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Abstract

The establishment and strengthening of primary health care is an important component of South African health sector reform. The PHC system is by and large nurse driven. The shortage of nurses therefore negatively impacts on PHC service delivery. Nurse shortage is a multifaceted problem caused by factors such as inadequate production of nurses, migration and the impact of HIV and AIDS. While increased production and creating financial incentives to recruit nurses in the health sector is a critical part of the PHC staffing solution, interventions at the work environment level are also needed to retain nurses in the public health care system. There is clear evidence that the health sector transformation and ongoing reforms in South Africa since 1994 affect PHC nurses' work environment.

This chapter attempts to unpack various HR related policies that have guided the transformation of the public sector in general, and the health sector in particular, with reference to their impact on PHC services. So far, the absence of norms and indicators to guide PHC staff production policy has helped to create a gap in the availability of nurses in relation to the growth in their need. Also, the application of transformation policy frameworks emanating from the Department of Public Service and Administration (DPSA) was not matched with the required capacity to manage the implementation of the interventions in the PHC system. Finally the absence of a coherent HR plan for the health sector has meant that interventions in this area were piece meal with at times a neglect of factors affecting nurses' motivation. These gaps in human resource management (HRM) are highlighted as areas needing urgent attention.

resource policies

health sector reform and the management of PHC services in SA

Introduction

The South African government adopted the primary health care (PHC) approach as an important strategy to attain the health sector reform goals of increased access to care, improved quality and reduce inequality.^{1,2,3} The district health system (DHS) is the chosen vehicle through which PHC services are delivered. PHC service provision is nurse driven in the South African public sector, although supported by visiting doctors. The Department of Health (DoH) estimates that about 30% of PHC clinics benefit from a doctors' visit at least once a week.² The generalist doctor who drives PHC in the private sector has a yet-to-be defined role in the public sector PHC. The place of the district hospital within or outside the PHC system has also been a matter of contention. It has been argued that the PHC system needs the support of a district hospital. Therefore the PHC system should be broadly defined to include district hospitals in SA. However, since nurses constitute the bulk of the workforce in clinics and health care centres, this chapter will focus on human resource issues related to PHC nurses and their managers.

The success of PHC reform policies depends on the extent in which shortages of staff in SA is addressed. Currently, the number of posts in the PHC system may be too few given that the public health sector is now serving more people than before 1994. The DoH acknowledges for example that the free health care policy and clinic upgrading and building programme led to an increase in PHC services utilisation.⁴ Need has also increased due to the burden of HIV and AIDS epidemic on the workforce. The loss of nurses to HIV and AIDS most likely has mirrored the general population. Up to 20% of nurses in the young age group were estimated to be infected with the HI virus in 2002.⁵

Emigration is another commonly cited cause of PHC staff attrition. A middle income country, South African HR production capability is arguably higher than that of many developing countries. But PHC nurses' emigration, initially limited to doctors and specialised nurses, has increased in recent years. In the United Kingdom alone, the number of South African nurses and midwives registered with the general council for Nursing, Midwifery and Health Visiting rose from 599 in 1998/99 to 1 460 in 1999/2000.⁶

Policies seeking to increase the production and recruitment of nurses are not likely by themselves to address the full range of problems influencing nurse shortage and performance in SA. Action to retain staff within the PHC system is an equally important undertaking that requires addressing the human resource management (HRM) weaknesses. Although the recent development of policies introducing financial incentives is an important element of this action, they are not sufficient given the other issues underlying problems in the work environment.^{7,8} Nurse migration for example merely reflects the symptoms of deeper problems besieging the public health system. Poor salaries, unfriendly work environment, increased work load, lack of recognition and career insecurity are key reasons why nurses leave SA.⁶ These factors are directly related to the field of human resource and organisation management.

But what aspects of HR related policies exactly influences the PHC work environment? There is clear evidence that the health sector transformation and reforms ongoing in SA since 1994 affect PHC nurses' work.^{7,9} This chapter attempts to unpack various HR related policies that have guided health sector transformation in SA with particular reference to their impact on PHC services.

