilled posts in at least one district (e.g. PHC Coordinator) impacts negatively on district service delivery and adds additional workload to the District Manager's portfolio since all programme managers' consequently report directly to him/her. • There are no financial managers appointed at district level and the resultant lack of financial delegations seriously impedes smooth operations in the district. • Expectations of high levels of responsibility from Level 8 appointments are unrealistic and do not allow the District Manager to apply meaningful delegation of duties. • Filling a multiplicity of posts (e.g. Hospital Manager and Professional Nurse) simultaneously does not allow for adequate servicing of the responsibilities.
North West	Organisation/structure • North West Province does not have exclusive provincial Health Legislation since the Health Department detached from the Social Development Department. Implementation • The new district organogramme appears to create disparities between the DMTs and the Hospitals, creating the impression that districts fall under hospitals, rather than the other way around. • The above is particularly applicable in sub-districts where the Sub-district Manager is a Level 11 and Hospital CEOs are Level 12. Hospital staff also appear to earn more after implementation of the Occupational Specific Dispensation (OSD. • Cases of inadequate staffing structure (e.g. three nurses to run five clinics) have resulted in closure of clinics and are negatively influencing the client's accessibility to the health services. Effectiveness • Cases of non-appointment of a district PHC Director has impacted negatively on leadership in the section. • A very high vacancy rate (54%) in the health department is being made worse by a provincial moratorium on appointments.

Western Cape	Organisation/structure • Western Cape's Service Transformation Plan (STP), known as Healthcare 2010, has been developed to guide health services improvement in the province. • Western Cape previously operated with four regional structures but is restructuring into a district-based system comprising the Metro and five "rural" districts. • The Metro Health District is divided into eight sub-districts, paired under four sub-structure offices. • District Hospitals (or Regional Hospitals where there are no District Hospitals) supply HRM support for PHC facilities (clinics and CHCs). • A new provincial Directorate: Nursing has been created. Implementation • Metro district currently has a Chief Director: Metro District Health Services and a Chief Director: Regional Hospitals, Associated Psychiatric Hospitals (APH) and Emergency Medical Services. • Each "rural" district has a District Manager (Level 13) responsible for PHC and District Hospital Services. • "Rural" districts have Sub-directorates for Comprehensive Health Services, Pharmaceutical Services, Professional Support, HR, Finance and Admin Support and Technical Support – the first five led by Deputy Directors. Effectiveness • Changes are expected in the Metro District due to the pending provincialisation of the municipality's PHC services. • There is no "rural" District equivalent of the provincial Directorate: Nursing, leading to communication anomalies and challenges for district management.

The role of Local Government in District Health Services has been a continually changing situation since the Constitution stipulated that Municipal Health Services will be a Local Government responsibility. In 2001 MinMec resolved that PHC would fall under Local Government. In 2005, the National Health Council resolved that PHC would be a Provincial responsibility, with Municipal Health Services (MHS) comprising only selected components of the Environmental Health package of services. In terms of the 2005 resolution, Municipal clinics were to be transferred under the provincial health structures, in a process known as 'provincialisation'.

Local Government remains Health's main linkage with the broader community, exercised through the District Health Council and Municipal Health Councillors. Local Government's Integrated Development Plans (IDPs) are intended as the channel for Health to coordinate its infrastructural and development needs with other government departments (such as Public Works, Water and Sanitation, Agriculture) in terms of cooperative governance. Table 2 gives a brief overview of the role of Local Government in DHS activities in the provinces. The content of the table is discussed further in the structures' Discussion section.

Table 2: Role of Local Government

EC	• Metro DM maintains an "accountability" linkage with District Health Council. • "Provincialisation" of PHC services partially completed in non-Metro districts but process "stuck" in Metro district. Not applicable in ex-homeland districts. • SLAs signed between Province and municipalities. DMs meant to be involved.
FS	• "Provincialisation" of PHC services completed. • Transfer of MHS responsibilities to municipalities completed technically but not necessarily working in practice. • Limited municipal involvement in DMT activities.
GP	• "Provincialisation" of PHC services completed in one district. No SLAs signed with Local Government in other districts. • Provincial and Municipal Environmental Health staff combine to deliver MHS.
KZN	• Municipal clinics have been assigned to Hospital supervision. Subsidies to municipal clinics have stopped because SLAs not yet signed. • MHS generally delivered by municipalities, although often supported by province. • Municipal health managers sometimes sit in on DMT meetings to report on operations.
LP	• One sample district reports limited interaction with Local Government. Intention to participate in IDP processes thwarted by poor communication. DM participates in Mayoral forum, District Managers forum and Municipality Managers forum.
MP	• Local Government does not play a significant role in the Health District. Districts participate in IDP process, but process seems poorly understood by role players.
NC	• Policy and a framework for decentralisation of district health services (excluding Level 1 hospitals) to local government was developed and endorsed by the Interim Provincial Health Council. This was never implemented with the change in approach to provincial control. • Some clinics are still managed by municipalities. • Municipal Health Services are delivered by municipalities. Non-MHS Environmental Health Services are still with municipalities, awaiting provincialisation. • Transfer payments for clinics and EHS are done directly between provincial health and municipalities. • Local Government is not represented at DMT meetings.
NW	• Process of provincialising municipal health facilities is at different stages in the province, although actual transfer appears to be on hold. Some clinics reported as still delivering according to the old preventative/curative division of services.
WC	• All municipal clinic services have been provincialised in the "non-metro" or "rural" districts. Only a few buildings still belong to the Municipalities. • The transfer of PHC services from the Metro municipality to the provincial health services is envisaged. • Efforts are made to alleviate problems caused by the split nature of the health services in the Metro district through collaboration at a district management level.

South Africa's public health services face tremendous challenges regarding human capital, with very high vacancy rates hampering service delivery. Questions arise about the impact of this phenomenon on the level of experience of those serving in the district management team. Table 3 reflects the number of years that Team members had served in a management position. The content of the table is discussed further in the structures' Discussion section.

Table 3: Years of service as members of the management team, as an indication of stability of staff complement

	Years of service as member of management team, expressed as a percentage of FGD participants			**Number of FGD participants**
	< 3 years	**3 – 10 years**	**> 10 years**	
EC	24%	48%	28%	21
FS	13%	56%	31%	16
GP	0%	60%	40%	10
KZN	11%	78%	11%	9
LP	29%	29%	42%	7
MP	50%	17%	33%	12
NC	0%	20%	80%	5
NW	Not collected			
WC	Not collected			
AVERAGE	18%	44%	38%	
Comment	• *"If you get people from the outside then they are here for a level and then get transferred to where they want to be".*			

DHS envisages "greater efficiency through decentralised management and the use of efficient management systems". The level of authority afforded a District Manager has a strong bearing on the DMs' ability to achieve this vision. The degree to which the DM is authorised to conduct the business of the district is therefore reflective of a province's commitment to the goal of decentralised management. Financial and HR delegations were investigated as a proxy measure of decentralisation. Table 4 reflects selected information per province regarding Financial and HR delegations. The content of the table is discussed further in the structures' Discussion section.

Table 4: Delegations of Authority and some district perceptions of the impact of varying delegations on service delivery

	Financial delegations	Human Resources (HR) delegations
EC	• DMs can now approve expenditure up to R1 million. • Some smaller items (e.g. S&T) still requiring provincial authorisation.	• Post advertisements currently approved centrally but will reportedly return to Districts next year (2009). • DMs can approve appointments up to Level 12. • Centralised management of posts, using consultants, proved a failure.
FS	• Hospital CEOs can authorise up to R1 million. • DMs can only authorise R200 000. • Overtime payments require provincial authorisation.	• HR delegations problematic for Districts. • Delegations differ between districts. • DMs can neither advertise posts nor appoint staff.
GP	• DM is permitted to sign for budgeted items, including items in the SCM processes. • Districts do not deal directly with finances.	• Acting DMs unable to approve appointments – resulting administrative delays sometimes leads to loss of good applicants.
KZN	• SCM delegation capped at R200 000 – experienced as very inhibiting to effective district management.	• DM has no control over institutional (Hospital) level appointments – regardless of budgetary constraints or overall district needs. • Above particularly problematic because appointments to specialised medical posts requires specialised assessment knowledge.
LP	• DMs financial delegations capped at R500 000 and Deputy Managers at R300 000. • Procurement transactions capped at R50 000 – above that requires provincial office to initiate a tender process. • Provincial office imposes *"limitations on using the budget"* even if delegation in place.	• DM authorised to employ staff, but requires provincial level approval. • Delays occur from provincial level in advertising and filling professional posts.
MP	• DMs financial delegations currently being reviewed. • DM currently authorise expenditure up to R100 000 and may delegate authority to other DMT members when absent.	• DM may appoint professional posts (to level 7) and non-professional posts (to level 6) but may not approve advertising these posts – this limits effective district management. • Districts have been instructed to *"hold on"* regarding implementing their HR delegations.

	Financial delegations	Human Resources (HR) delegations
NC	• Lack of delegation of authority makes it difficult to manage the district effectively. • Some DMs' authority capped at R5 000, others may not authorise any expenditure at all. • All payments made from provincial office, although paper work processed at district office. • All SCM procurements done at provincial level. • Province has the final input on district budgets.	• No delegation of authority for District level appointments. • Recruitment process very lengthy – taking up to six months to make appointments.
NW	• DMTs financial delegation is R200 000.	• No HR delegations to the DMT.
WC	• DMs can approve payments up to R500 000. • Procurement of equipment done in district through district bid committee. • DMs delegate certain responsibilities to DMT members. Formal letters of delegation exist.	• All HR issues are handled at district level – very few things have to be sent to Province.

Districts are merely a cog in the wheel of the Nation Health System, albeit an important cog with regard to PHC services. Just as facilities and sub-districts are dependant on the support of districts to be able to deliver services, so too is district dependent on the support of the various provincial structures for support, guidance and resources. Table 5 presents selected perceptions collected at district level of the perceived level of provincial support. The content of the table is discussed further in the structure's Discussion section.

Table 5: District perceptions of provincial level support

	Provincial support
EC	• Problems experienced with communication and feedback. Policies and guidelines one example. Unilateral decisions which are not communicated to districts are another. • Regular visits and support in problem-solving seen as desirable. • Inadequate coordination of Health Programme leaders' visits creates problems.
FS	• Newly created provincial DHS Manager's post promises positive results and is delivering. • Support staff for above post has, however, not been catered for. • Support to districts mainly through quarterly meetings where performance checked against QRS. • Only those programmes with indicators in QRS get joint attention from DHS and Programmes, unless something goes wrong. This can be seen as "a cost of measuring". • Disjuncture between DHS and Programmes impacts negatively on District management.
GP	• DMs meet monthly to discuss progress and related issues. They feel supported by their direct line management – *"Support is available if needed where there are tricky decisions to be made."* • Overall support from above was, however, viewed somewhat differently in some quarters. • From a systems perspective, good support from above was noted in financial matters but problems are sometimes experienced n the HR field.
KZN	• Adequate support reported from Area Office teams, including Technical Advisors. • More support desirable from support functions (HR, finance, legal services)
LP	• Districts report enjoying the necessary support from provincial office on both management and programme levels. • Problems experienced, however, with support from provincial Corporate Services, especially in advertising and filling posts – critical for effective district functioning.
MP	• Districts experience limited overall leadership and strategic direction from province – there is a need for coordinated leadership and greater role clarification. • Numerous, un-coordinated demands being made from various provincial directorates. • Lack of feedback on quarterly PMDS reports is discouraging.
NC	• DMT members feel isolated and not supported by Province. • General view is that Province is following a crisis management approach.
NW	• Districts are not feeling supported by Province. Felt that provincial (macro) posts are filled while district vacancies exist.
WC	• Provincial support to districts improved over last few years and districts experience that provincial staff always willing to support when needed. • After strengthening of provincial office sectors provincial staff (e.g. finance and HR) visit districts on a regular basis to provide support. • Districts feel a need to provide similar support within districts but are limited by insufficient staff.

5.1.2 Discussion

The overall impression in many of the provinces, although there are exceptions, is that of health districts in transitional states of development/restructuring with organogrammes partly implemented but simultaneously being reviewed, struggling to deliver health services. Also evident are groups and individuals displaying remarkable commitment and tenacity, often against tremendous odds, in an effort to deliver the best possible services despite the challenges being experienced on the ground.

"If it wasn't for the commitment and loyalty of the team the services would have fallen flat a long time ago."

While commitment and loyalty are admirable qualities and are to be promoted and nurtured, they should be "add-ons" in the system contributing toward the achievement of excellence, not be the cement that is currently holding together a severely challenged system. Burn-out follows too closely on the heels of over-extended commitment and loyalty.

There is reason to believe that, given an "enabling environment", these "pockets of excellence" or sites of best practice would serve as the examples necessary to lead the way towards the change needed to return DHS to its perceived heights of earlier years. Renewed energy and opportunity for creativity are needed to bring about the required change. "More of the same" is unlikely to be the catalyst.

"District has good human capacity but needs to be "GIVEN THE WINGS""

Leadership and management appear to be key factors in bringing about change in the service delivery via the district health system. More often than not policies, procedures and systems are in place to support reasonable service delivery – but implementation is lacking! A strong message coming through points to the advantage of first strengthening what there is to maximise effectiveness, within the current resource constraints, before adopting ad hoc initiatives – frequently suggested from "outside" and resulting in uncoordinated and unsustainable activities. Strengthening leadership and management requires a clear idea of what must be done and what competencies (knowledge, shills, behaviour and aptitudes) are required to get it done. It is often in the difference between the expected abilities and the actual (what is commonly referred to as the "competency gap") that explanations for the shortcomings in our health systems must be sought – and often found!

In an insightful article about closing the management competence gap, Filerman (2003) emphasises that the core competencies essential for managerial positions are not the same as public health competencies necessary for programme planning and evaluation, or for good clinical practice in the community. He continues by acknowledging that general management n competence and public health competence are both essential and they are complimentary, but they should not be confused. He adds that has been shown over and over again that public health competence without a firm foundation of management skills does not produce successful results. This issue is given more attention in the Competencies section of this report.

This discussion on DHS "structures" continues below by looking at whether South Africa has a common and shared vision of district health services and then investigates how the current re-structuring is progressing in the nine provinces. The adequacy and effective utilisation of resources (financial, human and physical) are considered, followed by some thoughts on constraints being experienced by districts generally and metros in particular. District interaction

with Local Government is considered briefly, followed by a reflection on experiences of provincial support at district level. Finally, specific consideration is given to the important issues of leadership and management.

District Health Services – what does this mean?

Anecdotal evidence together with concerns expressed at senior levels suggest that district health services were developing strongly in South Africa in the late 1990s but that, more recently, this momentum has been lost. If true, understanding this phenomenon can inform strategies to strengthen district management. The first question, however, is whether the country has a shared common vision of DHS?

Simple definitions provided by Harrison (1997) for a "district health system" and a "health district" state that: -

A district health system is *the vehicle for providing quality primary health care* to everyone in a defined geographical area. It is a system of health care in which individuals, communities and all health care providers of the area participate together in improving their own health.

A health district is a well-defined part of a province in which:
- primary health care (PHC) is delivered to *all* the people in the area
- *one* healthy authority is responsible for PHC, including community-based services, clinics and district hospitals
- decisions about health care for that district are made by that district's health authority and not at a higher level of the health department
- communities have a real say over their own health care.

A more complex (and complete) definition developed in 1986 by WHO's Global Programme Committee and which formed the basis of the vision and early policy documents for the health service in a post-1994 South Africa (Hall, 2004) reads:

> "A **district health system** based on **primary health care** is a more or less self-contained **segment of the national health system**. It comprises first and foremost a **well-defined population, living within a clearly delineated administrative and geographic area**, whether urban or rural. It **includes all institutions and individuals providing health care** in the district, whether governmental, private, or traditional. A district health system therefore **consists of a large variety of interrelated elements** that contribute to health in homes, schools, workplaces, and communities, through health and other related sectors. It **includes self-care and all health workers and facilities up to and including the hospital at first referral level and appropriate laboratory, other diagnostic and logistic support services**. Its component **elements need to be well coordinated by an officer assigned to this function** in order to draw together all these elements and institutions into a fully comprehensive range of promotive, preventive, curative and rehabilitative health activities."

The autonomy afforded provincial Departments of Health creates the conditions for different interpretations of what comprises a district health system and what structures and mechanisms are best suited for implementation thereof. Marked variations in provincial and district DHS structures have emerged, this predictably so as many variations are in response to different and unique province-specific situations on the ground. On the other hand, there appears to have been a paucity of guidance and leadership from a national level to ensure similar direction where differences are not dictated by local conditions and situation. For example, it appears that

aspects of the very concept of DHS are differently understood in Free State province where DHS and PHC operate as independent sections at provincial level. It is the national DoH's responsibility to continually espouse the vision and monitor that provincial implementation is in keeping with this vision.

In most of the provinces district (Level 1) hospitals appear to have been included within the DHS structure. In KwaZulu Natal (KZN) regional (Level 2) hospitals have been included in the district structure as well. In Eastern Cape (EC) specialised hospitals (TB, Psychiatry) have been moved into the districts as from 1st September 2008. In other provinces specialised hospitals are centrally controlled. In the EC hospitals are being de-clustered while hospital clusters remain in Free State (FS).

In all provinces, except KwaZulu Natal, PHC structures appear to fall directly under the district office. In the latter, however, clinics and community health centres still fall under a "mother" hospital, not the district - a widespread practice of the past. Since the PHC organogramme is not yet finalised in KZN province, this might still change in the future. In the Western Cape (WC) clinics and CHCs received HRM support from hospitals in the district.

Restructuring – nearing completion?

