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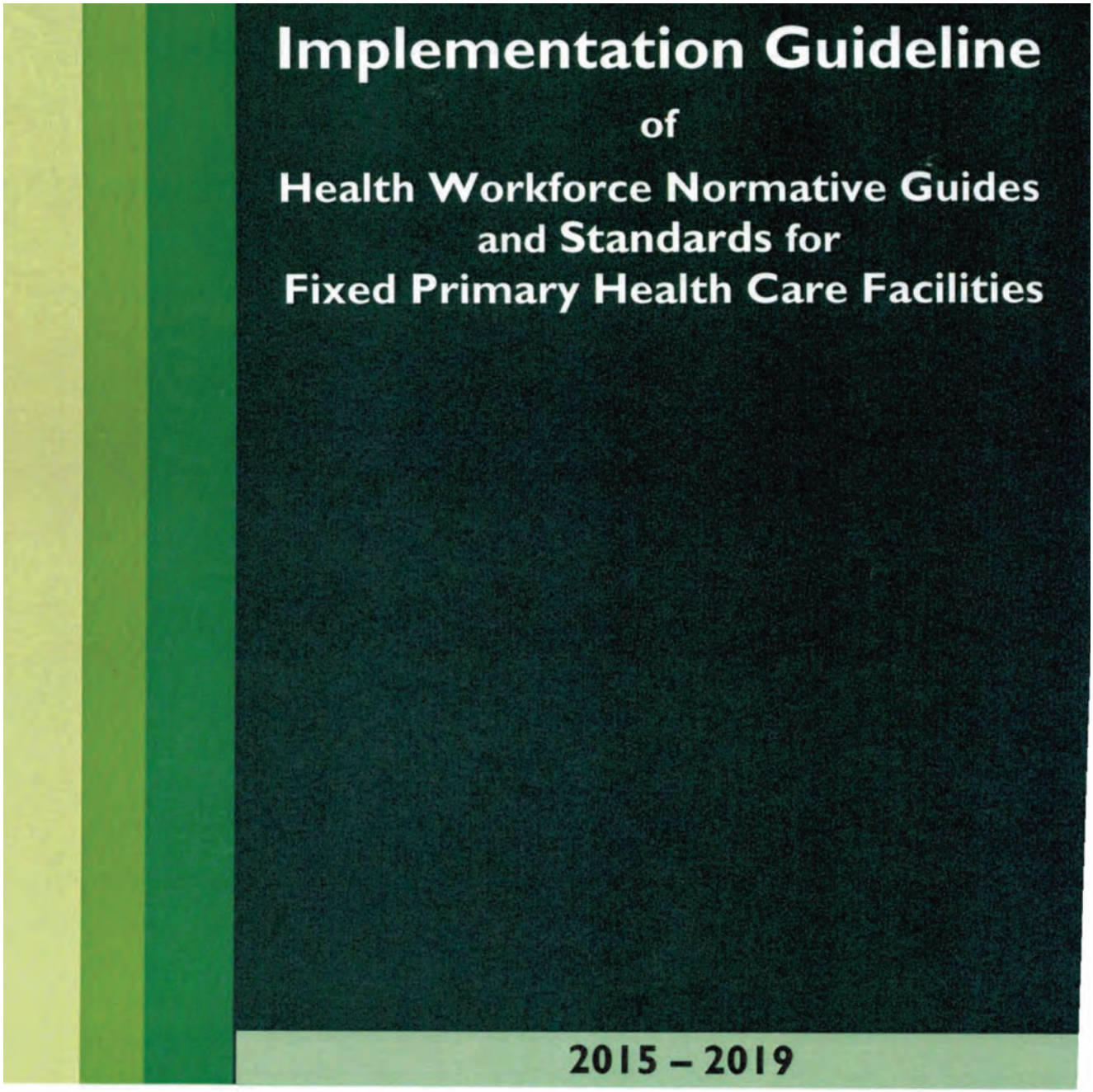

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Implementation guideline of health workforce normative guides and standards for fixed PHC facilities

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ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
AWT	Available Working Time
AS	Activity Standards
BCEA	Basic Conditions of Employment Act
CHC	Community Health Centre
CNP	Clinical Nurse Practitioner
DHIS	District Health Information System
DHPs	District Health Plans
EWG	Expert Working Group
HIV	Human Immunodeficiency Virus
HR	Human Resources
HRH	Human Resources for Health
HRIS	Human Resource Information System
HSS	Health Systems Strengthening
ICDM	Integrated Chronic Diseases Model
M&E	Monitoring and Evaluation
MOU	Maternity Obstetric Unit
NDOH	National Department of Health
NHC	National Health Council
NHI	National Health Insurance
NSDA	Negotiated Service Delivery Agreement
OPD	Outpatient Department
PDP	Personal Development Plan
PERSAL	Personnel and Salary information system
PHC	Primary Health Care
PSB	Professional Statutory Body
PSCBC	Public Service Coordinating Bargaining Council
PWT	Potential Working Time
SA	South Africa
SC	Steering Committee
SW	Standard Workload
TB	Tuberculosis
TTF	Technical Task Force
UHC	Universal Health Coverage
WC	Workload component
WHO	World Health Organisation
WISN	Workload Indicators of Staffing Need

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DEFINITIONS

Activity Standards (AS): Activity standard refers to time necessary for a well-trained, skilled and motivated worker to perform an activity to professional standards in the local circumstances.

Available Working Time (AWT): This refers to a health worker's time available in one year to do his/her work, taking into account authorised and unauthorised absences.

Expert Working Group (EWG): It consists of senior representatives of the relevant HRH categories who are experienced and respected by the health workers whose responsibility is to define main workload components and set activity standards for the targeted HRH categories.

Fixed PHC Facilities: These are PHC clinics or community health centres with permanent HRH and equipment providing eight to twenty-four hour service per day for five or more days per week.

Health workforce Normative Guide: A standard, model, or pattern in staffing levels and skills mix regarded as typical for the South African health system.

Norm: A statistical normative rate of provision or measurable target outcome over a specified period of time.

Normative Guide: Pertaining to the norm, this constitutes the full minimum complement of health workforce categories and the number of health workers in each category to cope with the existing workload based on the expected package of services for the facility.

Potential working time: This refers to potential annual working days per HRH category.

Skill mix: For purposes of this guideline, the skills mix refers to the mix of health workforce categories within each facility and among several facilities needed for each service component within the organisation.

Standard workload: Amount of work within a health service workload component that one health worker can do in a year (if the total working time were to be spent on this activity only).

Steering Committee: A Steering Committee (SC) consisting of senior management officials whose role is to approve the developed staffing needs and requirements based on the normative guides.

Technical Task Force (TTF): It consists of technical resource persons, who are responsible for actual support to facilities for interpreting and implementation of normative guides.

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Foreword by the Minister of Health

This Implementation Guideline of the Health Workforce Normative guides and Standards for fixed Primary Health Care Facilities is the first of its kind in South Africa. As part of the initiative to achieve Universal Health Coverage, referred to as National Health Insurance (NHI) in this country, we have recognised the need to provide comprehensive and concise guidance to all levels of the health system on key actions we need to focus on in order to address the burden of disease.

This public health sector guideline for the implementation of human resources for health (HRH) normative guides for fixed PHC facilities is designed to ensure efficient and effective utilisation of the health workforce. As required by the National Health Act of 2003, we are operationalising a rational and evidence based mechanism to plan and manage the health workforce in the health sector efficiently and effectively. This is a practical approach to move towards achieving Universal Health Coverage.

The National Department of Health (NDOH) lead the process of developing HRH normative guides and Standards for health workforce in fixed PHC facilities. The normative guides and standards were developed using the World Health Organisation (WHO) workload based methodology. The HRH normative guides development process was coordinated by employees of the Department of Health appointed as WISN coordinators, from the provincial and national levels including officials from the districts and facility levels, with technical support from the WHO country office. The HRH normative guides define the range of expected health workforce (both HRH categories and numbers) for fixed PHC facilities (clinics and Community Health Centres) in the country taking into account mainly the workload experienced in these facilities.

This guideline aims to facilitate implementation of the HRH normative guides and standards mainly in fixed PHC facilities with complementary efforts from all levels of the health system.

I wish to urge managers at all levels of the health sector to use this guideline in applying the normative guides and standards to achieve equitable distribution of the heath workforce in all fixed PHC facilities.

DR A MOTSOALEDI (MP)
MINISTER: HEALTH

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Preamble by the Deputy Minister of Health

It is with great pleasure that I present this Implementation Guideline of the Health Workforce Normative guides and Standards for fixed Primary Health Care Facilities. This guideline is primarily intended for fixed PHC facilities (clinics and Community Health Centres) to guide managers in planning and management so that different HRH categories are fairly distributed based on the workload. It should be used for HRH projection and production-planning purposes to ensure equitable distribution of the health workforce among fixed PHC facilities.