Overview of human resource related policies

Human resource development is potentially an adversarial policy terrain where a number of actors and institutions with differing agendas interact. Among the key actors are the Department of Public Service and Administration (DPSA), the DoH, Local Government, the Treasury, the unionised civil servants and health care professionals. This plurality of actors is likely to make the policy implementation process more difficult.

HR interventions have been reactive so far, lacking a coherent strategy. Since 1994, there has never been a national HR plan for the South African health sector. In practice, policy frameworks aimed at health sector transformation generally and those emanating from other ministries (e.g. DPSA and Provincial and Local Government) have had the most impact on HR development for PHC. These constitute the de facto HR policy environment and fall into three broad categories:

- Production policies.
- Policies related to human resource management (including the transformation of the public service and administration).
- Health care delivery policies. These policies are interrelated through complex mechanisms mediated by both formal and informal relationships among various actors and governmental institutions (Figure 1).

Policies on the production of professional nurses

An analysis of the trend in the availability of professional nurses per public sector user in population shows a decline since 2000 (see Table 1). The government has acted on its policy of increasing access to basic health care by building 1 345 new clinics between 1994 and 2004. A recent situation analysis compiled from national and provincial DoH reports estimates that 60% of PHC facilities have no nurses with primary health care training.¹ Thus, the government had in real terms increased PHC facilities within the health system over the years without concomitantly increasing the production or supply of nurses to fill them. The set of norms and standards for PHC clinics recommends that at least one PHC trained staff per clinic.¹⁰ This indicator however is inadequate to measure the need for HR at population level.

Figure 1: HR policies and their impact on organisational outcome

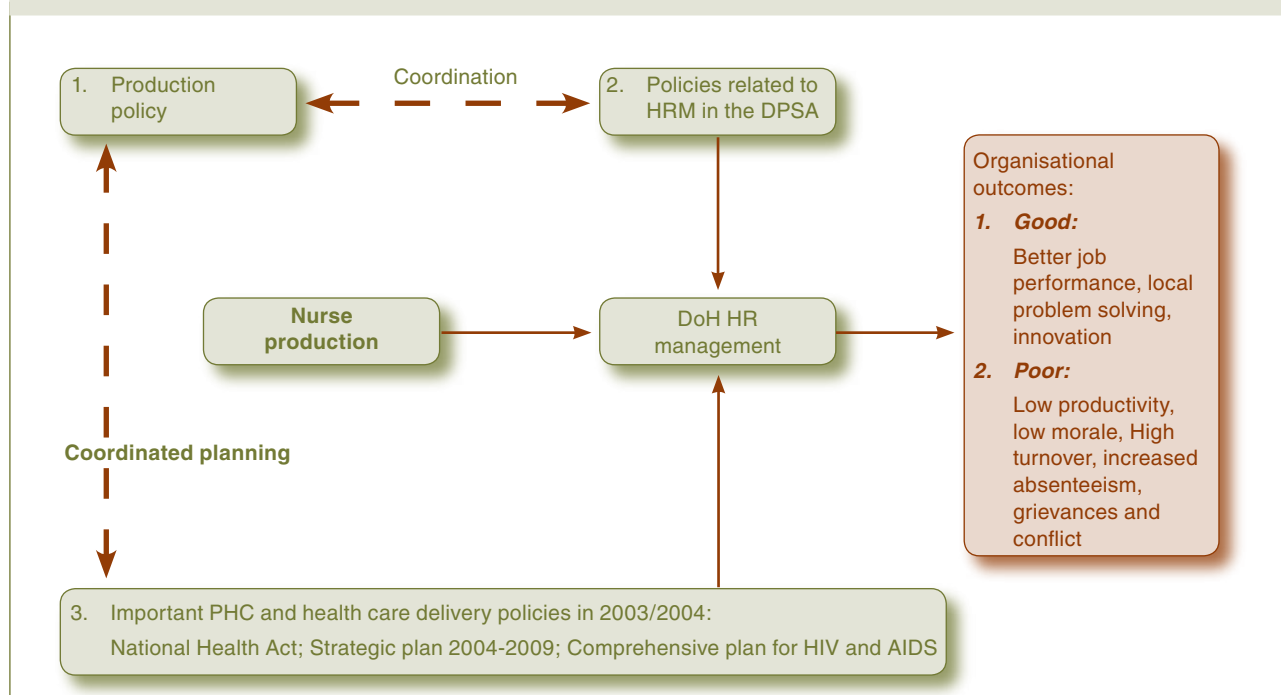


Table 1: Trend in nurse availability for the public sector in South Africa, 2000-2003^a