Most provinces appear to be in the process of re-structuring their district health services. A key feature of the process is the separation of clinical services from corporate services, ostensibly to release health clinicians to do the work they are trained to do, by creating an independent Corporate Services Section in the organogramme to handle the corporate activities. The restructuring also appears to be aimed at creating the structural requirements (in terms of posts and establishing a functional district management team) of implementing the vision of a decentralised District Health System. Some might argue that restructuring is creating top-heaviness in the organisation while others feel that this is merely normalising a management level that has become increasingly depleted over time. The answer probably lies somewhere between the two. Mpumalanga and Limpopo provinces do not appear to be following this route but both appear to be contemplating or planning a revision.

The overall picture of DHS restructuring in the country is one of "work in progress" (as per table 6 below), with partial implementation or the organogrammes, parts of the organogrammes still under development and other parts already being reviewed. Although there is widely held opinion that the envisaged organogrammes hold promise for effective district health services delivery, concerns were expressed on a number of occasions that the financial implications of the envisaged restructuring far outstrips the current budgets. Confidence in the long-term outcome is therefore often diminishing or lacking.

Table 6: Summary per province of progress concerning DHS restructuring

	State of re-structuring districts in the province
EC	Advanced stage, except in Metro. Hospital de-clustering and de-complexing in progress, which is delaying restructuring process. Funding constraints reported.
FS	Macro-structure implemented, micro-structure awaiting MEC acceptance. Funding constraints.
GP	District organogramme not yet approved. Four of six DMs are in acting positions.
KZN	Restructuring in progress. District organogrammes being reviewed by Province. PHC structures not yet finalised. Funding constraints.
LP	The 2004 District organogramme is still in use. Proposals for changes have been submitted.
MP	District organogramme implemented for five years, but due to be revised.
NC	Proposed organogramme not yet implemented. Districts do not consider this to be adequate for managing the districts.
NW	Restructuring in progress. Structure sometimes not funded or approved.
WC	Restructuring in progress from four regions to Metro and five "rural" districts.

An interesting observation from a senior provincial official suggests that *"….this restructuring has set the Department back 20 years."* The particular province has suffered repeated changes in higher level leadership, including loosing the will-carriers behind the restructuring concept and intention. This scenario is, in fact, oft repeated in different provinces and offers another insight into the apparent deterioration of district health services. Measures to promote and enhance stability in the workforce, as well as to retain institutional knowledge, are thus imperative when considering strengthening of the DHS.

Resources – how far can you split the cake?

As mentioned above, new district organogrammes often represent an ideal situation where the cost of implementation and the creation of the new posts outstrips the available resources. Do the plans represent the creation of a top-heavy structure or are they only normalising a situation of inadequate management capacity that has developed unchecked over the years?

Decentralising and the establishment of a DHS is going to require an expanded layer of middle management at District level to manage the district. This has financial implications. If budgets are not adjusted to enable the necessary appointments then DHS will remain a "pie in the sky" and service delivery will be negatively affected by their operating in a "suspended" situation regarding district organisational structure.

Apart from key district management appointments not being made and people acting in posts for extended periods, some districts have very high vacancy rates (e.g. 54%) at all levels and are being made worse by a provincial moratorium on appointments due to financial constraints. In this same province inadequate staffing (e.g. three nurses to run five clinics) has resulted in closure of clinics with the resultant negative impact on the clients' accessibility to health care services.

District management teams are comprised of long serving health officials (see table 3) with almost 40% having served in management positions longer than ten years and more than 40%

having served between three and ten years. A notable exception to the trend is Mpumalanga Province (MP) in which half the officials participating in the FGD had less than 3 years service in a management position, while Limpopo Province (LP) and Eastern Cape were also above the rest. On the other side of the continuum, KwaZulu Natal had a comparatively low proportion (11%) of participants with more than 10 years service while the Northern Cape had an exceptionally high proportion (80%). The latter case is interesting as these staff members appear to face greater challenges than most in delivering the services.

Closely linked to resources, their availability and their usage are the delegations regulating their management. Notable differences exist between provinces in both financial delegations and human resources (HR) delegations. In financial delegations, the maximum amounts that district managers' may authorise varies between provinces between R1 million (Eastern Cape) and R5 000 (Northern Cape). Limpopo Province and Western Cape district managers are capped at R500 000, while others are R200 000 and R100 000. Interesting in the Free State is that Hospital CEOs are capped at R1 million while DMs are capped at R200 000. In the Western Cape procurement is permitted through a district bid committee, while in other provinces other limitations in financial management exist that are perceived as inhibiting district management. Possibly of historic origin are relatively minor items such as overtime and S&T that still have to be authorised at provincial level in some provinces.

Although exceptionally important, financial management has not been given much airing in this report although it arose in many of the FGDs and interviews. One aspect of concern is that wide-ranging changes are made in provinces but budgets are not adjusted to accommodate these changes – examples being the provincial/district restructuring, the devolution of staff in municipal clinics to province and the provisions of the Occupational Specific Dispensation.

HR delegations are generally subject to marked restrictions at district level, Western Cape again being the exception where *"all HR issues are handled at district level – very few things have to be sent to Province"*. These limitations were frequently cited as barriers to effective district management, especially since protracted delays are frequently experienced in HR processes – sometimes up to six months. The frustration can be felt in the three extracts from district reports below. This is an area which would probably gain considerably from focused interventions.

> *"DMs can't appoint staff (not even cleaners), nor can they advertise posts. This has to be authorised at Executive Manager level. As it is, the appointment letters are prepared and signed by Level 5 Clerks, so it appears ironic that it must be a L5 Clerk in the Provincial office and not a L5 Clerk the District office. This lack of HR delegations leads to unacceptable delays – a staff selection document recently approved at district level is still not signed by the higher authorities six weeks later."*
>
> *"….. it sometimes leads to losing potential staff members due to the long period between application and appointment (i.e. applicants apply, are interviewed and selected but by the time the appointment letter is processed they have already found another job)."*
>
> *"A lack of delegation makes it very difficult to appoint staff. The recruitment process is very lengthy and it can take up to 6 months to appoint someone."*

Districts and sub-districts

Major differences between provinces are apparent in organisational structures relating to sub-districts. In some provinces (LP and MP are examples) there is minimal management capacity at sub-district level and no sub-district management teams – management is centralised at district

level. Most other provinces have sub-district management structures of varying capacities, although generally with centralised control vested in the District.

Reflection on possible reasons for the apparent demise of the previously vibrant DHS "movement" raises the weakening of the sub-district as a possibly major cause. Before the December 2000 municipal demarcations the current sub-districts were operating as districts and the current districts were more-or-less aligned with regional structures. Previously the health districts numbered in excess of 200 but now there are only 53, including the 6 metro and the 47 non-metro (or rural) districts. The extent of control has therefore expanded greatly and the district population is generally in excess, in some cases almost four times, of the WHO recommendation that health district populations be in the region of 250 000 to 500 000 but not exceeding 500 000. Table 7 reflects the number of districts within the recommended population size and those exceeding it and by how much. This change, made to align the health districts with the local government district boundaries, has a major impact on the scope of control and the degree of interaction possible for current health district leaders – the "personal touch" can be said to have been lost in the consolidation process. Further investigations comparing variables such as population size, population density and geographic size with the effectiveness of district management would undoubtedly be of benefit.

Table 7: Health district population size, in categories related to and exceeding WHO recommendation

	Categories of health districts' population size					**Metros**
	< 250 000	**250 000 – 500 000**	**500 000 – 1 000 000**	**1 000 000 – 1 500 000**	**1 500 000 – 2 000 000**	
No. of districts	8	8	21	6	3	6
% of districts	17,4%	17,4%	45,7%	13,0%	3%	

Notes:

1. Data from SAHR 2006/07, with cross-border districts combined with "mother" districts
2. Only 46 non-metro districts appear.
3. Actual district data reflected in Appendix 1

Metro and Non-metro districts

Metros are markedly different from the other districts, emphasising the fact that any planning for district management structures should take these differences into account as the "one size fits all" approach is not appropriate for effective service delivery. Apart from their differences in population size and the number of institutions, their relationship with Local Government brings unique realities. The split nature of the health services in these districts creates problems but efforts are made to alleviate this through collaboration at a district management level.

There appears to be somewhat of a hiatus around the provincialisation of the PHC services in Metros, this reportedly due to delays on national and provincial decision making, apparently at a political level. The question is reportedly being discussed at a national level, but since nothing is heard or read about these talks it appears that either communication is poor or nothing is happening.

The incomplete implementation of the "provincial" structure and staff and the split service delivery between two authorities is impacting negatively on Metro District's ability to maintain a satisfactory level of health services for the community, underlining the importance of creating a single health structure for Metro Districts. It was even suggested in some quarters that provincial

health services in the Metro should be integrated into the municipal structure for ease of management, but legislation does not facilitate such a move.

Another issue relevant to the often encountered "one size fits all" approach (although wider than metros alone) is the determination of district funding allocations based on population numbers and the assessment of district efficiency based on cost per patient. Although an obvious starting point and acceptable for profit-based initiatives, these measures are highly questionable in a public health situation. Simple economies of scale suggest that the per capita cost of delivering public health services in a remote area with a highly dispersed population will be far greater than in a densely populated area. This might, in fact, go part way to explaining the unusually challenging situation that the Northern Cape's district health system appears to experience. In a report on a systematic literature review of innovative models of comprehensive primary health care in rural and remote Australia (Wakerman et al., 2008) it was interesting to note that five different modes of operation have evolved to serve the rural and remote areas. The various models are influenced largely by population densities and are able to address diseconomies of scale which result from large distances and small, dispersed populations. This issue would appear to require further research so as to ensure that unfair funding handicaps are not brought in against already challenged service delivery situations.

District's interaction with Local Government

The Constitution, the National Health Act and other legislation (e.g. Municipal Acts) envisage close interaction between state departments in a cooperative governance model. This is relevant for Health Departments and Local Government. Key areas of involvement are the "provincialisation" of municipal clinics and the operational unscrambling of Environmental Health Services between those classified as Municipal Health Services and those remaining with provinces. Progress in these developments varies considerably between provinces. SLAs are meant to be signed but it would seem that they seldom are – with subsidies not being paid over because the SLAs are not signed. SLAs, when signed, are often between province and a municipality, whereas it's the district manager that has to handle interactions on the ground. Municipal Health Managers sometimes play a role in District Management Teams, but this was seldom reported as successful.

A key area of interaction is the Integrated Development Plan (IDP) from which coordination of services affecting the community is meant to take place. The IDP is also meant to serve as the forum for coordinated inputs between the different state Departments. Although ideal in theory, practice does not seem to be as envisaged. Districts generally reported that although they have tried to interact in and through this forum, administrative ineptitude and role players not knowing their roles have made it less than satisfactory.

Provincial support – a key factor

No district operates (or should operate) in a vacuum. Provincial support is crucial and critical to promote smooth operations at district level. Guidance is often required in tricky decisions and support needed when sensitive decisions have been made. Provincial players are more exposed to the wider situation and must orientate district players in terms of provincial and national developments.

The picture painted in terms of the findings listed in Table 5 suggests another area that would benefit from focused inputs. In five of the nine provinces district management teams indicated feeling supported by their provincial structures to which they report directly and four felt

unsupported. In at least three cases teams expressed concern about inadequate support from the Corporate or support services sections at provincial level.

Two extracts from district/provincial reports illustrate this issue of support from above, but from opposite perspectives:

> "Provincial support to districts improved over last few years and districts experience that provincial staff always willing to support when needed. After strengthening of provincial office sectors provincial staff (e.g. finance and HR) visit districts on a regular basis to provide support. Districts feel a need to provide similar support within districts but are limited by insufficient staff".
>
> "The District members naturally look to the DM for support, but *"How do I support people when I'm so disillusioned? I'm not getting any support, so how on earth do I support others"*.

Leadership – both the dynamo and the support

The success of a team is highly reliant on good leadership. Unity of purpose as reflected in adoption of and commitment to a set of goals is a product of good leadership. Creating an environment in which innovation and creativity are encouraged and valued is another.

Some extracts from Focus Group Discussion reports emphasises the importance of leadership:

- A skill that is also critical for the public service is "context shifting" (i.e. the ability to think out of the box). The ability to shift context however needs a driven leader with vision and passion. *"People need to get out of their comfortable zones, to function in different arena altogether, where they can view things in a new manner where it is possible to do things"*. This skill was highlighted as being integral for implementing the new district structure.
- *"We require a mindset of change in line with the transformation process that is taking place externally"*.

It is leaders who display visionary qualities, who function proactively, and who create the confidence in their team members to believe that things can be done differently and that change is possible who will "grease the wheels" towards successful DHS implementation. Good leadership will promote an enabling environment which is crucial to releasing the creative energy latent in many DHS managers and which is essential to meeting the challenges within the current resource-constrained service delivery environment. Reflect, for instance, on the spirit of hope that the interim Health Minister, Ms Barbara Hogan, has brought to the health-related workplace.

A few examples from provincial reports of poor or an absence of leadership illustrate the cost, both direct and indirect, of this.

- Sensitive decisions made and enacted in the District are sometimes refuted or reversed from Provincial level. Such actions undermine the DM's authority and discourage definite actions in the future, even when such actions are necessary for the well-being of the District.

Case Study : Who pays the rent?

The staff and patients of a certain clinic arrived one morning to find the clinic doors chained and the landlord refusing them access. Investigations revealed that the rent, originally paid by the Department of Public Works and then taken over by the Department of Health, had not been paid for three months. Further investigation revealed that, after a year or so of the latter arrangement, DoH had decided that the rent should henceforth be paid by the District. The District Manager was not informed of this decision and no provision was made for the additional financial outlay.

The District Manager, in an effort to resolve the situation, completed the paperwork for an irregular payment (despite the personal negative connotations normally associated with these), but was unable to settle the accumulated debt within reasonable time. The outcome was that the clinic had to vacate the premises and ended up sharing premises with another clinic in the area.

- Districts indicated that the lack of feedback from provincial level on the quarterly PMDS reports that are submitted is particularly discouraging. There is uncertainty as to whether the quarterly PMDS documents are read and engaged with as no attempts are made from provincial level to discuss these reports. "*I know what I am doing, I know the tremendous workload that I do and I know the quality of my work, but the lack of feedback is really frustrating. If you walk the extra mile then you expect something extra and the non-response is very de-motivating".*

Added to the above is the regularly reported situation that requests, motivations, issues and problems are submitted upwards but without response. Good leadership does not permit this to happen.
On the other hand, leadership qualities are evident in this case study showing a willingness to find innovative solutions to challenges being experienced:

Case study: Maintaining rural health services

Current government position is that rural areas must enjoy the same health services as urban areas. This would suggest that rural areas and the farms should be visited on a two-weekly basis. In 1996/9 the necessary resources were made available to manage the district. The District then had 23 mobile clinics and mobile points could be visited monthly. There were the resources to buy new mobiles if necessary. Now there are only 13 mobile clinics operating in the District, resulting in visits limited to every six to eight weeks. Diabetics and hypertensives can only be checked after long intervals. They are warned to come to the clinic if they experience blurred vision, but how are they to get there unless the farmer is going to town.

"If it's not possible to get mobile clinics then at least get small vehicles and arrangements can be made with the farmers for empty rooms which can be used as satellite clinics".

The National Department of Health's District Development Cluster has a critical role to play in creating and espousing the DHS vision. They must carry out their monitoring role and ensure that everything is on track. Guidance needs to be offered if different interpretations of DHS emerge. Just as districts seek support from provincial level, so too can national expect and plan to offer support to provinces.

Management abilities – strengthening the DMT

Although an important aspect of this project is identifying suitable training opportunities to strengthen management, due consideration needs to be given to the oft-quoted view that training is wasted if the environment does not allow for is use and implementation. There are cases where health officials can be considered as over-trained, yet they are still not delivering according to expectation. Attitude and behaviour have a strong influence on productivity, as also de-motivating factors within the work environment. In strengthening DHS management leaders are encouraged to ensure that the factors inhibiting self-motivated delivery are minimised before turning to training as the "panacea for all ills"!

Management and leadership are closely aligned. It is unlikely that most of the undesirable examples presented in the previous section would have occurred if sound management practices were in place. Similarly, good leadership should ensure that the necessary management practices are in place.

Senior and top management are often the cause of disruptions to organised delivery at the lower levels. *"[The] top level [of] management creates Crisis Management [at a district level]"* through, for example, ad hoc calling of meetings and sending down last minutes demands which totally disrupt the flow of things in the District. Although crises will and do occur which will require unplanned actions, *ad hoc*'ism is frequently the result of inadequate planning and should be the exception, rather than the rule. More often than not, ad hoc'ism reflects poor management somewhere in the chain of command.

District Management Teams, as with other management teams at lower and higher levels, must display a clear vision of what they intend to do and must demonstrate adequate planning, monitoring and evaluation to ensure the highest chance of meeting their goals.

District Management teams are faced with many challenges, often requiring innovative responses to resolve them. A challenge raised in more than one province was that of provincial and district structures not being aligned. For example, one province's Maternal, Child and Women's Health programme, which is a priority programme, is managed by one person at district level (i.e. Deputy Manager) but at provincial level it is managed by 5 Programme Managers.

> "New structures have to be aligned with each other. "*It seems like Province sometimes forget that when they make changes at that level, they also need to make the same changes at district level."*

Another factor influencing a DMT's effectiveness is the distribution of post levels within the team. Where a big gap occurs between the District Manager and the next level of managers (e.g. from Level 11 to level 8, as in the case of the Northern Cape) there is no one available to deputise for the DM. This prevents the DM from meaningfully delegating duties. Level 8 employees also do not have the qualifications or the experience necessary top lead and so all the "thinking work" is incumbent on the DM.