The guideline covers different processes that need to be undertaken to apply the HRH normative guides and standards in the fixed PHC facilities. It has been designed with the understanding that there are different forms of workload faced by similar facility types in different areas of the same sub-district. As such, it provides clear and concise guidance in determining staffing requirement for each PHC facility.

The guideline is categorised in different sections to facilitate appropriate implementation of the normative guides. The first section provides the rationale and basis of the implementation guideline, and elaborates how it should be applied. This is followed by a section that illustrates the HRH normative guides and standards adopted by the National Health Council in March 2014. The third section presents the key elements of this implementation guideline, and elaborates how different fixed PHC facility types should apply the HRH normative guides and standards informed by the actual workload. This section is organised in a set of steps that are clear and easy for each facility to follow. The fourth section highlights the management and stewardship required for the appropriate implementation of the normative guides. The implementation guideline ends with a short conclusion section.

It should be emphasised that the process of applying this implementation guideline is as interactive as possible. It is a process that a given facility, sub district, district or province needs to apply with due consideration of local values and judgements to ensure that the resultant HRH projections and plans are rational, and acceptable based on the country's current professional and operational standards. The application of this guideline should reflect the local realities that are appropriately documented to provide evidence on how the actual facility specific normative guides were applied.

This implementation guideline should also be used, to facilitate implementation of the HRH normative guides and to inform development of annual HR plans for health to contribute effectively towards optimal implementation of the PHC Service Package for South Africa.

DR MJ PHAAHLA (MP)
DEPUTY MINISTER OF HEALTH

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Acknowledgements by the Director-General: Health

A lot of efforts and resources have been devoted to the development of the health workforce normative guides and standards for fixed primary health care facilities. This guideline will be instrumental in facilitating the implementation of the normative guides and standards at PHC facilities. It is in this context that the leadership and guidance provided by the Deputy Director General: Hospital Tertiary Health Services and Workforce Management, Dr Terrence Carter, highly appreciated.

We also recognise efforts of the World Health Organisation (WHO) health systems experts who supported the country with training of trainers on WISN implementation: Ms Teena Kunjumen WHO Head Quarters, Dr. Adam Ahmat, Dr. Magda Awases and Ms Jennifer Nyoni from the WHO Regional office for Africa. We also acknowledge an important role-played by Dr Habib Somanje from the South African WHO Country Office for the technical assistance in the development of normative guides and this guideline and Dr. Humphrey Karamagi from the Kenya WHO Country Office for assisting with the drafting of this guideline.

We acknowledge and recognise the National WISN Coordinator, Ms Margaret Ravhengani for effective coordination of the development of the normative guides and this guideline. We also acknowledge Ms Gcinile Buthelezi for conducting the situational analysis on the staffing models used across the country and Mr Mokgoropo Makhaba for the bio-statistical support especially in determining the WISN study sampling framework. We also acknowledge the Provincial WISN Coordinators who played a major role in determining staffing requirements based on the WISN tool namely: Ms Magda Blom, Mr Sicelo Tshabalala, Ms Zamasoni Luvuno, Ms Nicolette Van Der Westhuizen, Mr Louis Van Wyk, Ms Nomsa Vena, Ms Thembeka Zondo, and Ms Gladys Singo and Dr. Olaf Baloyi. We are grateful to Ms Estelle Jordaan – Mediclinic, for her valuable guidance and many members of the department who participated in different stages of WISN implementation and normative guides development.

Acknowledgement is also due to all the participants of the National consultation meetings representing managers at all levels of the health system including the PHC facility managers. Their invaluable comments and inputs were instrumental in refining this guideline. We also wish to acknowledge Ms Prudence Ditlopo and Dr Duane Blaauw for proof reading the final copy of this guideline.

Finally, we wish to acknowledge the Technical Advisory Committee to the NHC and all that contributed towards the finalisation and approval of this guideline.

MS MP MATSOSO
DIRECTOR-GENERAL: HEALTH

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Section 1: Introduction

1.1 Rationale for the guideline

The Human Resource for Health normative guides and standards were developed in line with the requirements of the National Health Act, 2003(Act No. 61 of 2003), (hereinafter referred to as "the Act"). Section 48 (1) of the Act states that 'the National Health Council must develop policy and guidelines for, and monitor the provision, distribution, management and utilisation of human resources within the national health system'. Section 48 (2) of the Act elaborates further the need to facilitate and advance adequate distribution of human resources; the provision of appropriately trained HRH at all levels of the national health system to meet the population's health care needs; and the effective and efficient utilisation, functioning, management and support of human resources within the national health system.

The Negotiated Service Delivery Agreement (NSDA) in its Outcome 2 (a long and healthy life for all South Africans) highlights the inequitable distribution of HRH personnel as one of the challenges in the sector. Furthermore, the NSDA calls for determination of clearer targets for human resources (HR) that are linked to attrition rates, population demographics and epidemiological profiles, thus contributing to strengthening health systems effectiveness. The National Development Plan 2030 denotes the need to put in place an HR strategy aligned with national HRH norms and standards and the Health Care Service Package.

The 2015-revised draft Primary Health Care Service Package for South Africa is intended to address the entire life cycle of human beings from pre-birth to death, including end-of-life cycle. These normative guides are essential for delivery of this package of PHC services, which is core in the implementation of the Ideal Clinic concept including optimal utilisation of the referral system and the Integrated Chronic Diseases Model (ICDM).

One of the Strategic Objectives in Program 5 of the National Strategic plan 2014/15 – 2018/19 is the need to develop health workforce staffing norms and standards. This guideline forms part of the implementation of this strategic objective.

This guideline focuses on the implementation of HRH normative guides (both numbers and staff complement) at clinics and community health centres to provide the PHC service package in these settings taking into account the HRH required to provide services as outlined in the PHC package life cycle. The guideline also takes into account the current professional and operational standards required for provision of quality health care at different sizes of the PHC facilities i.e. small, medium and large.

For adequate attainment of these HRH normative guides, actions are required from different health sector actors to ensure that they are implemented. The National Health Council (NHC), therefore, directed development of implementation guideline for the HRH Normative guides, which are meant to:

- Create an enabling environment for implementation of the normative guides;

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- Inform the HRH planning process for effective production and distribution of Health workforce;
- Optimise the utilisation of existing HRH in PHC facilities. This will facilitate more equitable distribution of the existing HRH;
- Guide and assist managers for HRH planning and management of Health workforce related costs at all levels of care.

This implementation guide is primarily focused on the fixed PHC facilities, with the aim to strengthen health system towards attainment of health for all by ensuring that PHC services are equitable as proposed in the WHO 1978 Alma-Ata Declaration.

1.2 Legal and Policy Context

This guideline will be implemented taking cognisance of the existing regulatory and policy contexts. Chapters 3 to 7 of the Act relate to provisions on National Health; Provincial Health; District Health Services for Republic; Health Establishments; and Human Resources Planning and Academic Health Complexes.

Section 23 of the Act further states that, among other functions, the National Health Council must advise the Minister on targets, priorities, norms and standards relating to equitable provision and financing of health services; on human resources planning, production, management and development and on norms and standards for the establishment of health establishments. The Act also states in section 49 that the *"Minister, with the concurrence of the National Health Council, must determine guidelines to enable the provincial departments and district health councils to implement programs for the appropriate distribution of health care providers and health workers"*.

In line with the Public Service Amendment Act,2007 (Act No. 30 of 2007), the Public Service Regulations, 2001 as amended by Government Notices including Government Notice No. R9795 of 31 July 2012, Parts III, IV, VI, VIII and IX have provisions related to Planning, Work Organisation and Reporting; Job Evaluation; Working Environment; Performance Management and Development; and Training and Education respectively. For example, the Part on Working Environment has specified that the Head of Department shall determine the work-week, daily hours of work for employees and the opening and closing times of work places.

As part of the Public Finance Management Act,1999 (Act No. 1 of 1999) updated to Government Gazette of 1 April 2010, the Public Finance Management Act, 1999: Amendment of Treasury Regulations in terms of section 76 refers to strategic planning, where among several aspects, the strategic plan must include measurable objectives, expected outcomes, program outputs, indicators and targets of the institutions' programmers.

In line with this framework, the health sector is undergoing a reform process that is focused on PHC re-engineering. As part of this reform, the health sector is working towards improving efficiency and effectiveness of delivery of services, and has prioritised establishment of ideal clinics to optimise the use of investments in the public health sector and ensure better health outputs and outcomes for the sector. The HRH normative guides and standards for fixed PHC

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facilities are informed by, and aligned to the 2015 revised Primary Health Care Service Package for South Africa services to be provided in fixed PHC facilities. This guideline will therefore serve the purpose of operationalising the implementation of the HRH normative guides and standards for fixed PHC facilities.