Year	Number of nurses in public sector	PN per100 000 population
2000	41 734	120.3
2001	41 560	111.9
2002	40 318	106.8
2003	41 563	107.1

Source: Personnel administration system (PERSAL)

The evidence that the production of professional nurses has lagged behind the growth in the needs for health services in SA has not triggered appropriate policy development and action in the area of nurse production. The lack of clearly defined or accepted national staffing norms for PHC constitute a key gap in the harmonisation between the expansion of PHC services and the demand for nurses.¹¹ However, several supply and demand factors also contribute to the worsening state in the picture of PHC staffing. While migration is a well documented contributing factor to PHC staff shortages, the slow pace of training and population growth are also factors that have failed to be factored in nurse production. The Human Sciences Research Council's

(HSRC) Human Resource Development programme made projections of the gap between nurse supply and demand in SA to sustain a target ratio of 343 nurses per 100 000 population. These projections suggest that left to its course the estimated annual gap in the supply of nurses, which was 1 005 nurses in 2004, will have doubled by 2005 and will remain high till 2011 as shown in table 2 below.

To address the skills shortage in the PHC system, the DoH recently devised two important medium to long term policies. The first policy is based on recommendations from the Pick Report in 2001. The report proposed a review of the scope of practice at PHC level and the creation of a mid-level cadre to optimise the utilisation of the existing stock of doctors and professional nurses.¹² The medical assistant programme was launched in 2004. However, medical assistants will be based in district hospitals from where they would visit clinics as generalist doctors currently do in some provinces. As such, their direct contribution to PHC services in clinics is limited.

The second policy seeks greater government support of the existing community health workers (CHWs) programmes. An important group of CHWs, largely linked to community-based care for HIV and AIDS and often working on a voluntary basis, already exists in SA. A heterogeneous group of providers, CHWs represent

Table 2: Projected gaps in the supply of nurses, 2001-2011

Year	Projected Population	Nurses needed	Replacement demand	Estimated Supply	Estimated Gap
2001	45 349 800	155 484			
2002	45 969 270	157 429	6 599	5 837	762
2003	46 558 520	159 447	6 769	5 837	932
2004	47 112 480	161 344	6 842	5 837	1 005
2005	47 629 350	163 114	7 918	5 837	2 081
2006	48 101 620	164 732	8 618	5 837	2 781
2007	48 528 670	166 194	7 688	5 837	1 851
2008	48 913 280	167 511	8 264	5 837	2 427
2009	49 252 100	168 672	8 881	5 837	3 044
2010	49 554 890	169 709	7 843	5 837	2 006
2011	49 823 220	170 627	7 706	5 837	1 869

Source: HSRC's human resource development programme, HRD Review 2003 data tables

^a Population excludes medical aid members so as to approximate the public sector dependent population.

a major resource that may complement the formal PHC system. In 2003, the DoH initiated a comprehensive programme to promote and standardise this cadre of health care workers in support of PHC.

Although a controversial strategy with mixed results in other African countries, the CHW programme is currently high on the South African policy agenda.¹³ The CHW programme has been linked to the Expanded Public Works Programme, a government-led job creation and poverty alleviation strategy, thus shifting away from the notion of voluntary contributions. The dominant model emerging at present is the contracting of non-governmental organisations to employ and manage CHWs. However, the nature and level of remuneration and career pathways for this cadre of health care worker compared to their professional counterparts is likely to be a future policy challenge. In the medium to long term, CHWs may alleviate staff shortages in PHC facilities. But the inter-professional relations between nurses and the CHWs, mid-level workers, and generalist doctor should be carefully managed as the scope of work might overlap while conditions of service and status differ.

Policies related to HRM and the transformation of the public service

Two important policy frameworks form the foundation of the transformation of the public sector in general. These are the White Paper on the Transformation of the Public Service (WPTPS) and the White Paper on Human Resource Management in the Public Service (WPHRMPS). The implementation of these frameworks has had positive and negative impacts on human resource management in the health sector. On the positive side, the policies sent a clear message that the government is committed to creating a fairer, efficient and more equitable public service. However, the implementation of these policy frameworks in the health sector has directly and indirectly raised anxiety over performance management, rights, responsibilities and career opportunities.