The challenge of keeping trained staff is another area for DMT attention. This is especially important where moratoria on new appointments means a resignation can lead to depletion of the team for a possibly extended period.

One unresolved area of management in district service delivery is that of "dual reporting" – as in the case where, for coordination and supervision purposes, a district service provider reports within the district but for technical support and guidance the services of a supervisor or mentor

outside of the district is desirable. Innovation and creative thinking must surely find a solution to this dilemma. Creating vertical programmes, thereby moving the locus of control outside the district, can be costly to the district team. Does the answer lie in inter-sector (e.g. sub-districts or districts) technical support meetings to promote intra-group professional development and joint problem solving with support and guidance of the next level technical expert. An example could be the programme meetings of provincial representatives with the national programme manager.

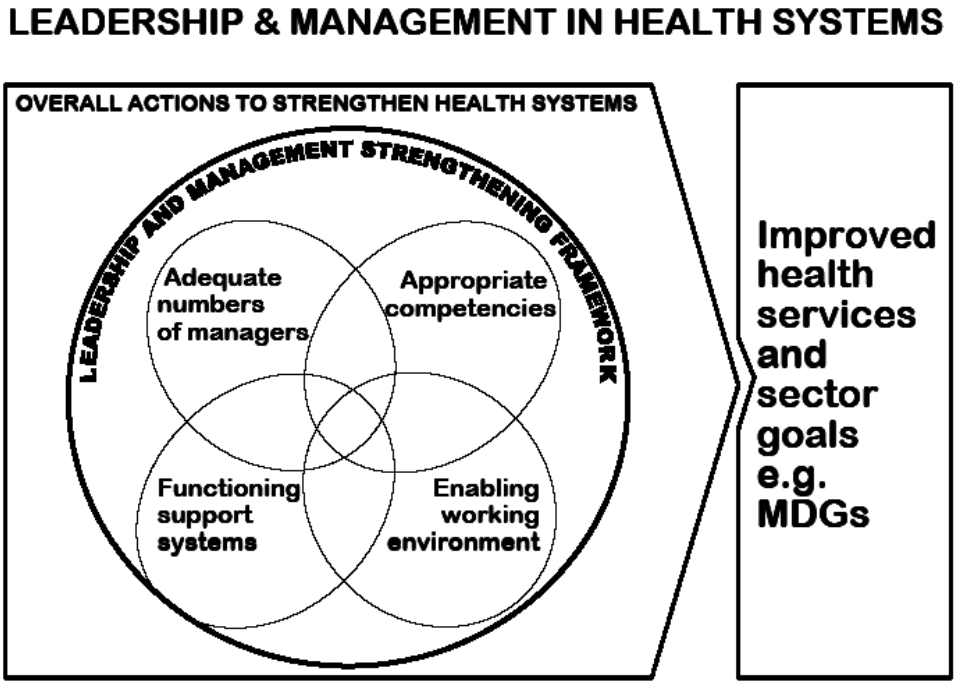
A possible approach for moving forward

The role of Leadership and Management in health district management is very well dealt with in a working paper in the WHO series, Making Health Systems Work, emanating from an international consultation on strengthening leadership and management in low-income countries. The four-day consultation took place in Accra, Ghana in January/February 2007. The findings of this project which are reported above resonate strongly with the issues raised in the WHO Working Paper. Because of the similarity of the issues, ideas have been drawn from the WHO initiative when formulating this project's proposals. One output of the consultation was a framework for strengthening health leadership and management in scaling up health services. Although the specific focus was on low-income countries, the consultation concluded that the framework is also relevant to other countries.

In discussing the achievement of health-related goals the report acknowledges the need for additional resources, but emphasises that better leadership and management are key to using these resources effectively to achieve measurable results. Good leadership and management, the report continues, are about providing direction to, and gaining commitment from, partners and staff, facilitating change and achieving better health services through efficient, creative and responsive deployment of people and other resources. While leaders set the strategic vision and mobilise the efforts towards its realisation, good managers ensure effective organisation and utilisation of resources to achieve results and meet the aims.

The Leadership and Management Framework (diagram 1 below) provides an ideal framework around which to centre approaches to strengthening the district health system in South Africa.

Diagram 1: A framework for strengthening health leadership and management in scaling up health services



The framework proposes that for good leadership and management there has to be a balance between the four dimensions:

1. Ensuring adequate **numbers** and deployment of managers throughout the health system;
2. Ensuring managers have appropriate competencies (knowledge, skills, attitudes and behaviours);
3. The existence of functional critical support systems (to manage money, staff, information, supplies, etc.);
4. Creating an enabling **working environment** (roles and responsibilities, organisational context and rules, supervision and incentives, relationships with other actors).

The authors point out that these four conditions are closely interrelated. Strengthening one without the others is not likely to work.

The Working Paper provides examples of issues to work on, with possible indicators. The contents of need to be tested against our South African context and adapted where appropriate. One area of particular note is the section on creating an enabling working environment. The section focuses strongly on organisational or structural issues (e.g. which, although extremely relevant and very important, could be seen as a second step in the South African context. From a project perspective the findings were that many of the "disabling factors" in the working environment stem not so much from structural issues as simple procedural, process and accountability issues. In other words, people who are paid to do a job simply not delivering the goods and getting away with it because leadership and management is poor! Some "disabling factors" might have structurally related causes, but the writers' belief is that much can be achieved by relatively simple changes of attitude and behaviour, even before tackling the areas of skills and knowledge and thereafter of organisational structures, processes and policies.

"Hot off the Press" is the report by The Working Group on Challenges in Global Health which met on 16 January 2009. The report (JCEI, 2009) includes chapters by an international team of

researchers and advisors on three specific building blocks of health systems - health financing, health information, and the health workforce - that are generally acknowledged to be critical components of any strong health system. While each paper offers specific recommendations for improvements that can be made in each individual building block, they also come to several common conclusions. Some interesting extracts that talk to the findings and recommendations of this project include:

- While there is still a dire need for more resources - financial, human, and knowledge resources - in the global health field, there is also a critical need to use existing resources more efficiently and more effectively. [T]he paper writers recommend complementing the quest for more resources with creative thinking on ways to achieve better health outcomes with the resources we already have.
- The paper writers recommend …. invest[ment] in capacity building for health sector decision making at the national and local levels and, at the same time, encourag[ing] stakeholders …. to drive their own planning and implementation processes.

An interesting aspect of the projects fieldwork was how few times the issue of information (health management information systems) arose in the Focus Group Discussions or the Interviews. This in contrast to the Working Group report, which lists health management information systems as one of three specific building blocks of the health system. One DM made it clear that she struggles to manage her district without proper information – but generally the fact that it was not raised more often is alarming and can either be seen as indicating that it is a common-sense issue which is taken as read or that we still have no "culture of information" in the management of our country's health system. One indisputable fact is that until accurate and timely information is demanded from above and made part of all performance assessment, the use of information in management will remain low on the priority list.

To do more with the same resources requires innovation. Innovation thrives in a receptive and supportive environment that recognises and values it. Although the SMS Competency Framework identifies Service Delivery Innovation as being critical for high performance in a senior manager's role, practice on the ground does not support this statement. Innovation requires, amongst other things, risk taking but contemporary bureaucratic thinking appears to shun it. Strengthening the District Health System is going to require enhanced levels of leadership and management. It is going to require unity of purpose according to a well-disseminated vision. It's going to require buy-in from all levels – both political and organisational. Strengthening DHS in South Africa is going to require a recommitment to the very concept of the District Health System as the appropriate vehicle to deliver Primary Health Care services in South Africa.

On the last issue, DHS does appear to be the best possible vehicle to deliver PHC service sin the country. The degree to which it succeeded in the early years, even though not yet incorporated structurally into the health system, is proof of this. That it has declined in vigour and achievements more recently must surely be expected in its current partially implemented and constantly "unfinished" state. Funding has never been made available to implement it, yet despite these hurdles the results in many cases are admirable. The system is working well in many other countries and strengthening initiatives in our own country must first look at the inadequacy of the leadership and management, together with inadequate resources, – particularly financial – before "throwing the baby out with the bathwater". There is enough expertise and potential expertise to make it work, if only it can be "given wings".

5.2 Competencies

5.2.1 Review of management competency framework

The concept of "competencies" is an approach to human capital management. In the Public Service Regulations (RSA, 2001) a competency is defined as a *"…blend of knowledge, skills, behaviour and aptitude that a person can apply in the work environment, which indicates a person's ability to meet the requirements of a specific post".*

In an effort to assess how existing Management Teams view the importance of different competencies, a list of 14 competencies was generated from the document review of management competency frameworks. The competency frameworks reviewed included the Senior Management Service (SMS) Competency Framework by the Department of Public Service and Administration (DPSA) (RSA, 2003); the National Department of Health's District Health System Management Competency Framework (Asia, 2002), the World Health Organization's Global Competency Model (WHO) and the PRO-NET Management Competencies Assessment Instrument (Sherman et al., 2002).

The results of the competency rating tool (Appendix 2) administered to members of the district management teams with whom Focus Group Discussions were conducted is shown in Table 8. The teams were asked to rate the competencies in terms of their personal perception of importance for district management team members, with the score of five (5) being extremely important and one (1) not very important. Additional competencies were only included to this list after discussion and sufficient consensus among the team.

The results in Table 8 are interesting. The Western Cape assessment was completed by a District Manager only and the result, straight 5's throughout, is exactly what a number of other District Managers around the country did – i.e. indicated that all competencies are equally important for successful management of a district. Although all FGD competency ranking scores were between 4 and 5, essentially supporting the District Managers viewpoint, the slight variation does allow some ranking of competencies. The highest scoring four competencies include Strategic Leadership, Communication, People Management & Empowering Environment and, fourthly, Financial Management. Of note is that in all the provinces except one the individual provinces' top scoring competencies were amongst the top four of the aggregated results, indicating strong agreement on the ranking. Limpopo Province, the exception referred to above, reported recently adopting, with great success, a project management approach to managing district health services and this could explain the programme and project management competency getting the highest rating.

The four "additional" competencies agreed to by the respective teams illustrate, in most cases, aspects of province's own specific challenges in health service delivery. The items contribute valuable ideas when contemplating ways of strengthening district management.

Table 8: Summary of all provinces' competency rankings, with overall scoring and ranking

FOCUS GROUP DISCUSSIONS : ANALYSIS OF COMPETENCY RANKING												
		EC	FS	GP	KZN	LP	MP	NC	NW	WC	SCORING	**RANKING**
Leadership	Strategic Leadership	4.57	4.75	4.90	4.89	4.64	4.92	5.00		5.00	4.83	1
Core	Communication	4.76	4.63	4.90	5.00	4.57	4.67	4.80		5.00	4.79	2
Core	People Management and Empowering Environment	4.67	4.88	4.90	4.67	4.57	4.25	5.00		5.00	4.74	3
Managerial	Financial Management	4.48	4.88	4.60	4.89	4.57	4.50	5.00		5.00		
Core	Honesty and Integrity	4.71	4.75	4.40	4.89	4.43	4.75	4.80		5.00	4.72	5
Core	Self Management	4.19	4.81	4.70	4.78	4.50	4.75	4.80		5.00	4.69	6
Managerial	Problem Solving and Analysis	4.52	4.50	4.50	5.00	4.57	4.75	4.60		5.00	4.68	7
Leadership	Service Delivery Innovation (SDI)	4.48	4.38	4.70	4.78	4.64	4.50	4.80		5.00	4.66	8
Core	Client Orientation and Customer Focus	4.71	4.13	4.80	4.78	4.29	4.67	4.80		5.00	4.65	9
Managerial	Knowledge Mangement	4.48	4.69	4.60	4.44	4.50	4.17	4.60		5.00	4.56	10
Managerial	Resource Management and Allocation	4.43	4.69	4.80	4.78	4.07	4.33	3.40		5.00	4.44	11
Managerial	Programme and Project Management	4.38	4.31	4.10	4.44	4.71	4.08	4.40		5.00	4.43	12
Leadership	Change Management	4.19	4.31	4.50	4.56	4.36	3.83	4.40		5.00	4.39	13
Managerial	Community/Partnership Collaboration	4.05	3.81	4.80	4.11	4.14	4.33	4.40		5.00	4.33	14
	Crisis management		4.53									
	Research			3.88								
	Faciltation and Coaching				4.67							
	Advanced computer literacy					4.00						

= highest ranked competency (or competencies where more than one had the highest score)

5.2.2 Discussion

Management competence is the essential pre-condition for programme success. Competencies are general descriptions of the behaviour or actions needed to successfully perform within a particular [work] context. Filerman (2003) suggests that the essential core competencies that must be assessed for every managerial position relate to the control of and accountability for resources, effective management of personnel and assuring results. Employees learn, develop and refine many of their competencies over the course of their careers. In contrast to a job description, which typically lists the tasks or functions and responsibilities of a particular role, a set of competencies (or competency profile) lists the abilities needed to conduct those tasks. Gillespie et al. (2004), for instance, lists six domains into which specific competencies fall, namely leadership, critical thinking, scientific/analytic, management, political and community development, and communication. The WHO Global Competency Model, aimed firstly at its own staff but serving as an interesting example of adaptation, lists 13 competencies under three broad groupings – core competencies, management competencies and leadership competencies. These same three broad classifications were adopted in the project competency framework used in the Focus Group Discussions and Interviews.

Filerman (2003), in advocating for adequate investment in managerial competence, observes that a barrier to international investment to support health sector initiatives reaching the people who need them is a lack of competent management at all levels. He further argues that "infrastructure is not an organogramme; it is not handbooks and procedures, job descriptions, computers, budgets and supply chains. Infrastructure is people. An effective infrastructure is the right people in the right places. Health systems lack people who have and use managerial competencies that match their responsibilities." His insightful sharing, with which many parallels can be observed in the South African context, continues that, "In most health systems in developing countries there is an acute shortage of the right people. There is also an acute lack of understanding of the direct link between the lack of "hard" management skills at all levels and the poor outcomes of the health systems."

Returning to implementation, once the necessary managerial competencies necessary for a particular manager to perform satisfactorily are identified, the next challenge becomes the measurement of these competences, and hence performance management. This is an HR challenge on its own about which much has been written and many tools exist. The DPSA SMS handbook indicates that a competency assessment battery has been developed based on these competencies, as also the performance management system that has been developed. Interesting readings which might inform further thinking on assessing the presence and application of managerial competencies include "Supervisor Competency Self-Assessment Inventory" (developed by the Family Planning Management Development Technical Unit, Management Sciences for Health in October 1998) (MSH, 1998) and "Management Competencies Assessment Instrument" (a publication of Building Professional Development Partnerships for Adult Education Project, PRO-NET 2000) (Sherman, 2002).

The following extract from a District Manager interview report supports the importance of conducting competency-gap exercises to guide any competency-development initiatives.

> The DM felt it would be very useful to have a competency gap-identification exercise conducted, both for the [District Management] Team and on a personal basis. This would be useful for focussing capacity enhancement initiatives and supervisory/mentoring activities.

The DM in question continued to share, however, that such an exercise had been conducted about four years back but, despite repeated requests, the results had never been shared. This again emphasises that key to any district strengthening endeavour is effective leadership and management. What could have been a positive motivating factor turned into a negative de-motivating frustration.

The WHO Leadership and Management Framework (WHO, 2007) emphasises the need for appropriate competencies in strengthening a health system or, in our case, a District Management Team. If competency development is going to be successful then the presence and application of competencies must be monitored to identify competency gaps and select appropriate competency development interventions. This report summarises international experience, of which South Africa can well take heed, that competency development is often driven by short-term, narrowly-focused need rather than aimed at providing adaptable generic competences which have long-term and broader cross-cutting benefits. Together with appropriate competency development interventions is the all-important assessment to ensure that the intentions are being achieved. This project's findings identified this latter issue to be a major shortcoming in the district management scenario.

The WHO report suggests the following logical set of steps related to leadership and management competency development:

- Realistic roles and tasks and hence, competences need to be defined for each management position.
- Information on the required managerial competences should be used to develop operational plans for competency development.
- Competencies need to be acquired through a variety of means, including coaching, mentoring and action learning. Traditional classroom-based learning is rarely adequate for acquiring competences. Some activities should be organised for management teams and some for individuals.

Using a Competency Framework will assist in ensuring a consistent approach to human performance throughout the Public Service from National to Provincial levels, and thus help to drive and support all human performance initiatives. A Competency Framework is the foundation for, and a key driver of, effective Human Resource Management (RSA, 2003).

The South African Public Service has developed a Senior Management Service (SMS) Competency Framework which captures the critical generic competencies which senior managers would be expected to possess, rather than functional/technical competencies which are essential to a specific department or a specific job. The SMS Competency Framework therefore consists of a set of eleven generic competencies that communicate what is expected of Senior Managers. These SMS competencies include Strategic capability and Leadership; Programme and Project Management; Financial Management; Change Management; Knowledge Management; Service Delivery Innovation; Problem Solving and Analysis; People Management and Empowerment; Client Orientation and Customer Focus; Communication; and Honesty and Integrity.

5.3 Capacity Enhancement Interventions

5.3.1 Existing training programmes targeting DMTs

The table below provides a list of capacity enhancement interventions[2] that were attended by district management in the recent past and found to be valuable. Where available, the following details were recorded for each intervention, i.e. intervention name and institution and length. The composite of provincial reports can be studied for more detail, as well as the training database of existing training programmes targeting district management teams (Appendix 3).