1.3 Background

The health sector in South Africa is prioritising the Negotiated Service Delivery Agreement (NSDA), out-put number four; i.e. '*Strengthening the health system effectiveness*', to facilitate efficient and equitable delivery of essential quality health services in a manner that assures Universal Health Coverage (UHC). A number of innovations are being presented to facilitate UHC, including but not limited to PHC re-engineering, improving health infrastructure availability, piloting of the National Health Insurance (NHI), amongst others. The implementation of mentioned strategies, necessitate for a clear, evidence based and rational approach to providing and managing the HRH for the initiatives to be appropriately implemented.

Elaboration of the HRH normative guides was conceived and conceded within the above-mentioned background. The HRH normative guides provide the parameters of the required health professionals, skill mix and expected service provision benchmarks that PHC facilities need to have, for efficient and effective service delivery.These normative guides are based on facility workload, developed through consultation with a wide group of stakeholders at National, Provincial, District, Sub-district and Facility levels. The following three critical groups managed the process for development of the normative guides:

1. A Steering Committee (SC) consisting of senior officials -national, provincial and district levels with the role to approve and supervise the development of the normative guides.
2. A Technical Task Force (TTF) consisting of technical resource persons who were responsible for developing the normative guides through the application of Workload Indicators of Staffing Need (WISN) tool.
3. Expert Working Groups (EWG) consisting of senior representatives of the relevant HRH categories who are experienced and respected by the health workers whose main responsibility was to define main workload components and set activity standards for the targeted HRH categories.

The resultant normative guides are, therefore, representative of the staffing requirements in fixed PHC facilities, based on expected workloads for different health workforce categories.

1.4 Use of the guideline

This guideline is designed to support implementation of the normative guides at fixed PHC facilities. Normative guides are expected to inform the content and context of the National, Provincial and District Health Plans (DHPs) and development of the HR Plans. This is in line with Section 21 (3), (4) and (5) of the Act wherein, the Director-General must prepare strategic, medium term health and human resources plans annually.
The guideline is intended for managers at all levels in HR planning and management including productivity, distribution and monitoring. The guideline should be used by key stakeholders as indicated in Table 1 below.

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Table 1: Stakeholders targeted by this guideline

No	Stakeholder	Applicability of the guideline to the identified stakeholders as aligned to the National Health Act
1	Statutory health councils	▪ Provision of information regarding registered HRH professional categories ▪ Generating evidence on HRH availability by HRH categories across provinces and districts.
2	Research institutions	▪ Generating evidence on adherence to service standards.
3	Professional associations	Input to understanding how HRH numbers and mix affect HRH productivity
4	Training institutions	Production and development of health workforce for rendering health services in line with the national health policy.
5	Organised Labour	Promotion of professionalism among HRH categories and negotiation with government for better working conditions.
6	Civil Society	Complement government in ensuring optimal utilisation of available health personnel and where possible assist with mobilisation of additional health workforce and capacity building.
7	Community	Through the health facility committees, community members oversee governance and compliance issues such as quality of care including analysis and management of patients' complaint.

The above list of stakeholders is not exhaustive. Provinces and district management teams should identify all relevant stakeholders for effective implementation of HRH normative guides.

1.5 Organisation of the guideline

This guideline is structured in five sections, each building from the preceding one as follows:

- The first section, which is the introduction, provides the rationale, the legal and policy contexts and the background relating to the guideline;
- The second section briefly introduces the HRH normative guides per category;
- The third section provides guidance on how stakeholders need to use the normative guides;
- The forth section highlights the management and stewardship arrangements as well as facilitating the lead in the implementation of the normative guides; and
- The final section provides the overall M&E process that will ensure that the normative guides are being implemented as expected.

Each of the sections can be read and applied as a standalone section, as they are designed to contain all the required information a given stakeholder requires in understanding and applying what needs to be done, to ensure implementation of the normative guides.

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Section 2: Overview of the HRH Normative Guides and Standards

2.1 Overview of health workforce standards

The following health workforce standards for service delivery are informed by the WISN concept and methodology:

2.1.1 **Potential Working Time (PWT)**: This refers to potential annual working days per HRH category. The PWT for a particular staff category should be equivalent to the required operational working days and hours of a particular health facility throughout the year.

There are 2 frequently appearing PWTs:

- First, PWT based on standard operational time – 8 hours and 5 days per week, excluding public holidays (249 days)
- Second, PWT based on whole year round operational time – 24 hours and 7 days per week (365 days), inclusive of weekends and public holidays.

The following applies to facilities that open for 5 days per week and 8 hours a day, excluding weekends and public holidays:

- Potential operational hours in a day = 8 hours
- Potential operational days in a week = 5 days
- Potential operational hours in a week = 40 hours (8 hours*5 days)
- Potential operational hours in a month = 160 hours (8 hours*5 days*4 weeks)
- Potential operational days in a year = 249 days (365 days – 52 weekends*2 – 12 public holidays)
- Potential operational hours in a year = 1992 hours (249 days*8 hours)

The following applies to facilities that open for 7 days per week and 24 hours a day throughout the year, inclusive of weekends and public holidays:

- Average potential operational hours in a day = 24hours
- Potential operational days in a week = 7 days
- Potential operational hours in a week = 168 hours (24 hours*7 days)
- Potential operational hours in a month = 672 hours (24 hours*7 days*4 weeks)
- Potential operational days in a year = 365 days
- Potential operational hours in a year = 8760 hours (365 days*24 hours)

The decision for changing the actual operational time of the PHC facility should be taken by the district, informed by the workload and/or operational requirements of the facility.

2.1.2 Available Working Time (AWT): This reflects a health worker's time available in one year to do his/her work, taking into account authorised and unauthorised absences.

- Apart from weekends, each HRH member is annually entitled to an average of 66 days off duty, based on:
  - At least 22 to 30 annual leave days

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- The 12 statutory public holidays (which can be taken in lieu)
- A maximum of 12 certified sick days
- A maximum of 10 special leave notice days
- An average of 10 training days based on the personal development plan

- Average AWT in a year (187+195)/2 = 191 days
- Available working hours in a year = 1528 hours (191 AWT days*8 hours)

Each HRH category should, as far as possible; work within the Basic Conditions of Employment Act,1997 (Act No. 75 of 1997).The HR managers should take into account the actual potential operational days and hours of PHC facilities when planning for staffing. It is important to note that the AWT is usually less than the PWT and hence the need to consider the additional staff required in each category to cover the entire PWT.

2.1.3 Activity Standards (AS): Activity standard refers to time necessary for a well-trained, skilled and motivated worker to perform an activity to professional standards in the local circumstances. The detailed standards for the activities carried out at the fixed PHC facilities are reflected in the draft 'Workload activity standards ratified by the HRH category experts and groups' document.

2.1.4 **Standard workload (SW)**: This refers to amount of work within a health service workload component that one health worker can do in a year (if the total working time was to be spent on this activity only). *Refer to the 2010, WISN Users' manual for the calculation details.*

2.1.5 **Workload component (WC)**: One of the main work activities that take up most of a health worker's daily working time. There are three kinds of workload components:

- **Health service activity**: Health service-related activities performed by all members of the staff category and for which annual statistics are regularly collected.

- **Support activity**: Important activities that support health service activities, performed by all members of the staff category but for which annual statistics are not regularly collected.

- **Additional activity**: Activities performed only by certain (not all) members of the staff category and for which annual statistics are not regularly collected.

These health workforce standards are informed by professional and operational requirements, and the need to ensure that health workforce are optimally utilised. *Refer to the 2010, WISN Users' manual for the examples of workload components and the details for estimating staffing requirements.*

2.2 Health workforce normative guides for fixed PHC Clinics

The normative guides are based on the need to have adequate HRH categories and skills mix to deliver the expected services at the PHC clinics. There is *a* minimum of 9 core HRH categories required for optimal implementation of the normative guides at the PHC clinics under the leadership of a facility/operational manager. Their description, and numbers required are shown in table 2 below. The main factor that determines the number of HRH in each category is

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workload. The numbers of HRH per category are also dependent on the number of hours the clinic is open per day. A minimum and maximum number of health workers for each HRH category are reflected based on existing workload that is frequently occurring in 60% or more of the clinics. The SET A normative guides are based on a PHC clinic that opens for 8 hours and 5 days per week. However, the WISN tool can be applied to adjust for different operating periods (days and hours). SET B and SET C are the results of that application to adjust for 12 hours and 7 days per week, and 24 hours and 7 days respectively. A minimum and maximum number of health workforce for each HRH category also reflect the range of the most frequently occurring workload in the clinics. This allows for adjustments based on existing workload and/ or service requirements.