The White Paper on the Transformation of the Public Service

The WPTPS provides a framework within which sectoral policies can be designed to create a coherent, representative, competent and democratic instrument for implementing government policies and meeting the needs of all South Africans.¹⁴ The White Paper outlined the following priorities to guide policy development:

- rationalisation and restructuring to ensure a unified, integrated and leaner public service;
- institution building and management to promote greater accountability and organisational and managerial effectiveness;
- transforming service delivery to meet basic needs and redress past imbalances;
- the democratisation of the state;
- human resource development;
- employment conditions and labour relations; and
- the promotion of a professional service ethos.

The first priority of rationalisation and restructuring of the public service has largely been concluded. The effects on health care workers' and their manager's job security and career progression were experienced differently in provinces depending on the number of homeland administrations that had to be integrated. For example, the then Northern Province had the unenviable task of integrating five previously independent administrations. It entailed drawing a new organogram and later, appointing managers from the often poorly performing old administrations against this streamlined structure.

The second priority of institution building and management to promote greater accountability, organisational and managerial effectiveness is of ongoing concern. Although the new public service management framework has been disseminated to guide improvement in service delivery, questions remain about the capacity of managers to actually apply this and other frameworks. A key weakness lies in the centralised approach to policy development that often fails to recognise front line workers as possible obstacles to policy changes and pre-empt their reaction.¹⁵ Yet nurses' resistance may take expression in the form of negative attitudes toward patients which in turn negatively influences patients and community trust in the nurse in particular, and government clinics and policies in general.^{7,8} How changes in the organisation and culture of service are conveyed to frontline workers and incorporated into broader PHC

management system is important in shaping health care workers' perceptions of the merits of policy changes. Poor communication and slow pace of the decision making processes through the bureaucracy of the public service are among the key features of the PHC work environment that demotivate nurses.⁷

Although the influence of mid-level managers on the PHC work environment is generally acknowledged, there is evidence that managers are inadequately prepared and resourced to support PHC service delivery. Weaknesses in management capacity exist at both PHC facility and district levels. At PHC facility level, Ijumba and Leon found that in addition to the lack of training for the staff appointed, the position of facility manager is low in rank and therefore unattractive to qualified managers.^{9,16} Also, the required systems, (e.g. transportation and staff recruitment) are not adequate to support management of PHC facilities. Such neglect of PHC management structures and systems in the period of change has, in general, prevented the creation of a supportive PHC work environment.

District hospitals also play an important role in the implementation of PHC in many places. The nature of support includes the supply of nurses and other staff; the management of drug and other supplies; referral for investigations and expert opinion. Using the implementation of the Public Finance Management Act (PFMA) in district hospitals as a case study, Penn-Kekana et al. argue that district hospital management teams have not been adequately prepared and supported in the implementation of reforms in the health sector.⁸ The resulting increased stress levels and demotivation impact negatively on the quality of services rendered.

This has direct bearing on the implementation of the third priority of transforming service delivery to meet basic needs and redress past imbalances. The interests of patients and that of providers cannot be assumed to be the same in developing health service related policies. The removal of user fees for PHC in 1994, one of the earliest policies aiming at making PHC services accessible to all South Africans offers a useful illustration. Perceptions of health care workers were that the removal of user fees would flood the clinics with unnecessary demands from community members who felt entitled to health care services. These perceptions still remain. Walker and Gilson recently investigated the experience of PHC nurses of the free care policy.¹⁵ The study describes the nurses' commitment and agreement with the policy. It also found that the frustration over resource limitation, poor communication and limited consultation was central to nurses' practical experience of the policy.

Furthermore, weaknesses in systems at the hospital or district management level have the effect of shifting responsibility for problem solving down to clinic nurses (without necessarily a concomitant increase in authority). For example, in addition to the expansion of the scope of clinical practice dictated by the comprehensive PHC approach, nurses in some areas contend with administrative tasks such as fixing problems related to the procurement of equipment, drugs and supplies.^{16,17} This adds to the heavy workloads resulting from the already high vacancy rates for the nursing staff in the public sector.¹⁸ The remaining priorities of the WTPTPS are further elaborated in white papers on HRM and service delivery.