Table 9: Capacity enhancement interventions that were attended by district management in the recent past and found to be valuable

Capacity enhancement interventions attended by district management
Fort Hare University: • Advanced Diploma in Management • Health Information Systems – specialised course in GIS • Public Finance Management Act (5 days)
KwaZulu Natal University: • MPH in Hosp Management (2 years with a research dissertation) • Post Graduate Diploma for Senior Middle Managers (Level 9 to 13) • Executive Management Development
WITS: • MPH in Hosp Management (2 years with a research dissertation) • Masters of Public Health (MPH) (3 yr course attending 1 week every month) • Post Graduate Diploma for Senior Middle Managers (Level 9 to 13) • District Management (One week per month over approximately 6-9 months) • PHC Management (Six weeks in total – based on one week blocks per month) • Post-graduate Diploma in PHC Management (1 year course – one week per month)
University of the Free State: • Hospital Management Course: 1997-98 (2 years, modular, with 1 week/month on-campus attendance)
Durban University of Technology (DUT): • Project Management (Short course – one a week)
University of Pretoria: • Strategic Planning (South African Development Countries (SADEC) in collaboration with University of Pretoria. A one month full-time course)
Stellenbosch University: • Policy Formulation
Winter School - University of the Western Cape (UWC): • Variety of useful courses contributing to a Masters in Public Health (MPH)
University of Cape Town (UCT): • Diploma in Health Management (18 months attending 10 days x 4 blocks) - School of Public Health & Family Medicine • Management (Johnson & Johnson 1-week management course) - UCT Business School at Waterfront in Cape Town

[2] Refers to formal and informal training, in-service guidance, coaching, mentoring, supervision and support, including other relevant interventions.

Capacity enhancement interventions attended by district management
Technikon of the Free State: • District Health Expenditure Review (DHER)
Applied Fiscal Research Centre –AFReC • Performance Budgeting and Financial Management Programme (Modular-based on-the-job training over 2 years)
Regional Training Centre (RTC): • ART Programme (specialised 3 days)
Training for Management in Port Elizabeth: • Project Management
Office of the Premier: • Promotion of Administration Justice Act (PAJA) • Project Management (One week course after which participants are sent out to do an assignment – Kaido)
SAMDI: • Advanced Management Development Programme (15 days: 3 blocks of 5 days each. For post levels 9-12) • Emerging Management Development Programme (15 days: 3 blocks of 5 days each, for posts levels 7 and 8) • Foundation Management Development Programme (10 days: 2 blocks of 5 days each) • Conflict Management / Resolution (2 days) • Team Building (2 days) • Advanced Management Development Programme (AMDP) (3 blocks (15 days)) • Emerging Management Development Programme
Damelin: • Project Management (3 months) • Financial Management (3 months)
Price Waterhouse Cooper: • Diversity Management (3 days) • Change Management (3 days) • Financial Management (5 days) • Mentoring and Coaching (3 days) • Competency Technique-Based Performance Assessment (3 days)
Superior Performance Training cc: • Project Management (5 days)
Pro Active (NGO based in Pretoria: • Policy Development • Budgeting
Regenusis: • Project management
Belgium Technical Project with NDOH (Kwelanga Training, Mandala Consulting, Free to Grow): • Financial management • Stress Management • People management • Teambuilding • Diversity Management • Change Management

Capacity enhancement interventions attended by district management

In-service and other:
• Using Information for Management, including DHIS and Pivot tables
• Monitoring and Evaluation
• District Health Plans (DHP) – Emmanuelle Daviaud
• District Management and Leadership
  • Disciplinary training for clinic managers, supervisors, LA managers (3 days)
  • BAS Budgeting and Financial Management (for LA Managers)
  • Team Building (Conducted in the District by a private company)
  • Health Information – Foundation course (3 days)
• Financial Management for Non-financial Managers (5 days)
• PERSAL
• Transformational Leadership
• Vulindlela Financial System
• Computer Training
• Supply Chain Management (2 days)
• Mental Health Care (2 days)

A review of the capacity enhancement interventions attended by district management highlights greater emphasis on building management capacity relating to the following top five competencies:

- Strategic Leadership
- Communication
- People Management and Empowering Environment
- Financial Management
- Programme and Project Management

With respect to duration, courses have ranged from 3 days to a modular based course extending over a period of 2 years, from two to five days and from 18 months to three years, the latter type run on a modular basis. Little or no information was available on any formal internal or external evaluation of courses being conducted at district or provincial level.

Overall, the priority training needs, which have been recommended for the future, fall into the ambit of General Management with specific focus on financial management, human resource management and project management. The lack of skills in monitoring and evaluation was also emphasised and this needs to be developed as part of supervision practices.

The district management teams raised certain interventions and support activities that they felt would be desirable. These are listed in the table below.

Table 10: Future training and development needs raised by district management

EC	• Financial Management • Human Resource Management (i.e. soft skills) • Project Management • Computer literacy training • Training in Monitoring and Evaluation (M&E) • Supervision – emphasising the importance of evaluation and feedback; checklists with matching guidelines; clear objectives and accepting that meaningful supervision requires adequate time. • Assisting managers to develop an understanding of what management actually means and requires. For instance managers need to be equipped to make and implement the unpopular decision should this be necessary. • One area of inputs is using the results of a competency gap analysis to give focused support to DMT members so as to strategically address gaps and shortcomings. • Information Management
FS	• Financial management • Health management (e.g. courses that equip trainees with a broader perspective, rather than just implementation) • Human Resources (e.g. planning, etc.) • Planning and implementation • Report writing ("*What to include in official and informal documents"*) • Training in Legislation and Policy
GP	• Supervision course for Area Managers • Financial Management for non-financial people - a SAMDI course (clarifies finance-related terminology to support everyday implementation). • Primary Health Care Management Course – Regenesys – Wits School of Public Health (1,5 years in a modular format) • Computer Skills • Labour Management (including interacting with the Unions) • Project Management courses • Public Management (Post Graduate or Masters level)
KZN	• Basic legislation for understanding of contractual agreements which districts need to implement. For example, the implementation of service level agreements. • Basic labour legislation for management at all levels. The district management teams strongly felt that labour issues are not managed well, especially at lower levels. • Using information for management at both district and institutional level. There is general lack of understanding of how information can be used for planning, forecasting, monitoring and evaluation. • Basic health economics with emphasis on linking budgets to performance. *"People need to realise that every decision they make is a financial decision even though they are talking about clinical service delivery".* • Client orientation and customer focus training for staff at facility level.
LP	• Project Management. District management have adopted the mechanism of running services like projects. *"People are excelling because they have adopted managing services like projects because they want to evaluate their performance in terms of time lines. Personally, I think project management is the way to go."* • Financial Management • Advanced Management Development Programme (AMDP) – provides a good

	introduction to the broad elements of management practice and reinforces the principles of project management. However, every year there are a limited number of managers who attend the AMDP at district level. • Advanced Computer Literacy • Planning, specifically focusing on the district health planning in relation to the Integrated Development Planning (IDP) process. • Collaborative policy implementation for all Programme Managers. • People management skills with specific focus on dealing effectively with disciplinary procedure. • Workplace recreational activities such as team building to be conducted on a regular basis. • Greater need for enhancing work flow and integration across components. *"We need to get out of this notion of ownership"*. • Change management – *"We require a mindset of change in line with the transformation process that is taking place externally"*. • Motivation skills are essential. *"You as a manager, to always make sure that you build up people so that they can be motivated to work"*. • De-briefing skills for handling stressful situations. *"We are loosing a lot of staff at service delivery level and we are finding difficult to cope with this as management. This task is too much for one staff member at the Employee Wellness Programme to manage"*.
MP	• Cost centre management training which focuses on outputs, i.e. how to align budgets with operational outputs. • Utilisation of information for decision making. – *"People do not align indicators to improving service delivery. We have got a resource, we have got information, but we don't know how to align it to our directives."* • Managerial training by the province focusing on systems that need to be implemented for improved and effective district functioning. This was suggested to enhance and facilitate good relations with the province.
NC	• Financial Management • People Management and Empowering Management • Change Management • Knowledge Management • Human Resources Planning • Performance Management • Risk Management • Supply Chain Management • Contract Management • Transport Orientation • Application of the HAS - Occupational Therapist • Spirometry Training – Occupational Therapist
NW	• Financial Management • Monitoring & Evaluation • Information Technology & Computer Literacy • Labour Relations • Risk Management
WC	• Financial Management very important • Supply Chain Management very important

The priority training needs which have been recommended for the future are congruent with what is needed with respect to implementing the new district structure. All are related to strengthening the DMT's ability to lead towards delivery, whether from a knowledge perspective (PHC management, financial management, labour management), from a practical aspect or in people skills (supervision and project management) or in terms of personal technical abilities (computer skills).

In conducting the focus group discussions with district management teams the researchers were strongly aware that capacity enhancement should not be limited to formal training. It has been found that much, if not most, could be achieved, often with immediate results, by investigating and addressing those operational and systemic issues that limit individuals' ability to deliver to their full capacity. A brainstorming session with the focus group on experiences of such barriers to delivery provided an interesting list – some of which do not need resources or restructuring but simply an awareness of the shortcoming and changed practice.

Communication is one such example. In the sender-transmission-receiver continuum a message sender should accept part of the responsibility for transmission and monitor up until confirmation of successful receipt is acknowledged. To simply press the "send button", literally or figuratively, and thereafter assume receipt places the full responsibility on the receiver. Adequate communication is also a crucial factor in change management. A team that knows the what, why, when, where and how of a change processes and is kept updated on progress is best equipped to play a positive part in the change process.

Similarly, feedback in the communication process is crucial to enhancing delivery. Examples that arose in the districts included feedback on performance, a human resources management issue, through to feedback on budgets, a systems management issue. Team members' ability to deliver will be severely curtailed if they are not given the information necessary to make the best possible decisions.

5.3.2 Discussion

Transformation in the Public Health is an enormous challenge, which requires exceptional skills and the ability to manage successfully. The most common approach to management development programmes are education and training which aim to improve management knowledge and skills of individuals and teams working in a specific organisational context.

Generally most provinces are making use of a combination of training programmes, from the more formal diploma-level course to the shorter once-off workshop which are run at district or institutional level and focus on a particular component of, or approach to management.

In almost all the provinces visited during this study group participants made reference to the value of the focus group discussion as an opportunity to share vision and commitment, to share common experiences and verbalise frustrations, and just to have time to link with one another in the constant daily grind of "getting by". This alone speaks volumes of the need to have "time out", to temporarily "shed the load" and to re-energise each other in a "battery charging" process. As humans it helps so much to know that one is not alone!

On a practical level and from another province, the creation of a Metro Exchange Programme was suggested as a district strengthening activity for Metro districts. It was felt that Metro districts cannot be compared to the functioning of non-Metro districts as they are unique and to

date there is limited sharing of best practices between them – although this might not be the case for Gauteng where there are three metros beside each other.

With regards to methodologies and approaches to training, managers indicated preference for short courses that are needs-driven, participatory and aligned to work objectives. Managers raised two critical concerns with respect to the planning and assessment of capacity enhancement interventions. Firstly, some provincial HRD sections identify targeted training for district management; however, managers noted that this department lacks understanding of the critical skills mix that is required at this level for effective district functioning. Secondly, post-training evaluation of courses is seldom undertaken to assess whether courses cover the relevant competencies and whether such courses are appropriate for systems that need to be implemented at provincial and district level. An additional challenge is the lack of time to implement and share leanings from these trainings.

Although the recommendations for future training include external courses, districts also felt that there is an urgent need for internal (in-service) training on provincial systems and guidelines to support improved service delivery. The PMDS and the SMS Frameworks are an example of areas in which such training needs to be prioritised. The lack of structured orientation and induction of new employees at all levels was also considered a key factor in fuelling poor understanding of both district and provincial level systems and work flow processes.

A formal evaluation of the Advanced Diploma in Management offered by the University of Fort Hare was conducted and this evaluation revealed that the majority of managers found the diploma relevant to their learning needs and in line with their key performance areas. However, 29% of managers in this evaluation noted that they would find it difficult to fully utilise their competencies as the job environment which may not enable them to do so (Munyaka, 2007). The main challenges in fully utilising these competencies was noted as follows: personnel within their facilities who refuse change and make the skills implementation process difficult, shortage of staff making delivery of service difficult, organisational culture that impacts on the attitudes of staff, time constraints to complete tasks due to various activities occurring at the same time, senior management delaying in giving solutions to problems brought to their attention and limited resources like the budget, equipment, office space and storage space.

During an informative part of the discussions the groups were requested to identify other issues thought to have the potential to enhance health service delivery. In one province the phrase “Giving us our Wings” was used, suggesting that much capacity and commitment exists but a variety of barriers hinder the enthusiastic application of these in managers’ day-to-day involvement. Examples included team building exercises (and it is interesting to note that in a number of districts around the country the Focus Group Discussion members indicated the value of the team interaction through FGD itself in revitalising the group); enhancing work flow and integration across components; change management; motivational skills and de-briefing skills for handling stressful situations. The last three could be included in the suggested people management item in future training priorities. The second speaks to the issue of promoting an enabling environment.

A review in one of the sample districts of the capacity enhancement interventions that have been attended by management teams over the past and present financial year indicated that no training was attended by any of the DMT members during 2007/08 and that the last training attended was in 2006. In another province a sub-district manager indicated that no formal training intervention has been implemented over the last financial year for sub-district managers while hospital CEOs were offered a special training package by Province.

Key points based on the discussions with district management teams on capacity building challenges and how to make training more effective are listed below:

Training seen as a once-off exercise

There is currently insufficient or no follow-through on training courses and workshops. These need to be evaluated to ascertain their worth for future staff members and to determine the support needs of the participants once they return to their workplace. Problems are experienced in district through lack of continuity of interventions (e.g. Baseline DHER training was conducted in about 1999 but the expected further training never materialised).

District management team members attend trainings and when they return find that there is insufficient time to implement their learnings from courses because of the tremendous workload.

The need to evaluate courses was also emphasised so as to ensure that they are of a satisfactory level. *"But also monitor the effect of the course – what is implemented, what change does it bring?"*

Mentoring and support

A critical skill for the public service is "context shifting" (i.e. the ability to think out of the box). The ability to shift context however needs a driven leader with vision and passion. *"People need to get out of their comfortable zones, to function in a different arena altogether, where they can view things in a new manner where it is possible to do things"*. Such a skill is integral for implementing the new district structure. Promotion of common courteously and respect for fellow colleagues are important. "*We have lost that simple basic courtesy - we don't need a course, but as management we need fellowship and need to enhance this through awards"*.

The role of supportive and developmental mentoring also arose – applicable to anybody in a management post. *"You need to capacitate your people."* Training interventions must be "in sync" with the rest of the Provincial operations. Workplace recreational activities such as team building were mentioned by some to be conducted on a regular basis.

Assessment of competencies

It was reinforced that one of the problems associated with courses that are conducted by various institutions is that there is no assessment of competencies gained from these courses. Districts regard the provincial office as a main driver for assessing such competencies and benefits of courses. *"Province never comes back to assess competencies; whether those participants were actually capacitated or not"*. The issue of whether participants actually benefit from these courses is, therefore, largely questionable.

Short courses versus long courses for managers

Overall, managers indicated that short courses that are run in workshop-style with active participation are most suitable including courses that have been tailor-made to suit the development of specific needs as opposed to "global knowledge courses". Hands-on courses which relate directly to the work objectives were also deemed extremely beneficial. Informal/practical courses like Supply Chain Management and Mental Health Care Act (2 days each) – "*Practical courses are better because it helps you in your day-to-day activities.*"

The cost of training managers

One district management team reported that the province does not allow implementation of new learnings and the DMTs do not have the authority/delegations to effect change.

- Shortage of staff is an impacting factor
- Funding is a challenge "*but there is always no funds*"

The perception is that training courses are usually very expensive and that the district budget can not always accommodate it. Some district management teams have not attended any training during 2007/08 because of budget constraints- "*the last training was in 2006*".

Induction and orientation of managers

Of priority is the need for proper orientation and induction of new employees at all levels in the department. *"People are employed and we just start to work"*. Greater internal support is needed from co-workers and supervisors (at both district and provincial level) to understand systems and the culture of the Department so that *"we know what is expected of you and which direction we are heading as a department"*. Without effective induction, progress is jeopardised; service delivery comes to a stand still. It was proposed by this district teams that induction for a new member should be approximately 1 week.

An orientation programme for new managers (covering issues such as DHIS, PFMA, Labour Relations) is considered valuable. The example of the Western Cape "buddy system" was mentioned whereby a new appointee is accompanied or mentored for a period of three months in a process that focuses on critical competencies.

The following benefits and advantages of introducing induction were noted:

- Employees will know what is expected from them, they will know how things work, they will be introduced to the people and the environment that they need to work in.
- Team effort will be enhanced and will make people feel part of a team.
- It will introduce employees to the organogramme, the reporting structure and delegations.
- It will also help in rapid assimilation into the workplace whereby employees can start to perform in their job because they have guidance and direction.
- Employees will know who to communicate with at province – channels of communication will be strengthened for effective delivery.

Strengthening management and supervision

Training efforts should not focus solely on lower level staff. Senior staff often need (and want) the same training to be able to manage more effectively. ("*How do you manage people that know more than you?*")

Strengthening of supervision practices to deliver services was also highlighted. *"People don't want to know that they are not performing. Supervision is a big problem - if we can get our supervision right, by identifying problems and following up on problems, then we can go a long way"*.

Some important management skills indicated by district management teams are:

- Change management – *"We require a mindset of change in line with the transformation process that is taking place externally"*.

- Motivation skills are essential. *"You as a manager, to always make sure that you build up people so that they can be motivated to work".*
- De-briefing skills for handling stressful situations. *"We are loosing a lot of staff at service delivery level and we are finding difficult to cope with this as management. This task is too much for one staff member at the Employee Wellness Programme to manage".*

Coordination of training

A further challenge experienced in the area of training is that one provincial Human Resources Development (HRD) coordinates training in districts and often this department does not understand the needs of the district. Processes and systems which have been adopted in the province are therefore not aligned to the content of the training. "*If structure is not in place everything else falls short".*

In one sample district the lack of HRD support due to staff shortages was reported to have a negative impact on processes for adequate implementation of capacity enhancement interventions.