In situations where the operation time is different from above, e.g. 6 days and 12 hours, the adjustment can be made to estimate optimum HRH requirement based on the WISN tool approach. As an example, the following formula can be applied accordingly to take into account of extended operational hours:

*For facilities operating for 7 days per week and 12 hours per day, with Available Working Time (AWT) of about 187 to 195 days per year, HRH requirements will be adjusted by 2.9 (rounded up to 3) per cadre (=12*7*52/191/8), where 12 and 7 is number of operational hours and days respectively; 52 is the total number of weeks in year; 191 is the AWT and 8 is the number of standard operational hours.*

*Similarly, for facilities operating for 7 days and 24 hours per day, with Available Working Time (AWT) of about 187 to 195 days per year, HRH requirements will be adjusted by 5.7 (rounded up to 6) per cadre (=24*7*52/191/8), where 24 and 7 is number of operational hours and days respectively; 52 is the total number of weeks in year; 191 is the AWT and 8 is the number of standard operational hours.*

Note that adjustment for different operational times could be done by replacing operational hours and or days in the formulae above.

It is important to note that all the categories that visit (outreach services) the facilities for a number of days and hours in a week, they are included in Annex 4 and most of them were determined through frequently observed tendencies as there were minimal workload statistics to facilitate the need to determine their HRH requirements based mainly on workload. In the same vein, operational managers, cleaners, grounds-men and security guards were estimated based on observed tendencies and not workload. These categories may need specific parameters like fixed time, fixed post and space covered per person.

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Table 2: HRH normative guides for PHC clinics

Core HRH	SET A: Open 5 days & 8 hours		SET B: Open 7 days 12 hours daily		SET C: Open 7 days 24 hours daily	
	Standard Normative guides		*Added(12*7*52/191/8)=3 to the Standard Normative guides in SET A*		*Added(24*7*52/191/8)=6 to the Standard Normative guides in SET A*	
	Benchmark Head Count: Minimum – 13192; Maximum – 26384					
	Minimum	Maximum	Minimum	Maximum	Minimum	Maximum
Operational / Facility Manager	1	1	1	1	1	1
HRH Categories						
Professional Nurse /CNP	2	4	5	7	8	10
Enrolled Nurses	3	7	6	10	9	13
Cleaner	1	2	4	5	7	8
Lay Counsellor	2	2	2	2	2	2
Admin Clerk/Data capturer	2	3	5	6	8	9
Grounds man	1	1	1	1	1	1
Security	2	4	5	7	8	10
Pharmacy assistant	1	2	1	2	1	2
Total	14	25	29	40	44	55

Source: HRH normative guides and Standards report

2.3 Health workforce normative guides for Community Health Centres

The CHCs offer a more comprehensive range of services compared to what the PHC clinics offer, and thus they need a more varied and extensive HRH. The normative guides are based on the need to have adequate HRH categories and skills mix to deliver this wider set of services of the PHC package at the CHCs. The HRH description, and numbers required are depicted in Table 3. A minimum and maximum number of health workers for each HRH category are also reflected, to allow for adjustments based on existing workload that is frequently occurring in 60% or more of the CHC facilities. The translation of the overall workload in relation to the headcount per facility is used to determine HRH requirements based on an 8-hour day, five days a week.

It is important to note that the HRH categories and administrative areas within the CHC are meant to cover the totality of service package for CHCs as indicated in the revised draft Primary Health Care Service Package for South Africa. However, in CHCs with low head count (workload), apart from the MOU, the rest of the units could be merged to operate like a clinic operating 24 hours per day and 7 days per week.

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Table 3: HRH normative guides for Community Health Centres

Core HRH	Benchmark Headcount: Minimum – 65895; Maximum Headcount - 105432			
	SET A Standard Normative guides		SET C Adjusted for 24 hours *Added(24*7*52/191/8)=6to the Standard Normative guides in SET A*	
	Minimum	Maximum	Minimum	Maximum
Middle Manager	1	1	1	1
Nursing (MOU)				
Operational Manager	1	1	1	1
Advanced Nurse midwife	2	3	8	9
Professional Nurse	4	6	10	12
Enrolled Nurse	7	10	13	16
Cleaner	1	2	7	8
Nursing (OPD)				
Operational Manager	1	1	1	1
Professional Nurse	2	4	8	10
Enrolled Nurse	7	13	13	19
Cleaner	2	4	2	4
Nursing (Casualty)				
Operational Manager	1	1	1	1
Professional Nurse	2	3	8	9
Enrolled Nurse	3	5	9	11
Cleaner	1	2	7	8
Oral Health				
Oral Hygienist	1	1	1	1
Dental Therapists	1	1	1	1
Dental Assistants	1	1	1	1
Pharmacy				
Pharmacist	1	1	1	1
Pharmacy Assistant	1	2	1	2
Optometry				
Ophthalmic nurses	1	1	1	1
Support HRH				
Cleaner	2	3	2	3
Lay counsellors	5	7	5	7
Admin clerks/Data Capturer	5	7	11	13
Grounds man	2	3	2	3
Driver	1	1	1	1
Porter	2	3	2	3
Messenger	1	1	1	1
Medical HRH				
Medical Officers	1	2	4	5
Clinical HRH				
Clinical Associates	2	4	8	10
Total	61	93	130	162

Source: HRH Normative guides and Standards report

The standard normative guides (Set A) represent HRH numbers based on the expected facility workload and standard working days and hours (5 days and 8 hours). If a facility is required to open for more than standard working days and hours respectively, the HRH numbers are adjusted to allow for the increased operational period.

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2.4 Taking account of On-Call time in Normative guides implementation.

- HRH categories that are on call are available for service during official off-duty hours at nights and weekends. These categories work only when there is a demand for the services.
- This type of working arrangement does not fit into the way available working time in a year is normally calculated.
- The way in which on-call time is taken into account in WISN calculations depends instead on the method of compensating the staff for on-call duty.
- Two main methods are in use: time off and or overtime payment in lieu of the on-call hours.
- In cases of time off, there is need to estimate the additional personnel in the HRH category concerned to cater for the time that some of the members in the HRH categories are off duty.

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Section 3: Interpreting and Applying the HRH Normative Guides and Standards

3.1 Using workload to determine facility specific normative guides

The guideline recognises the fact that different facilities have different workloads, and therefore the actual normative guide per facility would be varied – for efficient use of health care workers. Each facility can determine its own benchmark normative guides from the normative guides in a simple, stepwise manner based on its workload.

Each facility manager, together with the sub district manager supported by the district management, should carry out this process. Table 4 below should be completed for each facility, using the proceeding steps

Table 4: Template for determining facility actions based on normative guides

FACILITY TYPE:	FACILITY OPENING TIME (Days / hours):		FACILITY HEAD-COUNT:	FACILITY NAME:		PROVINCE: DISTRICT: SUB-DISTRICT:	
Clinic facilities Benchmark Headcount: Minimum – 13192; Maximum– 26384							
CHC facilities Benchmark Headcount: Minimum – 65895; Maximum – 105432							
Column 1 HRH category	Facility normative guides per category		Column4 Benchmark facility normative guide	Column5 Available HRH	Column6 Variance between benchmark normative guide and available HRH	Column 7 HRH in training pipeline	Column 8 Proposed emerging actions
	Column 2 Minimum	Column 3 Maximum					

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STEP 1: Determine the facility type

This step indicates the type of PHC facility i.e. whether a PHC Clinic or Community Health Centre.

STEP 2: Determine the normative guides set for the facility

a) The normative guides' sets are determined by facility's operational days and hours.
b) If opening hours are in between these, use the method described in Section 2.2. Therefore SET B and C were based on adjustment by adding 3 and 6 respectively to normative standards for SET A. For operational times different from SET B and SET C, adjust accordingly as indicated in section 2.2.
c) For CHCs, SET C normative guides are applicable. However, the estimation of the benchmark normative guide for the health facility requires the use of SET A and adjusting for the 24 hours. For operational times different from SET B and SET C, adjust accordingly as indicated in Section 2.2.
d) The normative guides set should be mapped in columns 2 and 3, for the minimum and maximum numbers for each HRH respectively.

STEP 3: Identify the workload for the facility.

An approximation is used based on the annual client headcount the facility received and registered in the previous year as a proxy of workload taking into account the application of the average time it takes to provide services to one client. This should be mapped at the top of column 4 in Table 4.

STEP 4: Determine the facility benchmark normative guide for each HRH category

a) This is determined from the normative guides set chosen for the facility, and the head count as a proxy of workload and mapped in column 4 of the template. The head count of the facility determines where, outside the range and between the minimum and maximum value for the HRH category the facility benchmark normative guide should be. This is determined by using benchmark points as indicated in figures 1 and 2. The three points in figure1 reflect the small, medium and large classification of clinics as stipulated in the revised draft Primary Health Care Service Package for South Africa.
b) Benchmarking Formula is as follows: Facility Headcount ÷ Maximum Benchmark Headcount x Maximum Normative Guide in SET A. **In cases where adjustment for different operational hours is required, it is mandatory that the benchmark normative guide is determined first and then add or subtract accordingly**. For example, for a facility operating for 24 hours and 7 days per week the adjusted benchmark normative guide will be determined as follows: (Facility Headcount ÷ Maximum Benchmark Headcount x Maximum Normative Guide in SET A) + 5.7. Note that 5.7 is determined through the adjustment formula indicated in Section 2.2.