The White Paper on Human Resource Management in the Public Service

The purpose of this White Paper was to "provide a policy framework that will facilitate the development of human resource management practices which support an effective and efficient public service, geared for economic and social transformation".¹⁹ As its title suggests, the White Paper places HR matters at the centre of the transformation agenda for the Public Service where salaries account for more than 50% of all public expenditure.¹⁹ Better value must therefore be derived from such an investment. To this end, the White Paper proposes that 'managing' the workforce is a more effective practice than 'administering' it.

HRM, as defined in the White Paper, introduces a set of values (fairness, equity, accessibility, transparency, accountability, participation and professionalism), and outlines the need for a change in management culture. Of interest to recent HR related policy developments in the health sector are the decentralisation of HRM particularly applied to supervision and recruitment processes, the nature of the employment contract in light of an expanding job description for PHC workers and the performance management system.

Decentralisation of HRM and health care worker recruitment in 2004

The WPHRM proposes that HRM responsibilities be decentralised and aligned with line function. In the PHC setting, facility managers and clinic supervisors will acquire additional formal HR responsibilities traditionally reserved for the personnel officer in the district or provincial office. The implementation of PHC human resource related policies is therefore closely linked to the manner in which services are

generally managed and the availability of resources.

Clinic supervisors play a particularly important role in PHC, linking service management and service delivery. Their problem solving skills are vital to the creation of a functional work environment. However, the contexts in which PHC services are delivered vary significantly and so does the support from clinic supervisor and management. In isolated rural facilities for example, the sheer lack of transportation physically cuts off clinics from their supervisors. In addition, even when they are accessible, demands on supervisors to attend meetings and workshops can be significant.²⁰

As the decentralisation process in SA unfolds, the shortage of staff in public facilities becomes a critical bottleneck to policy implementation and service delivery. The rural and scarce skills allowances are among the most publicised of recent HR policies in the health sector. But its implementation, like many other HR functions is still not decentralised. In the wake of the adoption of the scarce skills and rural allowance policies, all provincial health departments advertised extensively for vacant posts in 2004. While a formal evaluation of the success of this policy is still outstanding, there is anecdotal evidence that health care workers' recruitment was hampered by a variety of organisational factors including the highly centralised recruitment processes. Health district management structures are not yet able to create and advertise posts. This means that any appointment is processed through the provincial bureaucracy. The whole process of advertisement to interview to appointment can take up to four to six months. Yet the government competes with the better incentivised private sector and developed countries for health care professionals. Good candidates in the scarce skills category are often lost by the time the appointment is finalised.

The scarce skills allowance has an additional HR complication. It is a divisive measure and demotivating factor for the PHC system. Although an important step toward responding to the human resource problems, the scarce skills allowance excludes non-specialised professional nurses who constitute the bulk of PHC health care professionals.²¹ The early proposal that nurses be totally excluded from this intervention met stiff resistance from the nursing profession and led to extensive debates in the public health and welfare sectoral bargaining council.

Even the revised and adopted agreement still excludes the majority of professional nurses. The scarce skills agreement is therefore a strategy solely targeted at hospital level health care workers. As such, it signals that nurses in the PHC setting are not valued as much as their hospital based colleagues.

Rather than improving the work environment at PHC level, the scarce skills allowance is likely to further demotivate professional nurses.

Performance management and the nature of contract in the PHC

The WPHRMPS outlines three types of contracts for civil servants: continuous, fixed term and temporary. Most nurses in PHC clinics are on continuous contracts as health care service delivery can be categorised as a core activity of an on-going nature. Continuous contracts however "depend not only on the employee performance, but also on the extent to which his or her skills and potential match the organisation's operational requirements".¹⁹ The Public service therefore, while remaining a career service, starts raising the importance of concepts prevalent in the private sector such as performance linked contract, skills and operational requirements. With new, service related policies being developed, the implications for review of the scope of practice, skills upgrading, performance appraisal and contractual expectations are significant.