Need to develop two 'levels' of management skills

The need to develop two 'levels' of management skills was recommended in a study conducted by Human and Strachan (1996) to assess the self-perceived training needs of senior managers in 9 provinces in South Africa. The authors concluded that in the current context of transformation, there is a need to train managers both in "….generic management skills (how to manage organisations, finance, people and information), as well as transformational management skills (understanding health policy, being able to manage the complexity and change in the health sector, being able to set up new structures, having a bias for action and confidence to take risks); the latter being context specific (specific to the task of transformation), and essential in the process of managing change.

There are a number of training programmes which focus on developing the capacity of health service personnel who are currently in positions of management. Whilst the content – and manner in which these are presented to trainees – vary from one programme to the next, there are some common elements to all diploma programmes. For example, all courses tend to include basic elements of management such as programme management, financial management, human resource management and information management. Current public health policy and the district health system are investigated in most courses. The most distinctive is the Postgraduate Diploma in Health Management offered by Oliver Thambo Fellowship Programme (OTFP) at UTC.

Mix of approaches for management development

1. Formal training (most common approach) – consists primarily of classroom training usually provided by Universities.
2. On the job training (informal and even unintentional learning) – Example: internship or on-the-job training/mentoring
3. Action learning (more recent approach to management) – 'combination of formal training sessions with on-the-job problem solving" (Kerrigan and Luke, 1987). It is also known as "action training and research", capacity building", "joint development activities", etc. According to Pedler (1991), *action learning (AL) is an approach to the development of people within organisations that uses real-life tasks as the vehicle for learning. "It is based on the premise that there is no learning without action and no sober and deliberate action without learning"*

4. Non formal training (self-directed learning through peers) – Like when a group of peers share expertise

Table 11 summarises the relative advantages of each approach. Of the four, Action Learning would appear to offer most, because it combines the benefit for formal training with those of on-the-job training.

Table 11: Advantages of training approaches in achieving selected goals

Training Approach	Formal	On-the-job	Action Learning	Non-formal
1. Acquire knowledge	●	⊖	●	●
2. Understand concepts	●	○	●	⊖
3. Understand techniques	●	⊖	●	●
4. Acquire skills in use of techniques	⊖	●	●	○
5. Acquire skills in analysis of organisation problem	⊖	●	●	○
6. Acquire skills in developing and implementing action plans	⊖	⊖	●	○

Source: Kerrigan and Luke, (1987)

Key: ● High potential ⊖ Medium potential ○ Low to no potential

From this it is clear that formal training has great potential with all packaged knowledge (on teaching the known), but not with the development and use of management skills. On-the-job training shows good potential for two immediate objectives related to skills development, but less in one of them and also in the three related to knowledge acquisition. Non-formal training appears to be the weakest of the four. Action Learning has high potential across the board and therefore merits further consideration as a strategy for management development in developing countries.

Ensuring managers have appropriate competencies

WHO convened a workshop on strengthening health leadership in low-income countries. Ensuring managers have appropriate competencies were highlighted. Competency development is often driven by short-term, narrow-focussed need, rather than aimed at providing adaptable generic competences which will have long-term and broader cross-cutting benefits. Some common problems were listed.

- Short, once off training/workshops and other events which are not coordinated in terms of content, timing or participants.
- Training often focus on knowledge rather then skills, attitude and behaviour.
- Opportunity cost high because of managers absent from work.

Information on the required managerial competences should be used to develop operational plans for competency development. Traditional classroom-based learning is rarely adequate for acquiring competences. Some activities should be organised for management teams and some for individuals. (The WHO Leadership and Management Framework - WHO, 2007). It is therefore important to carefully consider capacity enhancement strategies and initiatives, sensitive to the unique district and sub-district level needs.

6. Recommendations

6.1 Structures

The success of a health district is strongly reflective of (i) the effectiveness of the District Health Management Team and (ii) the degree to which the Team's operational environment helps or hinders its operation.

1. Recommit to a common vision of DHS as the vehicle to deliver PHC in the country.
2. Negotiate top level support (including adequate financing) for strengthening DHS.
3. Finalise restructured district organogrammes.
4. Complete provincial restructuring processes and filling of DMT posts.
5. Refine or develop appropriate district assessment tools, allowing for differentiation of authority levels affecting outputs.
6. Evaluate and where necessary strengthen sub-district structures.
7. Ensure closer structural alignment between provincial and district structures.
8. Enhance coordination of NGO involvement in districts.
9. Investigate the relevance of simple population-based district funding models.
10. Review Financial and Human Resource delegations, especially in the light of other provinces' practices, to ensure maximum efficiency and effectiveness.
11. Manage the timely outputs of Corporate Services sections.
12. Encourage the establishment of DMT peer-support groups (e.g. Metro Districts' forum; provincial District Managers' Forums).
13. Initiate regular DMT review and reflection sessions to revitalise individuals' commitment and application.
14. Enhance productivity through ensuring an enabling environment** – both structurally and operationally.

**Enabling Environment

- Ensure that each person understands the expectations of them and the measures used to asses delivery.
- Recognise, acknowledge and support the staff serving at the service provider levels.
- Strengthen the concept of partnership between management and the service providers in achieving the overall goal of health service delivery.
- Recognise and reward innovative practice.
- Enhance the inter-level support and feedback component of management/supervision.
- Minimise management level disruptions to lower level plans and delivery efforts.
- Establish the mechanism and environment to identify "barriers to delivery" and together seek solutions or alternative ways.

6.2 Competencies

1. Ensure Leadership and Management capacity at national, provincial and district levels to identify and achieve the goals of DHS.
2. Clarify roles and tasks to support the development of competency profiles for DMT positions, differentiating clearly between managerial and technical competencies required for delivery.
3. Develop competency assessment tools for recruiting, "gap" analysis and planning capacity enhancement initiatives.
4. Develop operational plans for competency development.

6.3 Capacity enhancement interventions

1. Adopt the principle of first "strengthening what there is" and reducing barriers to delivery before investing in further capacity enhancement initiatives.
2. Develop provincial level capacity enhancement strategies and initiatives, but sensitive to the unique district and sub-district level needs.
3. Ensure strategies and processes to ensure that capacity enhancement initiatives are evaluated.
4. Promote and encourage the implementation and uptake of learnings and new ideas in the working environment.
5. Recognise the difference between management and technical expertise in selecting and using capacity enhancement initiatives.
6. In the current context of transformation managers need to be trained in both in generic management skills (how to manage organisations, finance, people and information), as well as transformational management skills (understanding health policy, being able to manage the complexity and change in the health).
7. Action Learning would appear to be more affective, because it combines the benefit for formal training with those of on-the-job training.

7. Proposed National Strategy

7.1 Structures

Recommital to the District Health System

It is the responsibility of the National Department of Health to ensure that all Provinces share the same vision of a DHS. Commitment to and a common understanding of a DHS are essential to instil ownership and to ensure the application thereof. Ongoing regular monitoring and evaluation by the NDoH will further more enhance the growth of a well functioning DHS in the country.

- Clarify and strategise for NDoH's leadership role and responsibilities in the DHS.
- Ensure political commitment to DHS as a vehicle to delivering PHC in the country.
- Revisit the DHS Vision and ensure adoption of a common understanding of what it means.
- Strategise for strengthening DHS in the country.
- Commit to regular monitoring and evaluation of DHS functioning in the country.
- Establish a mandated NDHSC Working Group to champion and implement the DHS strengthening initiative.

Establish criteria for a well-functioning District Health System

Many tools for planning and measuring service delivery at district and higher levels exist[3]. These essentially measure service delivery data whereas, as has been argued in this report, health

[3] PLANNING: Job descriptions, District Health Plans (DHP); District Health Expenditure Review (DHER)
MEASURING: Performance Management and Development System (PMDS); The Management, Economic, Social and Human Resources (MESH) monitoring tool,; Provincial and District Quarterly reporting Systems (PQRS and DQRS); District Best Practice (District Competition) assessment;

district performance is ostensibly a reflection of the Leadership and Management (L&M) competencies in a district. Although measurement of service delivery is essential since improved service delivery is the very goal of good leadership and management, tools measuring only service delivery do not provide adequate information (e.g. inputs and process data) essential for monitoring the effectiveness of L&M itself and to monitor progress after strengthening initiatives have been implemented.

- Review and strengthen or develop DHS indicators[4] and targets.
- Review and strengthen or develop assessment tool for national.
- Review and strengthen or develop benchmarking tool for provinces.
- Review and strengthen or develop benchmarking tool for districts.
- Update District Health Managers handbook.
- Adapt HMIS (and other) data collection tools.
- Conduct research on the relationships between health district funding and population density/distribution to assess budgeting practices.

Evaluate District Health System against set DHS criteria

Regular evaluation of the DHS in the country is of the utmost importance for the NDoH to be able to identify the challenges that exist and to monitor the status of the DHS in the country. Although evaluation tools like the MESH tool exist, it is not sufficient, resulting in uncertainties concerning the success of the DHS in the country. Not only the NDoH, but also the Provinces and Districts, should be able to evaluate themselves against a comprehensive set of criteria in order to identify best practice, gaps and shortcomings.

- Conduct initial (Baseline) national evaluation.
- Conduct initial (Baseline) evaluation for provinces.
- Support to provinces initiating DHS strengthening initiatives.
- Support to the districts initiating DHS strengthening initiatives.

7.2 Competencies

Competences to be defined for each management position

As stated earlier in the report a list of 14 competencies was generated from the document review of existing management competency frameworks. The competency frameworks reviewed included the Senior Management Service (SMS) Competency Framework by the Department of Public Service and Administration (DPSA) (RSA, 2003); the National Department of Health's District Health System Management Competency Framework (Asia, 2002), the World Health Organization's Global Competency Model (WHO) and the PRO-NET Management Competencies Assessment Instrument (Sherman et al., 2002).

The South African Public Service has developed a Senior Management Service (SMS) Competency Framework which captures the critical generic competencies which senior managers would be expected to possess, rather than functional/technical competencies which are

[4] EXAMPLES OF INDICATORS FOR MEASURING HEALTH DISTRICT FUNCTIONING:
Input: number of managers; post levels; delegations
Process: competency profiles; competency "gap" analyses; capacity enhancement initiatives
Output: service delivery (MESH and DQRS data)
Outcome/Impact: National Health Goals, health-related Millennium Development Goals

essential to a specific department or a specific job. The SMS Competency Framework therefore consists of a set of eleven generic competencies that communicate what is expected of Senior Managers. These SMS competencies are all included in the list of 14 competencies generated by the Research Team.

- NDHSC Working Group (referred to in 7.1), including HR representatives from all Provinces and National, to champion and drive this initiative.
- Clarify roles and tasks for DMT positions, differentiating clearly between managerial and technical competencies required for delivery.
- Review list of 14 competencies (see Appendix 2) generated from the document review and existing competency frameworks in order to develop competency profiles for DMT members (check whether or not one competency framework fits all).
- Include agreed competencies based on DMT roles and tasks in set criteria for a well functioning DHS, explaining the rationale for each competency.
- Include findings in the updated District Management handbook to serve as guideline for future recruiting, "gap" analysis, planning capacity enhancement initiatives and manager evaluation.

Competency assessment tools

Once the managerial competencies necessary for a particular manager to perform satisfactorily are identified, the next challenge becomes the measurement of these competences and, hence, performance management. This is an HR challenge on its own about which much has been written and many tools exist. The DPSA SMS handbook indicates that a competency assessment battery has been developed based on their selected competencies, as also the performance management system that has been developed. Interesting readings which might inform further thinking on assessing the presence and application of managerial competencies include "Supervisor Competency Self-Assessment Inventory" (developed by the Family Planning Management Development Technical Unit, Management Sciences for Health) (MSH, 1998) and "Management Competencies Assessment Instrument" (a publication of Building Professional Development Partnerships for Adult Education Project, PRO-NET 2000) (Sherman et al., 2002).

- NDHSC Working Group (referred to in 7.1) including HR representatives from all Provinces and National to champion and drive this initiative.
- Review existing competency assessment tools.
- Develop/strengthen competency assessment tools for recruiting, "gap" analysis, planning capacity enhancement initiatives and manager evaluation.
- Support to Provinces initiating competency assessments of DMT members.
- Report on competency gaps revealed when administering the competency assessment tool (Baseline surveys).

7.3 Capacity enhancement interventions

Curriculum for DMT training

There are a number of diploma level training programmes which focus on developing the capacity of health service personnel who are currently in positions of management. Whilst the content – and manner in which these are presented to trainees – varies from one programme to the next, there are elements common to all these diploma programmes. For example, all courses tend to include basic elements of management such as programme management, financial

management, human resource management and information management. Current public health policy and the district health system are investigated in most courses. The most distinctive is the Postgraduate Diploma in Health Management offered by Oliver Thambo Fellowship Programme (OTFP) at UTC.

- NDHSC Working Group (referred to in 7.1) including HR representatives from all Provinces and National to champion and drive this initiative.
- Develop a recommended curriculum for DMT training.

The following key aspects should be included in the curriculum for DMT training:

- Training focused on the two "levels" - generic and transformational - of management skills. Generic management competencies are listed in Table 12 (which lists the 14 competencies generated from the document review and existing competency frameworks). Transformational management skills, however, deal with an understanding of health policy, managing complexity and change in the health sector, setting up new structures, having a bias for action and the confidence to take risks (the latter being context specific to the task of transformation) essential in the process of managing change.

- Short courses (workshop-style with active participation) tailor-made to suit the development of specific needs as opposed to "global knowledge" courses. (Hands-on courses which relate directly to the work objectives were also deemed extremely beneficial.)

- Training courses and workshops must be evaluated to ascertain their worth for future staff members and to determine the support needs of the participants once they return to their workplace.

Operational plans for competency development

Information on the required managerial competences should be used to develop Provincial operational plans for competency development.

- Districts to develop competency development plans (instead of the traditional "skills development plans") based on the gap analysis described above.
- Districts to ensure that these plans are submitted to HR at Provinces in time to secure funding through the Skills Development Levy.

DMT training courses and skills enhancement

Competencies must be acquired through a variety of means including coaching, mentoring and action learning. Traditional classroom-based learning is rarely adequate for acquiring competences. Some activities should be organised for management teams and some for individuals.

- Provincial (and District) HR to identify courses addressing the perceived gaps in competencies by utilising the newly developed District Management Training Database to filter for trainings that can provide all or selected competencies.
- National HR to share the recommended DMT training curriculum with appropriate training institutions.
- National HR to take responsibility for updating the District Management Training Database.

- Provinces and districts to formalise reporting on training/skills enhancement interventions and subsequent evaluation of actual competency improvements in the individuals.
- Districts to manage the enhancement of an enabling environment to allow application of the training/skills enhancement outcomes in the workplace.

8. Conclusion

In conclusion, change is not a strictly "rational" or controllable phenomenon. In complex institutions and organisations such as the health services large scale change is also political and deals with deeply embedded assumptions, beliefs and values as well has strongly held perceptions.

There is reason to believe that, given an "enabling environment", existing "pockets of excellence" or sites of best practice would serve as the examples necessary to lead the way towards the change needed to return DHS to its perceived heights of earlier years. Renewed energy and opportunity for creativity are needed to bring about the required change. "More of the same" is unlikely to be the catalyst.