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Figure 1: Normative guides benchmark points for determining the PHC clinic benchmark normative guide

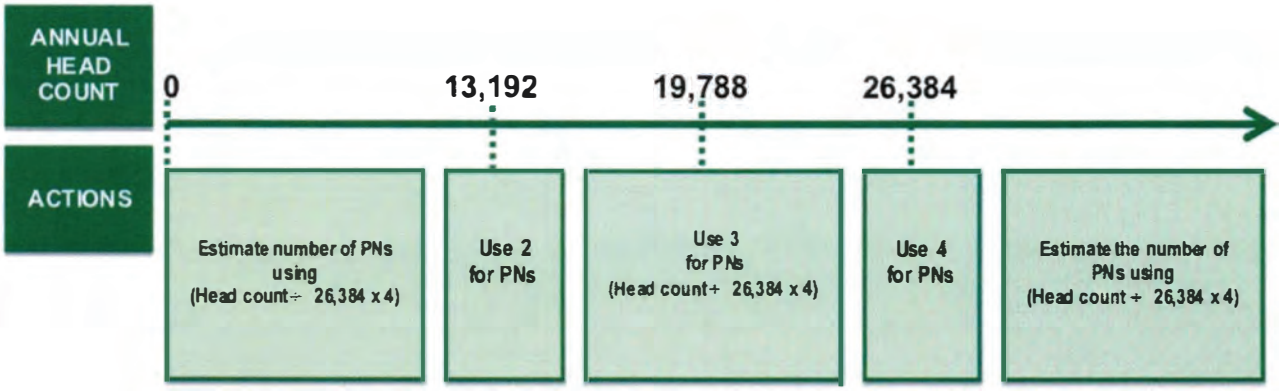
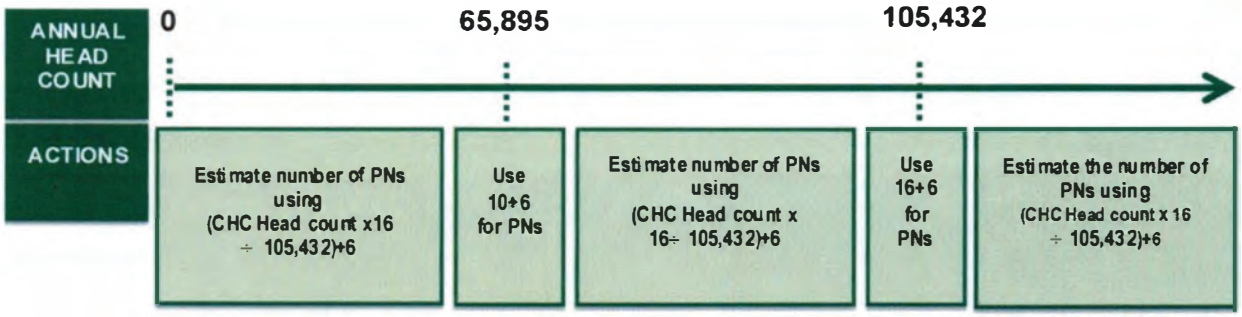


Figure 2: Normative guides benchmark points for determining the CHC benchmark normative guide



** Figure: 2 above included an adjustment factor (6) that should be added to account for 7 days and 24 hours operational requirements determined in Section 2.2.*

c) For the facilities that are significantly above the maximum headcount of 29,176 for clinics and 112134 for CHCs, the provinces should consider the need to balance utilisation, infrastructure and package of services provided to ensure that optimal quality care is offered.

d) For the facilities that are significantly below the minimum headcount (13192 for clinics and 65895 for CHCs), the district should review reasons for the low headcount in the facility, and make decisions on how to best utilise the available HRH including task sharing, given the low workload.

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e)Likewise, the same approach should be considered when determining the facility benchmark normative guide for each HRH category in CHCs as outlined in Figure 2.
f) Note that in figures 1 and 2, the PN is used as an example to illustrate the application of the normative guides and the benchmark head count.

STEP 5: Determine variance between existing HRH, and the determined facility normative guides

a)The Variance is determined by mapping the existing health workforce, against the determined facility benchmark normative guides. The variance is the difference between the facility benchmark normative guides, and the available number of health personnel in each HRH category. It should be zero (same value between benchmark normative guides and available health workforce), negative (more health workforce available as compared to the benchmark normative guides), or positive (fewer health workforce available as compared to the benchmark normative guides).
b)The existing number in an HRH category is mapped in column 5 while calculated variance is mapped in Column: 6 of the template, Table: 4.

STEP 6: Determine health workforce in the training pipeline

Step 6 offers the opportunity to account for all HRH that are undergoing medium to long-term training including both pre and post service training. The HRH planning should consider HRH in the training pipeline for absorption and correct placement on completion of the training programme.

STEP 7: Plan for corrective actions to facilitate movement towards the normative guides

a)Possible actions are dependent on the variance between the benchmark facility normative guides, and the existing number in HRH category. The information is mapped in Column 7 of the template, Table: 4.
b)Where the variance is zero, confirm by applying the WISN tool on HRH requirements. If the result is the same no direct action is needed. It is important to consider adjustment for clinics with SETs B and C and for all CHCs.
c)Where the variance is positive, actions relate to working towards getting the additional HRH needed. However, again confirm by applying the WISN tool on HRH requirements.
d)Where the variance is negative, actions relate to redeploying HRH after confirming by applying the WISN tool on HRH requirements.
e)If the variance is a fraction, then action relates to making HRH available for work in other facilities (negative fraction), or getting health workforce from other facilities to provide services in the facility (positive fraction).
f) For the sake of emphasis, it is important to note that the variance found using the headcount is confirmed by the application of the WISN based activity standards and standard workloads for each HRH category.
g)The variance from the normative guides should be assessed at least annually using the WISN tool.
h) Actions agreed should be interactive, and informed by availability, functionality and readiness of the facility to provide required services:

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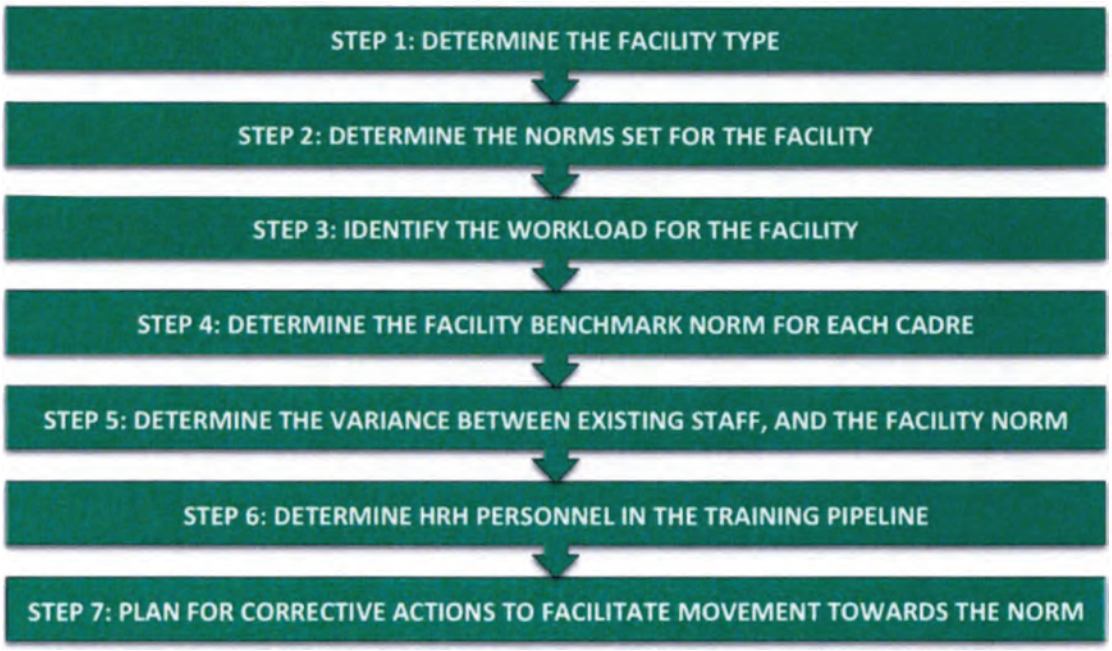
- Availability informed by existing complementary inputs (physical infrastructure, equipment, and others) that the HRH would need in order to provide services.
- Functionality informed by the state of the existing complementary inputs, to ensure they are in a fully useful state, such as balancing the functionality of a pharmacist with availability of medicines.
- Readiness informed by existing 'soft inputs' needed to make use of existing investments, such as electricity, safe water, skills mix, treatment protocols, and others.
- According to the Revised Primary Health Care Package of South Africa, 2015, therapeutic services that are limited to the hospital (such as audiology, speech therapy and psychology) should be provided based on the classification of the clinics according to the size, geographical location and ease of access to specialised services.
- Requirement for some HRH categories to provide out-reach services outside the fixed facility should be accounted for and estimated by using the fixed time that the category is expected to be away from the place of appointment.