Performance expectations are best clarified early in a contractual relationship. There are however two centres of authority managing different aspects of the same contract. On one hand, as with all civil servants, the determination of the post level and conditions of service for PHC workers is the responsibility of the DPSA. On the other hand, the provincial health department or the local government uses the DPSA post specifications to draw employment contracts with health care workers, for supervision and to conduct performance appraisal. The DoH is therefore responsible for setting performance standards for the quantity and quality of efforts that health workers deploy to achieve the organisation's objectives. These standards however have changed from time to time in response to changing priorities in the profile of disease burden or organisational requirement.

Since the advent of the DHS and the implementation of the comprehensive PHC package, the organisation of PHC nurses' work has changed. In the past few years, PHC nurses had to undergo training in a range of programmes such as integrated nutrition programme (INP), syndromic management of sexually transmitted infections (STI), management of pulmonary tuberculosis (TB), voluntary HIV and AIDS counselling and testing (VCT), PMTCT and the integrated management of childhood illnesses (IMCI). These changes in the scope of practice have been guided by the concept of integration of services or the 'supermarket

approach' to service delivery. Previously, PHC facilities offered different services such as immunisation on specific days of the week. Currently all services must be available every day and all PHC nurses must have the competency to render all services in the comprehensive PHC package.

Health care providers and managers alike are frustrated with the process of reorganising the scope of work for PHC nurses. It generates the needs for numerous training activities that are often poorly coordinated. Hence demands to up-skill PHC workers add pressure on service delivery and workload management. In particular pressure came from multiple programmes at national and provincial level with each wanting their programme to enjoy top priority.²²

Policies have been set for the quality of efforts of PHC workers.¹⁰ The Standard Treatment Guideline and Essential drugs list for SA for example is a widely disseminated, easy to use reference manual that covers most commonly encountered conditions at PHC level.²³ Other condition specific guidelines (e.g. management of hypertension, asthma and HIV and AIDS) have also been produced. But these guidelines are not linked to contract management processes. Furthermore, no norms for the quantity of work have been firmly established. An attempt to apply output norms in a survey of 155 clinics in KwaZulu-Natal, for example, suggest that currently, the majority of clinics surveyed produce less service than expected in relation to the number of nurses employed.²⁴ The lack of clarity on the job description and performance standards raises questions on the basis and the manner in which the appraisal and reward system for nurses is conducted. Similarly, the lack of standards for PHC workers' workload raises questions about the effectiveness of the appraisal and reward system: how much service must a nurse produce?

The appraisal and reward system

Following reforms in the public service administration in 1998, the automatic, years-of-service based promotion of civil servants was abolished and replaced in 2001 with a system where a supervisor must motivate for an employees' promotion or an incentive bonus. But the lack of contractually bound performance indicators and targets makes the process of decision making arbitrary and open to nepotism or gaming. There are no verification mechanisms. Ultimately, nurses who know what exactly is wanted in filling the required forms get rewarded, whether or not the answers represent actual performance.

Gilson et al. found that distrust of management is a dominant theme in discussion with nurses about their perception of management.⁷ Staff grade restructuring and the new performance management system are among factors feeding distrust. But the study also suggests that the problem is more about the poor understanding of procedures and practices. Better communication and discussion with nurses might dispel any existing misunderstanding. This important change of culture has potential impact on relationships amongst PHC workers in a small facility as a colleague's opinion of one's performance has bearing on the appraisal process.

Another area of performance appraisal difficult to capture on a score based system is the quality of the provider-user relationship. This Batho Pele White Paper of the public service and the Patients' Rights Charter in the health sector appeal to the individual civil servant's commitment to service and excellence. This requires a certain level of motivation and trust in the work environment that is generally lacking in the public health sector. Furthermore, the policies are designed in a manner to "become the watchdog of the new South African public service".²⁵ As such, health care workers in the already constrained public service environment perceive their use as punitive rather than developmental tools.

Key health care delivery policies in 2003/04

In 2003/04 several HR related policies with significant implication for PHC nurses have been passed or discussed.

The National Health Act 2003

The National Health Act (Health Act) has been in the making for a decade. It was finally passed by Parliament in 2003, and extensively discussed and challenged by stakeholders during 2004. The provisions in the Health Act shed much clarity on the configuration of the unitary national health system. This important piece of legislation provides for the development, provision and distribution of human resources especially around HR planning.