Furthermore, human resource "infrastructure should not be seen [only] as an organogramme - it is not handbooks and procedures, job descriptions, computers, budgets and supply chains. Human Resource infrastructure is people. An effective [human resource] infrastructure is the right people in the right places. Health systems lack people who have and use managerial competencies that match their responsibilities." (Filerman, 2003)

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APPENDIX 1: Districts' population compared to WHO standards

Health district's population size, arranged and marked in relation to WHO recommended district population size

DISTRICT POPULAITONS SIZES, ARRANGED BY PROVINCE

Prov	District	Population	/500 000
EC	A Nzo DM	627,574	1.3
	Amathole DM	1,857,529	3.7
	C Hani DM	879,807	1.8
	Cacadu DM	409,337	0.8
	N Mandela MM	1,121,375	2.2
	O Tambo DM	1,816,535	3.6
	Ukhahlamba DM	339,378	0.7
EC Total		**7,051,535**	
FS	Fezile Dabi DM	514,568	1.0
	Lejweleputswa DM	759,749	1.5
	Motheo DM	786,003	1.6
	T Mofutsanyane DM	765,464	1.5
	Xhariep DM	132,935	0.3
FS Total		**2,958,719**	
GP	Ekurhuleni MM	2,532,760	5.1
	Johannesburg MM	3,240,409	6.5
	Metsweding DM	208,263	0.4
	Sedibeng DM	920,227	1.8
	Tshwane MM	1,624,914	3.2
	West Rand DM	724,004	1.4
GP Total		**9,250,577**	
KZN	Amajuba DM	586,274	1.2
	eThekwini MM	3,153,217	6.3
	iLembe DM	617,216	1.2
	Sisonke DM	310,855	0.6
	Ugu DM	700,259	1.4
	uMgungundlovu DM	987,143	2.0
	Umkhanyakude DM	586,982	1.2
	Umzinyathi DM	468,960	0.9
	Uthukela DM	627,689	1.3
	Uthungulu DM	867,473	1.7
	Zululand DM	825,830	1.7
KZN Total		**9,731,898**	
LP	Capricorn DM	1,195,982	2.4
	Gr Sekhukhune DM	1,035,888	2.1
	Mopani DM	1,108,078	2.2
	Vhembe DM	1,293,106	2.6
	Waterberg DM	654,056	1.3
LP Total		**5,287,110**	
MP	Ehlanzeni DM	1,577,454	3.2
	G Sibande DM	911,954	1.8
	Nkangala DM	1,107,210	2.2
MP Total		**3,596,618**	

Prov	District	Population	/500 000
NC	F Baard DM	345,820	0.7
	Kgalagadi DM	33,103	0.1
	Namakwa DM	115,291	0.2
	Pixley ka Seme DM	185,140	0.4
	Siyanda DM	231,259	0.5
NC Total		**910,613**	
NW	Bojanala Platinum DM	1,261,009	2.5
	Bophirima DM	465,725	0.9
	Central DM	770,389	1.5
	F Baard DM nw	22,725	0.0
	Kgalagadi DM nw	164,502	0.3
	Southern DM	628,386	1.3
	Tshwane MM nw	476,205	1.0
	West Rand DM nw	69,529	0.1
NW Total		**3,858,470**	
WC	Cape Town MM	3,110,652	6.2
	Cape Winelands DM	639,619	1.3
	Central Karoo DM	62,362	0.1
	Eden DM	454,425	0.9
	Overberg DM	200,211	0.4
	West Coast DM	278,198	0.6
WC Total		**4,745,467**	
Grand Total		**47,391,007**	

KEY	
	1 - 250 000
	250 000 - 500 000
	500 000 - 1 000 000
	1 000 000 - 1 500 000
	1 500 000 - 2 000 000
	Metro district

Source: South African Health Review, 2007 (Note: only 52 districts)

DISTRICT POPULATION SIZE, ARRANGED IN ASCENDING ORDER

Prov	District	Population	/500 000
WC	Central Karoo DM	62,362	0.1
NC	Namakwa DM	115,291	0.2
FS	Xhariep DM	132,935	0.3
NC	Pixley ka Seme DM	185,140	0.4
NC	Kgalagadi DM	197,605	0.4
WC	Overberg DM	200,211	0.4
GP	Metsweding DM	208,263	0.4
NC	Siyanda DM	231,259	0.5
WC	West Coast DM	278,198	0.6
KZN	Sisonke DM	310,855	0.6
KZN	Ukhahlamba DM	339,378	0.7
NC	F Baard DM	368,545	0.7
EC	Cacadu DM	409,337	0.8
WC	Eden DM	454,425	0.9
NW	Bophirima DM	465,725	0.9
KZN	Umzinyathi DM	468,960	0.9
FS	Fezile Dabi DM	514,568	1.0
KZN	Amajuba DM	586,274	1.2
KZN	Umkhanyakude DM	586,982	1.2
KZN	iLembe DM	617,216	1.2
EC	A Nzo DM	627,574	1.3
KZN	Uthukela DM	627,689	1.3
NW	Southern DM	628,386	1.3
WC	Cape Winelands DM	639,619	1.3
LP	Waterberg DM	654,056	1.3
KZN	Ugu DM	700,259	1.4
FS	Lejweleputswa DM	759,749	1.5
FS	T Mofutsanyane DM	765,464	1.5
NW	Central DM	770,389	1.5
FS	Motheo DM	786,003	1.6
GP	West Rand DM	793,533	1.6
KZN	Zululand DM	825,830	1.7
KZN	Uthungulu DM	867,473	1.7
EC	C Hani DM	879,807	1.8
MP	G Sibande DM	911,954	1.8
GP	Sedibeng DM	920,227	1.8
KZN	uMgungundlovu DM	987,143	2.0
LP	Gr Sekhukhune DM	1,035,888	2.1
MP	Nkangala DM	1,107,210	2.2
LP	Mopani DM	1,108,078	2.2
LP	Capricorn DM	1,195,982	2.4
NW	Bojanala Platinum DM	1,261,009	2.5
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MP	Ehlanzeni DM	1,577,454	3.2
EC	O Tambo DM	1,816,535	3.6
EC	Amathole DM	1,857,529	3.7
EC	N Mandela MM	1,121,375	2.2
GP	Tshwane MM	2,101,119	4.2
GP	Ekurhuleni MM	2,532,760	5.1
WC	Cape Town MM	3,110,652	6.2
KZN	eThekwini MM	3,153,217	6.3
GP	Johannesburg MM	3,240,409	6.5

APPENDIX 2: District Management Competency Rating Tool

QUESTIONNAIRE: RATING OF COMPETENCIES

Province: …… District: ……..…..…… Date: …….

Please complete both parts of the questionnaire:

Part A – Basic Demographic Information

Part B – Personal Rating of Competencies (Overleaf)

PART A

Basic Demographic Information:
Please complete the following by encircling the appropriate category

Gender	**Male**			**Female**	
Age (years)	< 35		35-50		> 50
Years of service in the district management structure	<1	1-2	3- 5	5-10	> 10

PART B

PERSONAL RATING OF COMPETENCIES

Directions: Review each of the competencies independently. For each competency, using the Likert Scale of 1 to 5, rate the importance of the competency. One (1) indicates not very important while five (5) indicates extremely important. For each competency, enter a (X) in the appropriate number column against the competency.

		Importance of individual competencies				
	CORE COMPETENCIES	**1** Not very important	**2**	**3**	**4**	**5** Extremely Important
1	**People Management and Empowering Environment** (manage, encourage and develop people in a collaborative environment, advocates teamwork, effectively manage relationships)					
2	**Self Management** (recognises one's learning style, personal attributes, professional development needs, time management and initiative)					
3	**Honesty and Integrity** (committed, builds and displays high standards of ethical and moral conduct, applies self corrective measures, reliable and accountable)					
4	**Client Orientation and Customer focus** (acknowledges customer rights, service delivery according to Batho Pele principles)					
5	**Communication** (verbal and written communication, exchange of ideas, sharing of ideas and practices, internal and external)					
	MANAGERIAL COMPETENCIES					
6	**Financial Management** (managing budgets in line with service delegations and recognised financial practices)					
7	**Resource Management and Allocation** (human resources, physical resources and materials)					
8	**Problem Solving and Analysis** (systematic identification, analysis and resolution of existing and anticipated problems on a timely basis, manage risk appropriately)					
9	**Programme and Project Management** (strategy, planning, implementation, monitoring and evaluation from a programme perspective)					
10	**Community/Partnership Collaboration** (governance, stakeholder involvement and networking)					
11	**Knowledge Management** (promoting and sharing of knowledge, information, and lessons learnt, applying theory to practise)					
	LEADERSHIP COMPETENCIES					
12	**Strategic Leadership** (vision, direction, delivery from an organisational perspective)					
13	**Change Management** (organisational transformation, benchmarking)					
14	**Service Delivery Innovation (SDI)** (process integration, implement new ways of performing tasks, developing organisational learning)					
	ADDITIONAL COMPETENCIES					

APPENDIX 3: District Management Training Database

Course Category: Certificate

Course Structure: In-Service Block Training

Course Name	Training Institution	Course accredited	NQF level	Course length	Target group	Core Competency	Managerial Competency	Leadership Competency	Follow up Support
Advanced Management Development Programme (AMDP)	The South African Management Development Institute (SAMDI)	Yes	6	11-25 days	Middle Managers	All	All	All	Yes
Emerging Management Development Programme (EMDP)	The South African Management Development Institute (SAMDI)	Yes	5	11-25 days	Programme Managers	All	All	Strategic Leadership	Yes
Foundation Management Development Programme (FMDP)	The South African Management Development Institute (SAMDI)	Yes	4	6-10 days	Facility Managers	All	Programme and Project Management	None	Yes
Presidential Strategic Leadership Development Programme (PSLDP)	The South African Management Development Institute (SAMDI)	Yes	7	11-25 days	Senior Managers	All	All	All	Yes
Management Preparatory Programme	University of Free State	Unknown	(blank)	11-25 days	All Managers	All	All	All	No
Management Development Programme	University of Free State	Unknown	(blank)	1-2 years	All Managers	All	All	All	No
Management Development Programme	University of Western Cape	Unknown	(blank)	1-2 years	All Managers	All	All	All	No
Advanced Diploma in Management	University of Western Cape	Unknown	(blank)	1-2 years	All Managers	All	All	All	No

Course Name	Training Institution	Course accredited	NQF level	Course length	Target group	Core Competency	Managerial Competency	Leadership Competency	Follow up Support
Certificate Programme in Hospital Management	University of Witwatersrand	Yes	5	4-6 months	Facility Managers	Client Orientation and Customer focus	All	Strategic Leadership	No
Certificate Programme in Primary Health Care Services Management	University of Witwatersrand	Yes	5	4-6 months	All Managers	Client Orientation and Customer focus	All	Strategic Leadership	No
Project Management for the Public and Development Sectors	University of Witwatersrand	Unknown	(blank)	7-11 months	All Managers	None	Programme and Project Management	Strategic Leadership	No
Performance Budgeting and Financial Management Programme	Applied Fiscal Research Centre	Unknown	(blank)	1-2 years	All Managers	All	All	Strategic Leadership	No

Course Structure: In-Service Short Course

Acquisition Management	The South African Management Development Institute (SAMDI)	Yes	5	6-10 days	All Managers	None	Resource Management and Allocation	None	Yes
Asset Management	The South African Management Development Institute (SAMDI)	Yes	5	4-5 days	All Managers	None	Resource Management and Allocation	None	Yes
Change Management	The South African Management Development Institute (SAMDI)	Yes	3	1-3 days	All Managers	People Management and Empowering Environment	None	Change Management	Yes

Course Name	Training Institution	Course accredited	NQF level	Course length	Target group	Core Competency	Managerial Competency	Leadership Competency	Follow up Support
Compensation Management: Job Descriptions, Core and Job evaluation	The South African Management Development Institute (SAMDI)	Yes	Outcomes based	1-3 days	All Managers	People Management and Empowering Environment	None	None	Yes
Conflict resolution	The South African Management Development Institute (SAMDI)	Yes	3	1-3 days	All Managers	People Management and Empowering Environment	None	None	Yes
Contract Management	The South African Management Development Institute (SAMDI)	Yes	4	1-3 days	All Managers	None	Financial Management	None	Yes
Contract Management	The South African Management Development Institute (SAMDI)	Yes	4	1-3 days	All Managers	None	Resource Management and Allocation	None	Yes
Disability Management Creating a society for all: Implementing the Integrated National Disability Strategy Training Programme	The South African Management Development Institute (SAMDI)	Yes	3	1-3 days	All Managers	None	None	Service Delivery Innovation (SDI)	Yes
Diversity Management	The South African Management Development Institute (SAMDI)	Yes	3	1-3 days	All Managers	People Management and Empowering Environment	None	Service Delivery Innovation (SDI)	Yes
Ethics Management and Anti Corruption Strategies	The South African Management Development Institute (SAMDI) (s	Yes	4	4-5 days	All Managers	None	Financial Management	None	Yes

Course Name	Training Institution	Course accredited	NQF level	Course length	Target group	Core Competency	Managerial Competency	Leadership Competency	Follow up Support
Ethics Management and Anti Corruption Strategies	The South African Management Development Institute (SAMDI)	Yes	4	4-5 days	All Managers	None	Resource Management and Allocation	None	Yes
Gender Mainstreaming	The South African Management Development Institute (SAMDI)	Yes	3	1-3 days	All Managers	None	None	Service Delivery Innovation (SDI)	Yes
Grievance Procedures	The South African Management Development Institute (SAMDI)	Yes	6	1-3 days	All Managers	People Management and Empowering Environment	None	None	Yes
Hearing Procedures	The South African Management Development Institute (SAMDI)	Yes	6	4-5 days	All Managers	People Management and Empowering Environment	None	None	Yes
Human Resource Development	The South African Management Development Institute (SAMDI)	Yes	5	4-5 days	Facility Managers	People Management and Empowering Environment	None	None	Yes
Human Resource Planning	The South African Management Development Institute (SAMDI)	Yes	Outcomes based	4-5 days	All Managers	People Management and Empowering Environment	None	None	Yes

Course Name	Training Institution	Course accredited	NQF level	Course length	Target group	Core Competency	Managerial Competency	Leadership Competency	Follow up Support
Improving Service Delivery: Senior Manager's Programme	The South African Management Development Institute (SAMDI)	Yes	Outcomes based	1-3 days	Senior Managers	People Management and Empowering Environment	None	All	Yes
Introduction to Human Resource Management	The South African Management Development Institute (SAMDI)	Yes	Outcomes based	4-5 days	All Managers	People Management and Empowering Environment	None	None	Yes
Job Evaluation: Follow-up (Phase 2)	The South African Management Development Institute (SAMDI)	Yes	Outcomes based	1-3 days	All Managers	People Management and Empowering Environment	None	None	Yes
Job Evaluation: Initial Training (Phase 1)	The South African Management Development Institute (SAMDI)	Yes	Outcomes based	4-5 days	All Managers	People Management and Empowering Environment	None	None	Yes
Logistical Information System (LOGIS) I	The South African Management Development Institute (SAMDI)	Yes	4	11-25 days	Middle Managers	None	Resource Management and Allocation	None	Yes
Logistical Information System (LOGIS) II	The South African Management Development Institute (SAMDI)	Yes	4	6-10 days	Middle Managers	None	Resource Management and Allocation	None	Yes
Management Principles	The South African Management Development Institute (SAMDI)	Yes	5	4-5 days	Programme Managers	Communication	All	All	Yes

Course Name	Training Institution	Course accredited	NQF level	Course length	Target group	Core Competency	Managerial Competency	Leadership Competency	Follow up Support
Performance Management	The South African Management Development Institute (SAMDI)	Yes	4	1-3 days	All Managers	People Management and Empowering Environment	None	None	Yes
Project Management	The South African Management Development Institute (SAMDI)	Yes	5	1-3 days	All Managers	None	Financial Management	None	Yes
Project Management	The South African Management Development Institute (SAMDI)	Yes	5	1-3 days	All Managers	None	Resource Management and Allocation	None	Yes
Project Management	Damelin	Unknown	(blank)	1-3 months	All Managers	All	All	All	No
Project Management	Office of the Premier	No	(blank)	4-5 days	All Managers	None	Programme and Project Management	None	No
Promotion of the Administrative Justice Act	The South African Management Development Institute (SAMDI)	Yes	Outcomes based	1-3 days	All Managers	None	None	None	Yes
Promotion of the Administrative Justice Act	Office of the Premier	No	(blank)	4-5 days	All Managers	Self Management	Resource Management and Allocation	None	No
Seminar for Chief User and Chief User Clerk (LOGIS)	The South African Management Development Institute (SAMDI)	Yes	4	1-3 days	All Managers	None	Resource Management and Allocation	None	Yes

Course Name	Training Institution	Course accredited	NQF level	Course length	Target group	Core Competency	Managerial Competency	Leadership Competency	Follow up Support
Skills Development Facilitation	The South African Management Development Institute (SAMDI)	Yes	5	4-5 days	Programme Managers	People Management and Empowering Environment	None	None	Yes
Staffing Practices	The South African Management Development Institute (SAMDI)	Yes	5	6-10 days	All Managers	People Management and Empowering Environment	None	None	Yes
Strategic Planning	The South African Management Development Institute (SAMDI)	Yes	Outcomes based	1-3 days	All Managers	People Management and Empowering Environment	Financial Management	None	Yes
Supply Chain Management 1	The South African Management Development Institute (SAMDI)	Yes	5	11-25 days	All Managers	None	Resource Management and Allocation	None	Yes
Supply Chain Management 1 (Block 1+2)	The South African Management Development Institute (SAMDI)	Yes	5	4-5 days	All Managers	None	Resource Management and Allocation	None	Yes
Supply Chain Management for Cost Centre Managers and Clerks	The South African Management Development Institute (SAMDI)	Yes	5	1-3 days	All Managers	None	Resource Management and Allocation	None	Yes
Supply Chain Management for Municipalities and Municipal Entities	The South African Management Development Institute (SAMDI)	Yes	(blank)	1-3 days	All Managers	None	Resource Management and Allocation	None	Yes

Course Name	Training Institution	Course accredited	NQF level	Course length	Target group	Core Competency	Managerial Competency	Leadership Competency	Follow up Support
Team building	The South African Management Development Institute (SAMDI)	Yes	3	1-3 days	All Managers	People Management and Empowering Environment	None	None	Yes
Workshop in Supply Chain Management for Senior Managers in Municipalities and Municipal Entities	The South African Management Development Institute (SAMDI)	Yes	6	1-3 days	All Managers	None	Resource Management and Allocation	None	Yes
Batho Pele Implementation: Service Delivery for Operational Managers	The South African Management Development Institute (SAMDI)	Yes	4	1-3 days	All Managers	None	None	All	Yes
Johnson & Johnson Hospital Leadership Programme	University of Cape Town	Unknown	(blank)	4-5 days	All Managers	All	All	All	No
Financial Management	Damelin	Unknown	(blank)	1-3 months	All Managers	All	All	All	No
Using Information for Management (incl. DHIS & Pivot tables)	In-service & other training	No	(blank)	4-5 days	All Managers	None	Programme and Project Management	None	No
Monitoring and Evaluation	In-service & other training	No	(blank)	4-5 days	All Managers	None	Programme and Project Management	None	No
District Health Plans (DHP)	In-service & other training	No	(blank)	4-5 days	All Managers	None	Programme and Project Management	Strategic Leadership	No
District Management and Leadership	In-service & other training	No	(blank)	4-5 days	All Managers	None	Programme and Project Management	Strategic Leadership	No