Figure 3: Steps 1 to 7 for interpreting and applying the HRH normative guides & standards



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3.2 Applying the normative guides and standards by HRH category at clinics and CHCs and the other spheres of government

3.2.1 Applying the standards by Clinic and CHC facility HRH

The facility health workforce needs to play a role in applying the normative guides and standards. Each HRH member in the clinic and CHC should:

a) Know the AWT and potential working days, standard workload components to be accomplished in each year;
b) Use the potential working days to propose their leave plans for each year, and update these on a quarterly basis;
c) Undertake a personal review of the workload components they are expected to carry out, and develop a personal plan to ensure they are carrying out all their expected workload components;
d) Develop a personal development plan (PDP) to address required additional skills to implement the relevant workload components.

3.2.2 Applying the normative guides by Clinic and CHC facility HRH

Each HRH member in the Clinic and CHC should:

a) Know the expected numbers of HRH for their HRH category that the facility is expected to have based on workload;
b) Each HRH category, should understand the roles of the other HRH categories they have to work with to deliver required services.

3.3 Applying the normative guides and standards by Clinic and CHC managers

In the context of this section, the managers are the Operational/Facility Managers of the Clinics and CHCs of specific units.

3.3.1 Applying the standards by Clinic and CHC managers

To facilitate application of the standards in the Clinic and CHC, each manager should, for the HRH they are supervising:

a) Develop and display a chart showing the expected working time, activity, and standard workloads that HRH need to achieve in the facility;
b) Monitor adherence to activity standards amongst HRH that they are responsible for, and develop mentorship and support strategies for those that need to improve their skills based on HRH category expectations and nature of equipment in use;
c) Discuss and review personal development plans for the members they are in charge of, to support them work towards providing a wider set of elements of their workload;
d) Discuss and review leave plans for the members they are in charge of, in line with the Available Working Time (AWT) and potential working days;
e) Encourage each HRH category to understand the roles of other HRH categories to promote teamwork.

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3.3.2 Application of the normative guides by Clinic and CHC managers

To facilitate application of the normative guides in the Clinic and CHCs, each manager should:

a) Based on the facility workload, determine the actual reference normative guide for the facility/unit based on the method defined in section 2.1;
b) Develop, and monitor an HR plan, to guide movement towards attaining the normative guides for the facility type. Consideration should be made on the availability, functionality and readiness of the facility to provide required services, refer to Step 7 (h);
c) Constantly monitor productivity in each HRH category and for each member of the category, and provide appropriate mentorship and support including referral for psychosocial support;
d) Plan with the health workforce on how to address any gaps if numbers are below the HRH normative guides e.g. task sharing;
e) The facility manager should request for posts based on application of the normative guides, after verification using the WISN tool in collaboration with the sub-district and district managers.
f) Provide continuous information for monitoring the application of the normative guides, focusing on:
    - Facility specific normative guides being used;
    - Numbers of HRH for each HRH category available in the facility;
    - Average standard workload per individual where HRH categories are above or below the normative guides;
    - Numbers of HRH for each HRH category that are performing below, or above the expected activities as defined in the normative guides through observation.

The final total of required staff is often a fraction that should be rounded off to a whole number, this is fully illustrated in the 2010, WISN User's manual.

3.4 Applying the normative guides for health workforce projection

The normative guides are very critical in informing development of HR plans and monitoring at the sub-district, district, province and national levels, as they provide a benchmark against which the projections can be made. Both MTEF and annual HR plans should be comprehensive informed by normative guides through a health workforce management and development processes as well as the need to ensure optimum health workforce production.

3.4.1 Use of the normative guides by HRH managers at the sub-district, district, provincial and National Department of health

These normative guides are useful in supporting HRH planning, productivity management, distribution and monitoring.

a) For HRH planning, by category:
    - Determine the distribution of health workforce across all facilities;
    - The specific normative guides for each facility should be collated, to develop the expected numbers of personnel by HRH category at sub-district, district, province and national levels respectively;
    - Expected numbers in each HRH category are compared against the existing personnel, to determine the overall gap in the HRH category;

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- The gap forms the basis of budgeting for new HRH by category after considering redistribution in order to determine the real gap.

b) For informing health workforce productivity management, by HRH category:
- The HRH productivity is assessed and managed based on an agreed mechanism;
- Levels of productivity of HRH can then be compared in areas where they have their normative guides, areas above their normative guides, and areas below their normative guides to identify any effects of adherence to the normative guides on productivity of health workforce;
- Actions by management can then be taken, to better assure effective productivity.

c) For health workforce distribution, by HRH category:
- A review of existing health workforce against the normative guides should indicate areas with lower, or higher numbers of HRH per category;
- Redistribution of HRH should be informed by the need to ensure equitable number of different health workforce categories;
- Where HRH category has more personnel than what is required in terms of the normative guide, plans for redeployment should be developed and implemented as a guiding tool.

d) For health workforce monitoring, in each category:
- Management at sub-district, district, province and national level should determine different targets to be attained, with regard to normative guides indicators, (Section 5: monitoring, review and evaluation);
- Constant review of the existing numbers against the normative guides needs to be done to assess how much closer the different facilities, sub-district, district and province are implementing the normative guides.

3.4.2 Use of the normative guides by service delivery programmes

The normative guides are critical in programs directly addressing health challenges, such as Maternal, Child and Women's Health, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (HIV and AIDS), Tuberculosis (TB), Malaria and others.

a) Each program should identify which health personnel are important in delivering its programme interventions.
b) Each program should have information on the availability and gaps for the specific HRH categories important in delivering its program interventions.
c) Planning and monitoring of interventions by each program should include information on status of availability of its key HRH categories, based on the normative guides. It may not be advisable to plan for new interventions without considering the availability and adequacy of skills mix.
d) Each program should include, in its strategies, advocacy for ensuring availability of HRH to deliver their planned interventions based on these normative guides and standards.

3.4.3 Use of the normative guides by statutory health councils, research institutions associations, training institutions and the community

The HRH councils, associations and research institutions should be key drivers in building evidence, monitoring and advocating for attainment of the HRH normative guides.

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a) The Professional Statutory Bodies (PSB) should each have a mechanism to analyse data on HRH availability by HRH category to highlight evidence of gaps against the normative guides, by provinces and districts.
b) The PSB should have a mechanism to generate and analyse information on adherence to service standards.
c) Further, the PSB should facilitate generation of evidence indicating the relationship between HRH numbers in a category, productivity and clinical outcomes.
d) The PSB should also provide information regarding registered HRH categories.
e) Research institutions should generate evidence on HRH availability by HRH categories across provinces & districts and evidence on adherence to service standards.
f) Furthermore, research institutions should provide inputs towards understanding how HRH numbers and skills mix affect productivity.
g) Training institutions should produce and develop health workforce for rendering health services in line with the national health policy to assist addressing existing HRH gaps.
h) Communities should have substantive discussions with the health facility management on the HRH numbers and skill mix of PHC facility required based on workload taking into account the quality of services provided.

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Section 4: Management & Stewardship of Implementation of the HRH Normative Guides

4.1 Governance leadership and coordination

The overall governance and leadership of the normative guides implementation is carried out within the existing Department of Health framework, as these normative guides are limited to the public health services.

The governance and leadership shall therefore involve all spheres of government, in line with the current arrangements for the health services management. These shall aim to attain the following:

a) Ensuring that the national, provincial, district, sub-district and the facility levels are effectively carrying out their roles in implementing the normative guides;
b) Taking into account the perceptions and views of clients in implementing the normative guides and ensuring that the process is transparent and accountable to the public;
c) Facilitating involvement of relevant stakeholders in the implementation of the normative guides;
d) Ensuring that appropriate legal and regulatory environments exist to facilitate implementation of the normative guides.

The linkages amongst the governance and management functions for normative guides implementation are shown below. These linkages need to fully interpret the provisions in the legal frameworks –both Acts and Regulations and ensure that the current working relationships in different spheres are reinforced to promote transparency and mutual accountability in implementing the normative guides.

Figure 4: Governance and management of normative guides implementation as aligned with the WISN Tool

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4.2 Management roles & responsibilities in HRH normative guides implementation

The management of the normative guides implementation is the responsibility of teams from the facility, sub-district, district, province and national levels with roles and responsibilities as indicated in Table 5. In order to ensure that the roles and responsibilities are carried out effectively; a detailed implementation plan should be developed. The implementation process should be interactive and applied in a bottom up approach and not as a desktop analysis. The ultimate responsibility for the implementation of HRH normative guides rests with the head of the district (District Manager) supported by the WISN teams as outlined in Annexure 3 of this document.