The National Health Council (NHC) is established as the highest body to develop HR planning policies to be implemented by provincial and district councils.²⁶ In this task, a Forum of Statutory Health Professions Councils is created with a mandate ranging from advising the Minister on HR

planning issues, to protecting the interest of the public and users, to accounting for the performance of health care workers.

The Health Act also confers to the Minister, powers to pass regulations on a variety of HR issues including training, creating of new categories of health care personnel, recruitment and retention. As with previous DPSA legislation, resources and capacity to implement the provision of the Health Act and manage change are critical success factors. For example, the funding source for PHC services previously delivered by municipalities remains unclear. Provinces will require additional funding to absorb the local government PHC services as prescribed in the Health Act. A related challenge lies in the harmonisation of nurses' remuneration and conditions of service.

The Strategic Priorities for the National Health System: 2004-2009

The National Department of Health has produced a five year plan (2004-2009) with clearly defined indicators and targets. The removal of HR obstacles to service delivery is prioritised and the Strategic plan has the following key activities to address the HR obstacles:

- ▶ Implement a plan to fast track filling of posts
- ▶ Strengthen human resource management
- ▶ Implement national human resource plan
- ▶ Strengthen the implementation of the CHW programme and expand the mid-level worker programme
- ▶ Strengthen a programme of action to mainstream gender.

To this end a top level post, Deputy Director General for human resources, has been created and the process of drafting of a national human resource plan started. A strategic framework for Human Resources for the Health Plan is now available for discussion and input by stakeholders. It is hoped that the national human resource plan will provide practical and comprehensive guidelines for strengthening HRM at national, provincial and district level.

Comprehensive HIV and AIDS package

Pressure on government is increasing locally and internationally to roll-out the ART programme to more sites in the country. But the government argues that the low capacity of the health system does not allow SA to meet its targets as determined in the 3 by 5 programme.²⁷

The provision of ARV started in appropriately equipped and resourced health facilities.²⁸ But once these facilities reach their full capacity, a down referral to PHC facilities will be required. But managing HIV infected patients is a complex task involving counselling, chronic disease orientation and often, dealing with death and dying. With about 60% of clinics and health centres functioning without a PHC nurse,¹ a rapid expansion of the HIV and AIDS programme will strain capacity at PHC facilities. The human resource strategy must therefore project the short to medium term impact of a down referral of patients to PHC facilities and prioritise nurse production strategies, as well as filling the gaps in the recruitment and retention interventions targeting professional nurses.

Transformation and change in the health sector has gone a long way but is by no means completed. The Health Act and strategic priorities offer greater clarity on objectives and institutional responsibility. However, their translation into better PHC health care service is likely to encounter challenges, some of which have foundations in the transformation of the public service and administration. Other HR challenges are related to the difficulty of building ownership (e.g. among professional nurse bodies for the national HR plan and among doctors for the medical assistant programme). For details see chapter 11 in this Review.

The success of the Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment in particular requires greater human resource capacity than is currently available. In addition to the increase in the absolute number of providers in the accredited sites, skills upgrading, coordination and improvement in the referral system are also needed. In the near future, these health sector specific policies will create more demand on the mid-level management, health care workers' scope of practice and performance management indicators. As the work environment and incentive structure change, so will the movement of health care workers within the public sector e.g. from rural facilities to better equipped ARV accredited sites.

Conclusion

Policy challenges to the human resource problems in the South African PHC system are multi-faceted. Although of good intent, several policies from different ministries have had an untoward impact on PHC nurse work environment. The expansion of PHC physical infrastructure in pursuit of greater access for the majority of citizens was not matched by an equivalent production of PHC nurses. This was later compounded by population growth, the loss of staff through migration and HIV and AIDS. The resulting shortage of staff has increased the workload for those nurses remaining in the health system. Also, the expanding scope of practice in response to evolving organisational (e.g. integration of PHC services) and epidemiological (e.g. TB, STI, HIV and AIDS) priorities feeds the perception of overload at PHC level.