Course Name	Training Institution	Course accredited	NQF level	Course length	Target group	Core Competency	Managerial Competency	Leadership Competency	Follow up Support
Financial Management for non-Financial Managers	In-service & other training	No	(blank)	4-5 days	All Managers	None	Financial Management	None	No
Disciplinary Training for Clinic Managers, Supervisors & Line Managers	In-service & other training	No	(blank)	1-3 days	All Managers	People Management and Empowering Environment	None	None	No
BAS Budgeting and Financial Managers (for LA Managers)	In-service & other training	No	(blank)	4-5 days	All Managers	None	Financial Management	None	No
Team building (conducted in District by private company)	In-service & other training	No	(blank)	4-5 days	All Managers	People Management and Empowering Environment	None	None	No
Health Information (Foundation Course)	In-service & other training	No	(blank)	1-3 days	All Managers	None	Programme and Project Management	None	No
PERSAL	In-service & other training	No	(blank)	4-5 days	All Managers	None	Resource Management and Allocation	None	No
Transformational Leadership	In-service & other training	No	(blank)	4-5 days	All Managers	None	None	Change Management	No
Vulindlela Financial System	In-service & other training	No	(blank)	4-5 days	All Managers	None	Financial Management	None	No
Computer Training	In-service & other training	No	(blank)	4-5 days	All Managers	Self Management	None	None	No

Course Name	Training Institution	Course accredited	NQF level	Course length	Target group	Core Competency	Managerial Competency	Leadership Competency	Follow up Support
Supply Chain Management	In-service & other training	No	(blank)	4-5 days	All Managers	None	Resource Management and Allocation	None	No

Course Structure: Workshop

Change Management	Price Waterhouse Coopers	Yes	(blank)	1-3 days	All Managers	People Management and Empowering Environment	Resource Management and Allocation	Change Management	No
Performance Management	Stellenbosch University	Yes	(blank)	1-3 days	All Managers	People Management and Empowering Environment	Resource Management and Allocation	None	No
Project Management	Stellenbosch University	Yes	(blank)	4-5 days	All Managers	People Management and Empowering Environment	Programme and Project Management	Strategic Leadership	No
Service Delivery Enrichment Programme	The South African Management Development Institute (SAMDI)	Yes	Outcomes based	1-3 days	All Managers	None	None	Service Delivery Innovation (SDI)	Yes
People Management	Kwelanga Training	Yes	4	1-3 days	All Managers	All	Problem Solving and Analysis	Change Management	No

Course Name	Training Institution	Course accredited	NQF level	Course length	Target group	Core Competency	Managerial Competency	Leadership Competency	Follow up Support
People Management	Stellenbosch University	Yes	(blank)	1-3 days	All Managers	People Management and Empowering Environment	Resource Management and Allocation	Change Management	No
Project Management for Non-Project Managers	Kwelanga Training	Yes	4	1-3 days	All Managers	People Management and Empowering Environment	Programme and Project Management	Strategic Leadership	No
Project Management for Non-Project Managers	University of Pretoria	Unknown	(blank)	1-3 days	All Managers	None	Programme and Project Management	None	No
Project Management for Non-Project Managers						People Management and Empowering Environment	Programme and Project Management	None	No
Managing Conflict	Kwelanga Training	Yes	5	1-3 days	All Managers	People Management and Empowering Environment	Problem Solving and Analysis	Strategic Leadership	No
Cultural Diversity	Kwelanga Training	Yes	3	1-3 days	All Managers	People Management and Empowering Environment	None	Change Management	No
Finance for Non-Finance Managers	Kwelanga Training	Yes	4	1-3 days	All Managers	None	Financial Management	None	No

Course Name	Training Institution	Course accredited	NQF level	Course length	Target group	Core Competency	Managerial Competency	Leadership Competency	Follow up Support
Finance for Non-Finance Managers	Price Waterhouse Coopers	Yes	(blank)	4-5 days	All Managers	None	Financial Management	None	No
Finance for Non-Finance Managers	University of Cape Town	Yes	(blank)	4-5 days	All Managers	All	Financial Management	All	No
Finance for Non-Finance Managers	University of Pretoria	Unknown	(blank)	4-5 days	All Managers	People Management and Empowering Environment	Financial Management	None	No
Managing Diversity	Mandala Consulting	Yes	5	1-3 days	All Managers	People Management and Empowering Environment	None	Change Management	No
Managing Diversity	Price Waterhouse Coopers	Yes	(blank)	1-3 days	All Managers	People Management and Empowering Environment	Resource Management and Allocation	Change Management	No
Stress Management	Kwelanga Training	Yes	5	1-3 days	All Managers	Self Management	None	Change Management	No
Stress Management	Mandala Consulting	Yes	5	1-3 days	All Managers	Self Management	None	None	No
Stress Management	Free to Grow	Yes	5	1-3 days	All Managers	Self Management	None	None	No
Teambuilding to meet goals	Mandala Consulting	Yes	5	1-3 days	All Managers	People Management and Empowering Environment	None	None	No

Course Name	Training Institution	Course accredited	NQF level	Course length	Target group	Core Competency	Managerial Competency	Leadership Competency	Follow up Support
Personal Effectiveness Programme	Free to Grow	Yes	5	4-5 days	All Managers	Self Management	None	None	No
Assertiveness at work	Free to Grow	Yes	4	1-3 days	All Managers	Self Management	None	None	No
Mentoring and Coaching	Price Waterhouse Coopers	Yes	(blank)	1-3 days	All Managers	People Management and Empowering Environment	Resource Management and Allocation	Strategic Leadership	No
Mentoring and Coaching	Stellenbosch University	Yes	(blank)	1-3 days	All Managers	People Management and Empowering Environment	Resource Management and Allocation	Strategic Leadership	No
Competency Technique Based Assessment	Price Waterhouse Coopers	Yes	(blank)	1-3 days	All Managers	People Management and Empowering Environment	Resource Management and Allocation	Service Delivery Innovation (SDI)	No
Microsoft Office Suite Curriculum Advanced	CTU Training Solutions	Unknown	(blank)	4-5 days	All Managers	None	None	None	No
MS Project XP	CTU Training Solutions	Unknown	(blank)	4-5 days	All Managers	None	Programme and Project Management	Service Delivery Innovation (SDI)	No
Project Management Fundamentals	CTU Training Solutions	Unknown	(blank)	1-3 days	All Managers	None	Programme and Project Management	Service Delivery Innovation (SDI)	No

Course Name	Training Institution	Course accredited	NQF level	Course length	Target group	Core Competency	Managerial Competency	Leadership Competency	Follow up Support
The fundamentals of Project Management	Papillon Training	Yes	4	1-3 days	All Managers	People Management and Empowering Environment	Programme and Project Management	Service Delivery Innovation (SDI)	No
Diversity and Conflict Management	Papillon Training	Yes	5	1-3 days	All Managers	People Management and Empowering Environment	Resource Management and Allocation	Change Management	No
Financial Management for Line Managers	Stellenbosch University	Yes	(blank)	4-5 days	All Managers	None	Financial Management	None	No
Managing Outcomes in the Public Sector	Stellenbosch University	Yes	(blank)	4-5 days	All Managers	People Management and Empowering Environment	Resource Management and Allocation	Service Delivery Innovation (SDI)	No
Public Management Certificate	Stellenbosch University	Yes	(blank)	4-5 days	All Managers	All	All	All	No
Advanced Project Management (pre-requisite Project Management)	Stellenbosch University	Yes	(blank)	4-5 days	All Managers	People Management and Empowering Environment	Programme and Project Management	Strategic Leadership	No
Enhancing Service Delivery	Stellenbosch University	Yes	(blank)	1-3 days	All Managers	All	All	All	No
Leadership Innovation and Change Management	Stellenbosch University	Yes	(blank)	4-5 days	All Managers	People Management and Empowering Environment	All	All	No

Course Name	Training Institution	Course accredited	NQF level	Course length	Target group	Core Competency	Managerial Competency	Leadership Competency	Follow up Support
Strategic thinking, planning & management in the public sector	Stellenbosch University	Yes	(blank)	4-5 days	All Managers	All	All	All	No
Outcomes based monitoring and evaluation	Stellenbosch University	Yes	(blank)	4-5 days	All Managers	None	Knowledge Management	Service Delivery Innovation (SDI)	No
Public Sector Management Reform	Stellenbosch University	Yes	(blank)	1-3 days	All Managers	People Management and Empowering Environment	Resource Management and Allocation	Change Management	No
New Managers Programme (NMP)	University of Cape Town	Yes	(blank)	6-10 days	Facility Managers	All	All	All	No
Embracing Complexity and Diversity	University of Cape Town	Yes	(blank)	6-10 days	All Managers	All	All	All	No
Short Course: Project Management	University of Johannesburg	Yes	6	4-5 days	All Managers	People Management and Empowering Environment	Programme and Project Management	All	No
Short Course: Facilitate the evidence collection process	University of Johannesburg	Yes	4	1-3 days	All Managers	None	Resource Management and Allocation	None	No
Short Course: Performance and Quality Management	University of Johannesburg	Yes	5	1-3 days	All Managers	People Management and Empowering Environment	Programme and Project Management	None	No

Course Name	Training Institution	Course accredited	NQF level	Course length	Target group	Core Competency	Managerial Competency	Leadership Competency	Follow up Support
Short Course: Information Management Systems	University of Johannesburg	Yes	5	1-3 days	All Managers	None	Knowledge Management	None	No
Short Course: Labour Relations	University of Johannesburg	Yes	5	1-3 days	All Managers	People Management and Empowering Environment	Problem Solving and Analysis	Change Management	No
E-degree Project Management	University of Johannesburg	Yes	7	6-10 days	All Managers	People Management and Empowering Environment	Programme and Project Management	None	No
Using HR for competitive advantage	University of Pretoria	Unknown	(blank)	1-3 days	All Managers	People Management and Empowering Environment	Resource Management and Allocation	None	No
General Management for results	University of Pretoria	Unknown	(blank)	1-3 days	All Managers	People Management and Empowering Environment	Resource Management and Allocation	None	No
Managing for results	University of Pretoria	Unknown	(blank)	1-3 days	All Managers	People Management and Empowering Environment	Resource Management and Allocation	None	No

Course Name	Training Institution	Course accredited	NQF level	Course length	Target group	Core Competency	Managerial Competency	Leadership Competency	Follow up Support
Managing Managers for results	University of Pretoria	Unknown	(blank)	1-3 days	All Managers	People Management and Empowering Environment	Resource Management and Allocation	None	No
Winter School Programme (various short courses in Public Health)	University of Western Cape	Unknown	(blank)	4-5 days	All Managers	All	All	All	No
Integrated HIV services in District and Primary Health Care settings	University of Witwatersrand	Unknown	(blank)	4-5 days	All Managers	Client Orientation and Customer focus	Programme and Project Management	Service Delivery Innovation (SDI)	No

Course Structure: Distance Learning

Certificate Advanced Health Management (CAHM)	Foundation for Professional Development	Yes	6	1-2 years	All Managers	All	All	All	No
FPD/Yale Advanced Health Management Programme	Foundation for Professional Development	Yes	Outcomes based	7-11 months	All Managers	All	All	All	No
Manchester Business School Advanced Management Programme	Foundation for Professional Development	Yes	Outcomes based	7-11 months	All Managers	All	All	All	No
Advanced Management Programme	Foundation for Professional Development	No	Outcomes based	1-2 years	All Managers	All	All	All	No
Introduction to Health Systems and Management	University of Limpopo	Yes	(blank)	4-6 months	All Managers	All	All	All	No

Course Name	Training Institution	Course accredited	NQF level	Course length	Target group	Core Competency	Managerial Competency	Leadership Competency	Follow up Support
Introduction to Health Policy	University of Limpopo	Yes	(blank)	4-6 months	All Managers	All	All	All	No
Intermediate Health Systems and Management	University of Limpopo	Yes	(blank)	4-6 months	All Managers	All	All	All	No
Intermediate Health Policy	University of Limpopo	Yes	(blank)	4-6 months	All Managers	All	All	All	No
Introductory Community Oriented PHC	University of Limpopo	Yes	(blank)	4-6 months	All Managers	All	All	All	No
Intermediate Community Oriented PHC	University of Limpopo	Yes	(blank)	4-6 months	All Managers	All	All	All	No

Course Structure: External Full-time

Certificate Office Management and Technology	Central University of Technology	Yes	5	1-2 years	Facility Managers	Communication	Knowledge Management	None	No
Management 1	Rhodes University	Yes	Outcomes based	1-2 years	Facility Managers	All	All	All	No
Management 2	Rhodes University	Yes	Outcomes based	1-2 years	Facility Managers	All	All	All	No
Management 3	Rhodes University	Yes	Outcomes based	1-2 years	Facility Managers	All	All	All	No
Management 4 / Honours	Rhodes University	Yes	Outcomes based	1-2 years	Facility Managers	All	All	All	No
Associate in Management	University of Cape Town	Yes	(blank)	1-2 years	All Managers	All	All	All	No
Certificate Human Resource Management	University of Johannesburg	Yes	4	1-2 years	All Managers	All	All	All	No
	University of South Africa	Yes	4	1-2 years	All Managers	All	All	All	No
Certificate Project Management	University of South Africa	Yes	4	1-2 years	All Managers	All	All	All	No

Course Category: Diploma

Course Structure: In-Service Block Training

Diploma in Health Management	University of Witwatersrand	Unknown	(blank)	1-2 years	All Managers	All	All	All	No

Course Structure: External Full-time

Course Name	Training Institution	Course accredited	NQF level	Course length	Target group	Core Competency	Managerial Competency	Leadership Competency	Follow up Support
National Diploma Public Management	Central University of Technology	Yes	6	3-4 years	Facility Managers	All	All	All	No
National Diploma Public Management	Cape Peninsula University of Technology	Yes	6	3-4 years	Facility Managers	All	All	All	No
National Diploma Public Management	Durban Institute of Technology	Yes	6	3-4 years	Facility Managers	All	All	All	No
National Diploma Public Management	Mangosuthu Technikon	Yes	6	3-4 years	Facility Managers	All	All	All	No
National Diploma Public Management	Nelson Mandela Metro University	Yes	6	3-4 years	Facility Managers	All	All	All	No
National Diploma Public Management	North West University	Yes	6	3-4 years	Facility Managers	All	All	All	No
National Diploma Public Management	Walter Sisulu University	Yes	6	3-4 years	Facility Managers	All	All	All	No
National Diploma Human Resource Management	Central University of Technology	Yes	6	3-4 years	Facility Managers	All	All	All	No
National Diploma Human Resource Management	Cape Peninsula University of Technology	Yes	6	3-4 years	Facility Managers	All	All	All	No
National Diploma Human Resource Management	Durban Institute of Technology	Yes	6	3-4 years	Facility Managers	All	All	All	No

Course Name	Training Institution	Course accredited	NQF level	Course length	Target group	Core Competency	Managerial Competency	Leadership Competency	Follow up Support
National Diploma Human Resource Management	Mangosuthu Technikon	Yes	6	3-4 years	Facility Managers	All	All	All	No
National Diploma Human Resource Management	Tshwane University of Technology	Yes	6	3-4 years	Facility Managers	All	All	All	No
National Diploma Human Resource Management	University of Johannesburg	Yes	6	3-4 years	Facility Managers	All	All	All	No
National Diploma Human Resource Management	Vaal University of Technology	Yes	6	3-4 years	Facility Managers	All	All	All	No
National Diploma Human Resource Management	Walter Sisulu University	Yes	6	3-4 years	Facility Managers	All	All	All	No
Diploma Office Management and Technology	Central University of Technology	Yes	6	3-4 years	Facility Managers	All	All	All	No
National Diploma Office Management and Technology	Cape Peninsula University of Technology	Yes	6	3-4 years	Facility Managers	All	All	All	No
National Diploma Office Management and Technology	Durban Institute of Technology	Yes	6	3-4 years	Facility Managers	All	All	All	No
National Diploma Office Management and Technology	Mangosuthu Technikon	Yes	6	3-4 years	Facility Managers	All	All	All	No
National Diploma Office Management and Technology	Nelson Mandela Metro University	Yes	6	3-4 years	Facility Managers	All	All	All	No
National Diploma Office Management and Technology	Tshwane University of Technology	Yes	6	3-4 years	All Managers	All	All	All	No
National Diploma Office Management and Technology	Walter Sisulu University	Yes	6	3-4 years	Facility Managers	All	All	All	No

Course Name	Training Institution	Course accredited	NQF level	Course length	Target group	Core Competency	Managerial Competency	Leadership Competency	Follow up Support
National Diploma Public Service Management	Mangosuthu Technikon	Yes	6	3-4 years	Facility Managers	All	All	All	No
National Diploma Management	Nelson Mandela Metro University	Yes	6	3-4 years	Facility Managers	All	All	All	No
	Tshwane University of Technology	Yes	6	3-4 years	All Managers	All	All	All	No
National Diploma Management	University of Johannesburg	Yes	6	3-4 years	Facility Managers	All	All	All	No
National Diploma Management	Walter Sisulu University	Yes	6	3-4 years	Facility Managers	All	All	All	No
Diploma Human Resource Management and Practices	University of Johannesburg	Yes	5	1-2 years	All Managers	All	All	All	No
Diploma Public Management	University of Limpopo	Yes	6	3-4 years	Facility Managers	All	All	All	No
National Diploma Labour Relations	Vaal University of Technology	Yes	6	3-4 years	Facility Managers	All	All	All	No
National Diploma Adminsitrative Management	Walter Sisulu University	Yes	6	3-4 years	Facility Managers	All	All	All	No

Course Category: Degree

Course Structure: In-Service Block Training

Course Name	Training Institution	Course accredited	NQF level	Course length	Target group	Core Competency	Managerial Competency	Leadership Competency	Follow up Support
Advanced Diploma in Management	University of Fort Hare	Yes	6	1-2 years	Middle Managers	All	All	All	No