Table 5: Management roles and responsibilities

Unit	Key persons	Roles and responsibilities
Health facility	Operational/Facility Manager	▪ Facility HRH mapping, and distribution based on normative guides ▪ Monitoring trends in facility adherence to standards ▪ Unit HRH mapping based on normative guides ▪ Development and support to HRH based on individual development plans ▪ Monitoring trends in facility adherence to standards
Sub-district	Sub-district Manager	▪ Sub-district HRH mapping, and distribution based on normative guides ▪ Working with the facilities to ensure that the normative guides inform development of facility health plans ▪ Monitoring trends in sub-district adherence to standards ▪ Identifying and liaising with stakeholders to support facilities in implementing the normative guides
District	District Manager	▪ Establish normative guides implementation team ▪ District HRH mapping, and distribution based on normative guides ▪ Working with the sub-districts to ensure that the normative guides inform development of sub-district HR plans ▪ Monitoring trends in district adherence to standards ▪ Identifying and liaising with stakeholders to support district in implementing the normative guides
Provincial departments of health	Head of Department (HOD)	▪ The Head of Department supports implementation of the HRH normative guides by: o Providing management leadership, and o Relevant resources required for the implementation of the normative guides. o Establishing a unit responsible for overall implementation of the normative guides within the HR planning component
	District Health Services and PHC coordinators	▪ Provincial HRH mapping, and distribution based on normative guides ▪ Monitoring linkages between normative guides adherence and health workforce productivity. Identifying and liaising with stakeholders to support provincial implementation of the normative guides

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Unit	Key persons	Roles and responsibilities
		▪ Working with the districts to ensure that the normative guides inform development of DHPs and District HR plans ▪ Monitoring implementation provincial adherence to normative guides
National Department of health	Director-General	▪ The Director General supports implementation of the HRH normative guides by: o Preparing and integrating strategic, medium term human resources plans annually o Providing strategic leadership, and o Relevant resources required for the rollout of the normative guides. ▪ Establishing a unit responsible for overall implementation of the normative guides within the HR planning component
		▪ Monitoring of national HR mapping, and distribution based on normative guides ▪ Monitoring country-wide implementation adherence to normative guides ▪ Identifying and liaising with stakeholders to support implementation of the normative guides ▪ Working with the provinces to ensure the normative guides informs development of provincial HR plans

4.3 Governance roles & responsibilities in the implementation process

The oversight of the normative guides implementation shall primarily be carried out at the national level through the Director General's office. Existing mechanisms for reporting and provision of feedback will be used to conduct timely data analysis and interpretation to inform the policy decisions and equitable resource allocation.

The key stakeholder groups involved include:

- National management team in the NDOH
- Service programs branches in the NDOH
- Facility managers, sub-district, district, provincial and national WISN coordinators and HR management teams
- Statutory health councils
- Teaching and research institutions
- Health workforce associations
- Labour organisations

The WISN Steering Committee, consisting of senior officials at national, provincial and district levels shall function as the overall technical management and coordination body. It shall be expanded to include representatives of the above-mentioned stakeholders into a normative guides implementation task team. This normative guides implementation team shall form time-limited Technical Working Groups as and when these may be needed to complement

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management efforts where required. Their main function is to support the implementation of normative guides.

Actual implementation, however, shall be facilitated through the existing management structures, using existing management and reporting mechanisms taking into account the need to strengthen accountability at all levels. The workforce development and planning cluster at NDOH shall develop detailed operational plans that will inform all spheres of government. Clear operational plans shall allow for appropriate and equitable funding to be provided at all levels, to ensure that the normative guides are implemented.

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Section 5: Monitoring, Review and Evaluation of the HRH Normative Guides Implementation

5.1 Key data and statistics

The normative guides implementation shall be monitored at facility, sub-district, district, provincial and national levels quarterly. The following are the indicators plus their targets for monitoring the process.

Table 6: Indicators and targets for monitoring normative guides and Standards implementation

Domain	Description	Targets				
		Yr. 1	Yr. 2	Yr. 3	Yr. 4	Yr.5
Process indicators	Percentage of facilities that have determined facility benchmark for each HRH category	60%	100%	100%	100%	100%
	Percentage of districts with revised DHPs informed by the HRH normative guides		40%	60%	80%	100%
	Number of provincial HR plans informed by the HRH normative guides		3	9	9	9
Output indicators	Percentage of facilities having required numbers of health workforce in all types of categories as per normative guides			25%	50%	75%

The data required to generate these indicators are:

a) Numbers of health facilities, by type of facility
b) Numbers of HRH required, as per facility benchmark normative guides for each HRH category Numbers of existing health workforce per facility and HRH category

This data will be sourced from facility managers and the following data sources, namely, the Personnel & Salary information system (Persal), Vulindlela[1] database and DHIS systems. This process shall be carried out at the facility, sub district, district and provincial levels, and reported through the existing reporting channels. The indicator information shall be compiled once a year, using the most up to date data from the above data sources. The information shall as much as possible be verified by the actual information at the facility and incorporated in the reports accordingly prior to dissemination.

The targets for the indicators are determined, based on the need to progressively move all the CHCs and Clinics towards attaining the normative guides within 5 years of the implementation of the normative guides. In the 1st year (2015), movement will be focused on determining facility benchmark normative guides for each HRH category in 60% of the facilities across the country. In subsequent years, all the Clinics and CHCs shall be prioritised respectively in an incremental manner.

[1] *Vulindlela is an initiative of National Treasury to promote effective financial management within the public sector*

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5.2 Data architecture and management

The data that exists to inform the indicator trends currently has challenges relating to completeness and accuracy.

Data verification shall be carried out annually, using existing mechanisms in the strategic planning and M&E units at both national and provincial spheres and make appropriate corrections to the respective datasets to ensure that more representative values of the data are used.

The analysis shall be built into the Human Resource Information System (HRIS), so that the emerging information is part of the HRIS outputs. This calls for an integrated system like the HRH Observatory, which is able to link with and draw from different databases to generate the required health information for effective normative guides implementation.

5.3 Performance Monitoring Review and Evaluation Framework

The performance monitoring and review process shall be embedded in the existing health planning and reporting system.

On a quarterly and annual basis, progress will be reviewed at the PHC facility, sub-district, district, provincial and national levels based on their respective HR plans.

In addition, an annual report on the progress towards implementation of the normative guides shall be produced under the coordination of the HR management branch in the NDOH. It is anticipated that all the facilities will have implemented the normative guides within 5 years. At this time, the normative guides will need to be reviewed to account for the significant changes of the disease burden, workload activity standards, etc.

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Section 6: Conclusion

This guideline provides step-by-step guidance and the required framework to ensure implementation of the HRH normative guides. The WISN Tool in support of the 2015-revised draft Primary Health Care Service Package for South Africa informed the HRH normative guides. It is, however, important to note that each province should have the flexibility and capacity to offer additional services in order to address the burden of disease in their area, as well as the demands of the specific population in that specific geographical location.

The normative guides implementation assist in ensuring equitable distribution of health workforce within and between HRH categories to ensure effective skills-mix and teamwork at all clinics and community health centres. This guideline and the normative guides will be subjected to review after 5 years to ensure that the health workforce complement and numbers remain relevant and that they continue to address health reforms that may arise from time to time.

This guideline should enable PHC facilities to benchmark facility staffing against the normative guides to determine the variance between existing and required health workforce. To ensure efficient redistribution of HRH, decision to add or reallocate HRH should be confirmed by applying the WISN Tool. The application of this guideline requires a reasonable understanding of the provincial, district, sub-district and facility operational context and the Workload Indicators of Staffing (WISN) manual (concept and methodology).

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ANNEX 1: Defining Available Working Time for HRH Categories

It is important for a manager to understand how much time different HRH categories have available for work, taking into account the provisions of the BCEA.

Health workforce personnel are expected to work, in a humane and rational manner that maximises the capacity to provide health services. As such, the available work time for each HRH category needs to be worked out, taking into consideration:

- Total number of days the HRH needs to be on leave
- Public holidays they are entitled to
- Sick leave entitlements,
- Special leave entitlements
- Estimates for time spent in trainings

Health workforce personnel at times don't utilise their leave entitlements, leading to burnout and reduced productivity of health workforce. A good manager should encourage the HRH to take their legally entitled days off. As such, each HRH should have in their personal development plan a schedule for days off to allow the managers ensure services are not affected.

A manager can estimate the available working time for specific category of health workforce based on the formula below:

*AWT = A – (B + C + D + E) x F where AWT is the total available working time; A is the number of possible working days in a year; B is the number of days off for public holidays in a year; C is the number of days off for annual leave in a year; D is the number of days off due to sick leave in a year; E is the number of days off due to other leave, such as training, etc., in a year; and F is the number of working hours in one day.