The general reforms in the public service have also had an impact on PHC service environment. There is a clear vision and a coherent strategy for transformation of HRM in the public service: a move from personnel management to human resource management. Central to the transformation is the decentralisation of HR functions and greater involvement of line managers. Clinic supervisors and facility managers therefore are called to shoulder greater HR responsibilities particularly in the performance management system. The application of the White Paper on the Transformation of the Public Service; and the White Paper on Human Resource Management in the Public Service policy frameworks, in particular to the health sector, was not matched with the necessary capacity to manage the processes of change in the PHC setting. Important norms and standards to guide the planning for HR and performance management are lacking in the health sector. Also, HR interventions have so far been piecemeal, reactive and incoherent. The critical short staffing situation elicited centrally planned and managed retention and recruitment strategies with limited benefits to the PHC workers.

Recommendations

Change management is an important prerequisite to sustain morale and motivate staff to perform in a manner that meet basic health service needs of the population and redress past imbalances. This requires good HR planning to ensure adequate supply of PHC staff and renewed investment in strengthening the capacity of clinic supervision, facility and district health management. To remedy the human resource problem in the South African PHC system the following recommendations are made:

In the short term:

- Create a decentralised or outsourced recruitment mechanism to shorten the time taken to finalise appointments of health care workers at PHC level.
- Monitor the impact of the scarce skills allowance on the migration of the currently non eligible PHC nurses.
- Produce a national HR plan with clearly defined staffing norms for PHC service taking into consideration demand factors such as population growth, attrition, organisational change (e.g. integration) and change in burden of disease; and defined standards for the quality of care. The forthcoming HR plan therefore has to take into account both quantitative nurse supply concerns and qualitative issues in the work environment that impact on PHC nurse motivation and performance.
- Concurrent to the drafting of the national HR plan, the DoH must devise a rescue strategy to rebuild PHC nurse's trust in the management and policy makers within the health sector. This can take the form of local level 'lekgotla' similar to what the Presidency has just embarked on to revitalise local government service delivery.

In the medium term

- Review the skills and competencies required of PHC managers. An upgrade of rank and posts to attract good managers at this level may be necessary to match the envisioned decentralisation of key HR responsibilities.
- Improve systems such as transportation of supervisors so as to improve contact time of support to front line workers, and by so doing, communication between supervisor and staff. This is in recognition of the fact that HR management is a process rather than an event.
- It is also important to monitor and engage with policy development outside the health sector that may impact negatively on HR.

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voice of

Sister Jaconuum Cupido has worked her entire life for the State and has no intention of migrating to the private sector.

"I see a minimum of 60 patients a day, many days up to a 100."

"There are so many people (in the public sector) who need us. We are very short staffed and there are so many patients, the need is great," says Cupido, who has been a professional nurse in the Northern Cape for over 12 years.

Cupido is currently one of two professional nurses working at Springbok Clinic, a primary health care facility in the far north of the vast province.

During her hectic day, Cupido has to attend to, among others, the antenatal services for pregnant women, primary health care, chronic medication for conditions such as diabetes and hypertension, psychiatric patients, family planning and immunisation.

Patients usually start drying up around 3.30pm, giving Cupido and her colleague time to make appointments for referral patients, catch up on administration and have the lunch they missed.

"I usually stay for another hour or two," says Cupido, who does not receive any compensation for overtime.

"I don't expect it either," she adds.

"When I walk in at 7.15am, there is already a long queue of patients and we immediately start attending to them. By the official starting time of 7.30am, we've probably seen around five patients already."

a Nurse

Sister Jaconuum Cupido

of Springbok Clinic, Northern Cape

She admits that at the end of the day she is “absolutely drained and exhausted”.

Cupido describes her physical work environment as “neat and organised”. She is, however worried about some drugs that are often out of stock.

“For several weeks we did not have Disprin. We have also run out of medication for diabetics and that poses serious challenges,” she says.

The rural allowance has helped a lot, says Cupido, who used to work at Kimberley Hospital before moving to Springbok.

A first generation nurse, Cupido credits her mom with motivating her to study nursing.

“She wanted to be a nurse, but in those days they were not able to study. So, she always encouraged me.

“Despite the challenges I love my job. If I have my life over again, I would make the same career choices. No doubt about it.”

“It sometimes gets to me when I realise that the following day will simply be a repeat and the next group of patients will be waiting for me. Nothing can be postponed. You have to just keep going.”