Course Structure: External Full-time

B Tech Public Management	Central University of Technology	Yes	7	1-2 years	Middle Managers	All	All	All	No
B Tech Public Management	Cape Peninsula University of Technology	Yes	7	1-2 years	Middle Managers	All	All	All	No
B Tech Public Management	Durban Institute of Technology	Yes	7	1-2 years	Middle Managers	All	All	All	No
B Tech Public Management	Nelson Mandela Metro University	Yes	7	1-2 years	Middle Managers	All	All	All	No
B Tech Public Management	University of South Africa	Yes	7	1-2 years	Middle Managers	All	All	All	No
B Tech Human Resource Management	Central University of Technology	Yes	7	1-2 years	Middle Managers	All	All	All	No
B Tech Human Resource Management	Cape Peninsula University of Technology	Yes	7	1-2 years	Middle Managers	All	All	All	No
B Tech Human Resource Management	Durban Institute of Technology	Yes	7	1-2 years	Middle Managers	All	All	All	No
B Tech Human Resource Management	Mangosuthu Technikon	Yes	7	1-2 years	Middle Managers	All	All	All	No
B Tech Human Resource Management	Tshwane University of Technology	Yes	7	1-2 years	Middle Managers	All	All	All	No

Course Name	Training Institution	Course accredited	NQF level	Course length	Target group	Core Competency	Managerial Competency	Leadership Competency	Follow up Support
B Tech Human Resource Management	University of Johannesburg	Yes	7	1-2 years	Middle Managers	All	All	All	No
B Tech Human Resource Management	University of South Africa	Yes	7	1-2 years	Middle Managers	All	All	All	No
B Tech Human Resource Management	Vaal University of Technology	Yes	7	1-2 years	Middle Managers	All	All	All	No
B Tech Human Resource Management	Walter Sisulu University	Yes	7	1-2 years	Middle Managers	All	All	All	No
B Tech Office Management and Technology	Central University of Technology	Yes	7	1-2 years	Middle Managers	All	All	All	No
B Tech Office Management and Technology	Cape Peninsula University of Technology	Yes	7	1-2 years	Middle Managers	All	All	All	No
B Tech Office Management and Technology	Durban Institute of Technology	Yes	7	1-2 years	Middle Managers	All	All	All	No
B Tech Office Management and Technology	Tswane University of Technology	Yes	7	1-2 years	All Managers	All	All	All	No
B Tech Office Management and Technology	Walter Sisulu University	Yes	7	1-2 years	Middle Managers	All	All	All	No
B Tech Project Management	Central University of Technology	Yes	7	1-2 years	Middle Managers	All	All	All	No
B Tech Project Management	Cape Peninsula University of Technology	Yes	7	1-2 years	Middle Managers	All	All	All	No
B Tech Human Resource Development	Cape Peninsula University of Technology	Yes	7	1-2 years	Middle Managers	All	All	All	No

Course Name	Training Institution	Course accredited	NQF level	Course length	Target group	Core Competency	Managerial Competency	Leadership Competency	Follow up Support
B Tech Human Resource Development	Tshwane University of Technology	Yes	7	1-2 years	Middle Managers	All	All	All	No
B Tech Human Resource Development	University of South Africa	Yes	7	1-2 years	Middle Managers	All	All	All	No
B Admin degree	Nelson Mandela Metro University	Yes	6	3-4 years	Middle Managers	All	All	All	No
B Admin degree	University of Free State	Yes	6	3-4 years	Facility Managers	All	All	All	No
B Tech Management	Nelson Mandela Metro University	Yes	7	1-2 years	Middle Managers	All	All	All	No
B Tech Management	Tshwane University of Technology	Yes	7	1-2 years	All Managers	All	All	All	No
B Tech Management	University of South Africa	Yes	7	1-2 years	Middle Managers	All	All	All	No
B Tech Management	Walter Sisulu University	Yes	7	1-2 years	Middle Managers	All	All	All	No
B Admin Human Resource Management and Labour Relations	North West University	Yes	6	3-4 years	Facility Managers	All	All	All	No
B Admin Human Resource Management	North West University	Yes	6	3-4 years	Facility Managers	All	All	All	No
B Admin Human Resource Management	Stellenbosch University	Yes	6	3-4 years	Facility Managers	All	All	All	No
B Admin Human Resource Management	University of Venda	Yes	6	3-4 years	Facility Managers	All	All	All	No
B Admin Human Resource Management	University of Zululand	Yes	6	3-4 years	Facility Managers	All	All	All	No

Course Name	Training Institution	Course accredited	NQF level	Course length	Target group	Core Competency	Managerial Competency	Leadership Competency	Follow up Support
B Admin Local Government	North West University	Yes	6	3-4 years	Facility Managers	All	All	All	No
B Comm Management Sciences	Stellenbosch University	Yes	6	3-4 years	Facility Managers	All	All	All	No
B Comm Management	University of Cape Town	Yes	6	3-4 years	All Managers	All	All	All	No
B Comm Management	University of South Africa	Yes	6	3-4 years	Facility Managers	All	All	All	No
B Comm Management	University of Western Cape	Yes	6	3-4 years	Facility Managers	All	All	All	No
B Tech Management Services	University of Johannesburg	Yes	7	1-2 years	Middle Managers	All	All	All	No
B Comm Human Resource Management	University of Johannesburg	Yes	6	3-4 years	Facility Managers	All	All	All	No
B Comm Human Resource Management	University of Limpopo	Yes	6	3-4 years	Facility Managers	All	All	All	No
B Comm Human Resource Management	University of Pretoria	Yes	6	3-4 years	Facility Managers	All	All	All	No
B Comm Human Resource Management	University of South Africa	Yes	6	3-4 years	Facility Managers	All	All	All	No
B Comm Human Resource Management	University of Venda	Yes	6	3-4 years	Facility Managers	All	All	All	No
B Comm Human Resource Management	University of Zululand	Yes	6	3-4 years	Facility Managers	All	All	All	No
B Comm Information Management	University of Johannesburg	Yes	6	3-4 years	Facility Managers	All	All	All	No
B Comm Public Affairs	University of Pretoria	Yes	6	3-4 years	Facility Managers	All	All	All	No

Course Name	Training Institution	Course accredited	NQF level	Course length	Target group	Core Competency	Managerial Competency	Leadership Competency	Follow up Support
B Admin Public Management	University of Pretoria	Yes	6	3-4 years	Facility Managers	All	All	All	No
B Publications degree	University of Free State	Yes	6	3-4 years	Facility Managers	All	All	All	No
B Admin Public Administration	University of Western Cape	Yes	6	3-4 years	Facility Managers	All	All	All	No
B Admin Public Administration	University of Venda	Yes	6	3-4 years	Facility Managers	All	All	All	No
B Comm Public Administration	University of Western Cape	Yes	6	3-4 years	Facility Managers	All	All	All	No
B Tech Labour Relations	Vaal University of Technology	Yes	7	1-2 years	Middle Managers	All	All	All	No
B Tech Community Nursing	Vaal University of Technology	Yes	7	1-2 years	Middle Managers	All	All	All	No
B Admin Public Sector Management and Administration	University of Fort Hare	Yes	6	3-4 years	Facility Managers	All	All	All	No
B Social Science Human Resource Management	University of Fort Hare	Yes	6	3-4 years	Facility Managers	All	All	All	No
Higher Diploma District Health Services Management and Administration	University of Fort Hare	Yes	7	1-2 years	Middle Managers	All	All	All	No

Course Category: Postgraduate

Course Structure: External Full-time

M Tech Human Resource Management	Durban Institute of Technology	Yes	7	1-2 years	Middle Managers	All	All	All	No

Course Name	Training Institution	Course accredited	NQF level	Course length	Target group	Core Competency	Managerial Competency	Leadership Competency	Follow up Support
M Tech Human Resource Management	Durban Institute of Technology	Yes	7	1-2 years	Middle Managers	All	All	All	No
M Tech Human Resource Management	Tshwane University of Technology	Yes	7	1-2 years	Middle Managers	All	All	All	No
M Tech Human Resource Management	University of Johannesburg	Yes	7	1-2 years	Middle Managers	All	All	All	No
M Tech Human Resource Management	Vaal University of Technology	Yes	7	1-2 years	Middle Managers	All	All	All	No
D Tech Human Resource Management	Cape Peninsula University of Technology	Yes	8	1-2 years	Senior Managers	All	All	All	No
D Tech Human Resource Management	Tshwane University of Technology	Yes	8	1-2 years	Senior Managers	All	All	All	No
D Tech Human Resource Management	Vaal University of Technology	Yes	8	1-2 years	Senior Managers	All	All	All	No
M Tech Office Management and Technology	Tshwane University of Technology	Yes	7	1-2 years	All Managers	All	All	All	No
M Tech Public Management	Cape Peninsula University of Technology	Yes	7	1-2 years	Middle Managers	All	All	All	No

Course Name	Training Institution	Course accredited	NQF level	Course length	Target group	Core Competency	Managerial Competency	Leadership Competency	Follow up Support
M Tech Public Management	Durban Institute of Technology	Yes	7	1-2 years	Middle Managers	All	All	All	No
M Tech Public Management	Nelson Mandela Metro University	Yes	7	1-2 years	Middle Managers	All	All	All	No
M Tech Public Management	University of South Africa	Yes	7	1-2 years	Middle Managers	All	All	All	No
D Tech Public Management	Cape Peninsula University of Tech	Yes	8	1-2 years	Senior Managers	All	All	All	No
D Tech Public Management	Durban Institute of Technology	Yes	8	1-2 years	Senior Managers	All	All	All	No
D Tech Public Management	Nelson Mandela Metro University	Yes	8	1-2 years	Senior Managers	All	All	All	No
Masters in Public Management	Nelson Mandela Metro University	Yes	8	1-2 years	Middle Managers	All	All	All	No
Masters in Public Management	North West University	Yes	8	1-2 years	Middle Managers	All	All	All	No
Honours Public Management	North West University	Yes	8	1-2 years	Middle Managers	All	All	All	No
Honours Public Management	North West University	Yes	8	1-2 years	Middle Managers	All	All	All	No
Honours Public Mx	North West University	Yes	8	1-2 years	Middle Managers	All	All	All	No

Course Name	Training Institution	Course accredited	NQF level	Course length	Target group	Core Competency	Managerial Competency	Leadership Competency	Follow up Support
Honours Public Management	North West University	Yes	8	1-2 years	Middle Managers	All	All	All	No
Honours Public Management	University of Limpopo	Yes	8	1-2 years	Middle Managers	All	All	All	No
Honours Public Management	University of Pretoria	Yes	8	1-2 years	Middle Managers	All	All	All	No
Masters Human Resource Management	North West University	Yes	8	1-2 years	Middle Managers	All	All	All	No
Masters Human Resource Management	University of Johannesburg	Yes	8	1-2 years	All Managers	All	All	All	No
Masters Human Resource Management	University of Limpopo	Yes	8	1-2 years	All Managers	All	All	All	No
Masters Human Resource Management	University of Pretoria	Yes	8	1-2 years	All Managers	All	All	All	No
Masters Human Resource Management	University of Venda	Yes	8	1-2 years	All Managers	All	All	All	No
Honours Human Resource Management	North West University	Yes	8	1-2 years	Middle Managers	All	All	All	No
Honours Human Resource Mx	Stellenbosch University	Yes	8	1-2 years	Middle Managers	All	All	All	No

Course Name	Training Institution	Course accredited	NQF level	Course length	Target group	Core Competency	Managerial Competency	Leadership Competency	Follow up Support
Honours Human Resource Management	University of Johannesburg	Yes	8	1-2 years	Middle Managers	All	All	All	No
Honours Human Resource Management	University of Kwa-Zulu Natal	Yes	8	1-2 years	Middle Managers	All	All	All	No
Honours Human Resource Management	University of Limpopo	Yes	8	1-2 years	Middle Managers	All	All	All	No
Honours Human Resource Management	University of Pretoria	Yes	8	1-2 years	Middle Managers	All	All	All	No
Honours Human Resource Management	University of South Africa	Yes	8	1-2 years	Middle Managers	All	All	All	No
Honours Human Resource Management	University of Western Cape	Yes	8	1-2 years	Middle Managers	All	All	All	No
Honours Human Resource Management	University of Venda	Yes	8	1-2 years	Middle Managers	All	All	All	No
Postgraduate Diploma Local Government Administration	Rhodes University	Yes	6	1-2 years	Middle Managers	All	All	All	No
Postgraduate Diploma HIV/AIDS Management	Stellenbosch University	Yes	6	1-2 years	Middle Managers	All	All	All	No

Course Name	Training Institution	Course accredited	NQF level	Course length	Target group	Core Competency	Managerial Competency	Leadership Competency	Follow up Support
Honours Public Administration	Stellenbosch University	Yes	8	1-2 years	Middle Managers	All	All	All	No
Honours Public Administration	University of Pretoria	Yes	8	1-2 years	Middle Managers	All	All	All	No
Honours Public Administration	University of South Africa	Yes	8	1-2 years	Middle Managers	All	All	All	No
Honours Public Administration	University of Western Cape	Yes	8	1-2 years	Middle Managers	All	All	All	No
Honours Public Administration	University of Fort Hare	Yes	8	1-2 years	Middle Managers	All	All	All	No
Honours Public and Development Management	Stellenbosch University	Yes	8	1-2 years	Middle Managers	All	All	All	No
Masters HIV/AIDS Management	Stellenbosch University	Yes	8	1-2 years	All Managers	All	All	All	No
M Tech Human Resource Development	Tshwane University of Technology	Yes	7	1-2 years	Middle Managers	All	All	All	No
M Tech Human Resource Development	University of South Africa	Yes	7	1-2 years	Middle Managers	All	All	All	No
D Tech Human Resource Development	Tshwane University of Technology	Yes	8	1-2 years	Senior Managers	All	All	All	No
Postgraduate Diploma Mx	University of Cape Town	Yes	6	1-2 years	All Managers	All	All	All	No

Course Name	Training Institution	Course accredited	NQF level	Course length	Target group	Core Competency	Managerial Competency	Leadership Competency	Follow up Support
Postgraduate Diploma Information Management	University of Johannesburg	Yes	6	1-2 years	All Managers	All	All	All	No
Honours Human Resource Development	University of Johannesburg	Yes	8	1-2 years	Middle Managers	All	All	All	No
Honours Information Management	University of Johannesburg	Yes	8	1-2 years	Middle Managers	All	All	All	No
Masters Human Resource Development	University of Johannesburg	Yes	8	1-2 years	All Managers	All	All	All	No
Postgraduate Diploma Human Resource Management	University of Kwa-Zulu Natal	Yes	6	1-2 years	All Managers	All	All	All	No
Postgraduate Diploma Management	University of Kwa-Zulu Natal	Yes	6	1-2 years	All Managers	All	All	All	No
Postgraduate Diploma Management	University of Witwatersrand	Yes	7	1-2 years	All Managers	All	All	All	No
Postgraduate Diploma Leadership and Management	University of Kwa-Zulu Natal	Yes	6	1-2 years	All Managers	All	All	All	No
Honours Management	University of Kwa-Zulu Natal	Yes	8	1-2 years	Middle Managers	All	All	All	No
Honours Management	University of Western Cape	Yes	8	1-2 years	Middle Managers	All	All	All	No

Course Name	Training Institution	Course accredited	NQF level	Course length	Target group	Core Competency	Managerial Competency	Leadership Competency	Follow up Support
Masters Leadership and Management	University of Kwa-Zulu Natal	Yes	8	1-2 years	All Managers	All	All	All	No
Masters Management	University of Kwa-Zulu Natal	Yes	8	1-2 years	All Managers	All	All	All	No
Masters Management	University of Western Cape	Yes	8	1-2 years	All Managers	All	All	All	No
Masters Public Management	University of Limpopo	Yes	8	1-2 years	All Managers	All	All	All	No
Masters Public Management	University of Pretoria	Yes	8	1-2 years	Middle Managers	All	All	All	No
Masters Public Management	University of Venda	Yes	8	1-2 years	All Managers	All	All	All	No
Masters Public Administration	University of Pretoria	Yes	8	1-2 years	Middle Managers	All	All	All	No
Masters Public Administration	University of South Africa	Yes	8	1-2 years	All Managers	All	All	All	No
Masters Public Administration	University of Western Cape	Yes	8	1-2 years	All Managers	All	All	All	No
Masters Public Administration	University of Fort Hare	Yes	8	1-2 years	All Managers	All	All	All	No
Postgraduate Certificate Public Health	University of Western Cape	Yes	6	1-2 years	All Managers	All	All	All	No
Postgraduate Diploma Public Health	University of Western Cape	Yes	7	1-2 years	All Managers	All	All	All	No

Course Name	Training Institution	Course accredited	NQF level	Course length	Target group	Core Competency	Managerial Competency	Leadership Competency	Follow up Support
Masters in Public Health	University of Western Cape	Yes	8	1-2 years	All Managers	All	All	All	No
Masters Public and Development Management	University of Witwatersrand	Yes	8	1-2 years	All Managers	All	All	All	No
Masters Hospital Management	University of Witwatersrand	Yes	8	1-2 years	All Managers	All	All	All	No
Postgraduate Diploma PHC Management	University of Witwatersrand	Yes	7	1-2 years	All Managers	All	All	All	No
Honours Development Management	University of Venda	Yes	8	1-2 years	Middle Managers	All	All	All	No
Honours Political Science & Public Administration	University of Zululand	Yes	8	1-2 years	Middle Managers	All	All	All	No
Masters Political Science & Public Administration	University of Zululand	Yes	8	1-2 years	All Managers	All	All	All	No
Honours Social Science Human Resource Management	University of Fort Hare	Yes	8	1-2 years	Middle Managers	All	All	All	No
Masters Social Science Human Resource Mx	University of Fort Hare	Yes	8	1-2 years	All Managers	All	All	All	No