*In fixed PHC facilities, the average AWT is 191 days.

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ANNEX 2: Applying Skills Mix to Guide Determination of Required HRH Categories at Facilities

The term skill mix can refer to the mix of posts in the establishment; the mix of employees in a post; the combination of skills at a specific time; or alternatively, it may refer to the combinations of activities that comprise each role, rather than the combination of job titles. For purposes of this guideline, the skills mix reflects the HRH categories and the numbers within each and among several categories. After assessing the HRH needs based on the normative guides, facility managers need to determine whether the HRH complement is complete and whether in each HRH category the numbers are within the normative guides, above or below. This process needs to be validated by the sub-district area managers taking into account the existing workload.

A facility with a full complement of its skills mix is considered appropriately staffed. Decisions to add more HRH or redistribution to other facilities need to be carefully considered taking into account other factors especially distance, geographical barriers and existing and expected workload. Some facilities may have a low HRH complement but at the same time have low workloads while others may have a higher HRH complement as well as a higher workload. These scenarios may remain the same as long as the existing HRH complement is able to meet the health needs of the people without excessive workload pressure on any of the existing HRH categories.

Determining overall HRH requirements to meet the normative guides is best done at a higher level using unrounded numbers from the lower levels. Hence, at a district/sub-district level, it is not recommended to round up HRH requirements by facility before adding the total HRH for the district/sub-district. Rounding up of HRH requirements by HRH category should be done after adding all the HRH requirements in all PHC facilities within the district/sub-district. Even when adding up HRH requirements at district and provincial levels, it is recommended that unrounded numbers from the facilities be used.

If the workloads of some of the existing HRH categories are already high, then recruitment of new HRH may be the best solution and in a situation where the workloads for some of the HRH categories are very low, then redistribution of the extra HRH to the facilities in need may be considered as the best solution. The processes for redistribution and recruitment of additional HRH should follow the existing regulations.

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ANNEX 3: Terms of Reference for WISN Committees

This guideline is proposing the sub district, district and provincial management spheres to have a WISN committee established and functional. This committee has as its overall focus 'providing overall coordination in the implementation of the HRH normative guides' in their area of responsibility.

The WISN committee shall have three levels at which it functions:

1. A Steering Committee (SC) consisting of senior management officials at the given sphere whose role is to approve HRH needs and requirements based on the normative guides in the facilities within its area of jurisdiction, and agree on the management work plan.
2. A Technical Task Force (TTF) consisting of technical resource persons at the given sphere, who are responsible for actual support to facilities to analyse and interpret their normative guides.
3. Expert Working Groups (EWG) consisting of senior representatives of the relevant HRH categories at the sphere who are experienced and respected by the health workers whose main responsibility is to define main workload components and set activity standards for the targeted HRH categories.

The committee at each sphere should have representatives from the sphere below, to ensure adequate linkages across all health systems levels. Thus, the National steering committee should include representation from the provinces; the provincial steering committee should include representation from the districts in the province; the district steering committee with representation from sub districts, and the sub district committee with representation from its facilities.

A coordinator should be identified at the steering committee level, to guide and lead the technical process at the given level.

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ANNEX 4: Normative Guides for Out-reach / Visiting HRH Categories

Some HRH categories are represented as fractions (0.1 HRH, for example). These are those categories for which full time availability is not required due to a low workload. The fraction represents time that a given category is needed at the facility. The HRH member is not physically located at the CHC or clinic. The HRH category reflected as 0.1 implies that a single HRH member can support up to 10 CHC facilities or clinics (0.1* 10 = 1) with their services depending on the level of the workload at the facility they normally operate from and the travel time to the facility they visit. For example, one HRH full time equivalent (FTE) for a month is equal to 8 hours x 5 days x 4 weeks = 160 hours. If a facility visit is required at 0.1 or 10% FTE, the total number of hours to visit that facility is 160hours x 0.1 = 16hrs. It is important to note that at the visiting facility, the lowest number of visits per month could be only 2 (16 hours ÷ 8 hours per day) while the maximum number could depend on the acceptable number of hours to warrant a visit. Thus, if it is acceptable to visit a facility for only one hour, there would be a total of 16 days in a month. It is noteworthy that the higher the frequency, the higher the opportunities for patients to access with the visiting HRH services.

There are two trade-offs to consider when deciding the number of visits per month for a particular facility. The first consideration is travel time to the facility. The higher the travel time the higher the HRH FTE required to meet the needs of the facility being visited. The second consideration is the total number of consultation rooms available for visiting HRH. Sharing of consultation rooms and equipment like blood pressure weighing machines during a visit may add more time to the FTE required for each of the categories making a visit on the same day.

These categories are normally not part of the establishment of the clinics and CHCs they visit and may be located at the sub district to cater for a number of clinics and CHCs. Although some clinics and the CHCs open for 24 hours, the services of the visiting categories are usually required at a maximum of 8 hours on the visiting day. For this reason, their numbers are not adjusted upwards on the basis of opening hours. If some of these categories are located in institutions that are close to the clinics or CHCs, a referral arrangement could be applied to ensure that patients/clients receive services at the referral facility. This would require proper record keeping including paying attention to waiting time at the referral facility.

Visiting/Outreach HRH normative guides for PHC clinics

ADDITIONAL HRH	SET A		SET B		SET C	
	Minimum	Maximum	Minimum	Maximum	Minimum	Maximum
Dental Therapists	0.5	0.5	0.5	0.5	0.5	0.5
Dental Assistants	0.5	0.5	0.5	0.5	0.5	0.5
Medical Practitioner	0.25	0.5	0.25	0.5	0.25	0.5
Dentist	0.05	0.1	0.05	0.1	0.05	0.1
Family Physician	0.05	0.1	0.05	0.1	0.05	0.1
Pharmacist	0.05	0.1	0.05	0.1	0.05	0.1
Physiotherapist	0.05	0.1	0.05	0.1	0.05	0.1

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ADDITIONAL HRH	SET A		SET B		SET C	
Occupational Therapist	0.05	0.1	0.05	0.1	0.05	0.1
Dietician / Nutritionist	0.05	0.1	0.05	0.1	0.05	0.1
Social Worker	0.05	0.1	0.05	0.1	0.05	0.1
Psychologist	0.05	0.1	0.05	0.1	0.05	0.1
Health Promoter	0.05	0.1	0.05	0.1	0.05	0.1
Environmental Health	0.025	0.05	0.025	0.05	0.025	0.05
Nutritional Advisor	0.05	0.1	0.05	0.1	0.05	0.1
Optometrist	0.025	0.05	0.025	0.05	0.025	0.05
Audiologist	0.05	0.1	0.05	0.1	0.05	0.1

Visiting/out-reach HRH normative guides for Community Health Centres

ADDITIONAL HRH	Standard Normative guides (SET A)		Adjusting for 24 hours (SET C)	
	Minimum	Maximum	Minimum	Maximum
Oral Health				
Dentists	0.1	0.1	0.1	0.1
Pharmacy				
Pharmacists	0.5	0.5	0.5	0.5
Optometry				
Optometrists	0.05	0.05	0.05	0.05
Allied Health Personnel				
Physiotherapist	0.1	0.1	0.1	0.1
Occupational therapy	0.1	0.1	0.1	0.1
Speech and Hearing Therapy	0.1	0.1	0.1	0.1
Radiographer	0.5	0.5	0.5	0.5
Social workers	0.2	0.2	0.2	0.2
Clinical psychologists	0.1	0.1	0.1	0.1
Dietician	0.1	0.1	0.1	0.1
Community Services				
Health promoters	0.1	0.1	0.1	0.1
Environmental health	0.1	0.1	0.1	0.1
Medical Personnel				
Family Physician	0.1	0.2	0.1	0.2

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ANNEX 5 Determining the Average Number of Patients per HRH Category per Day

Analysis of the data among the sampled facilities revealed that most of the HRH categories spent about 90% of their time attending to patients while the remaining 10% of the time was spent on category and individual allowance factors. This implies that on a typical 8-hour day, approximately 432 minutes are dedicated to provision of health care to patients while 48 minutes are on support activities (preparation of reports, attending meetings etc.) and individual activities.

The experts also agreed that on average, it takes 12.5 minutes to attend to a patient in the clinic or CHC. It should be noted that this average took into account the range of activity standards of different types of health services demanded and their frequencies as well as the operational professional standards. It thus implies that one health worker will attend to a maximum of 34.56 patients per day although daily fluctuations are expected to occur. The 34.6 patients per PN is derived from the division of the available operational hours dedicated for patients by the average number of minutes it takes to attend to one patient. It should further be noted that additional observations in sampled clinics attested to the 90% dedicated for patients and the 10% of the time for the allowance factors. *Refer to the 2010, WISN Users' Manual for the calculation of the Standard workload and HRH requirement per category.*

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