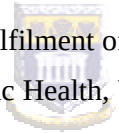
A SITUATIONAL ASSESSMENT OF HUMAN RESOURCES PLANNING IN THE MNQUMA LOCAL SERVICE AREA OF THE EASTERN CAPE PROVINCE, SOUTH AFRICA

BASTIAAN LEENDERT REMMELZWAAL



Mini-thesis submitted in partial fulfilment of the requirements for a Master's Degree in the School of Public Health, University of Western Cape

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KEYWORDS

South Africa

Eastern Cape Province

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Decentralisation

Human Resources

Human Resources Planning

Training

Capacity Building

Competence

ABSTRACT

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B L Remmelzwaal

MPH mini-thesis, School of Public Health, University of Western Cape.

The process of health-sector reform in South Africa brings with it the decentralisation and delegation of some of the planning and management functions from the national to the provincial and from the provincial to the district and local levels. Evidence suggests that this process of decentralisation has caused an element of confusion and ineffectiveness among planners at the sub-provincial level.

In 1996, partly in response to this challenge, the donor agency, Lux-Development, launched a technical assistance project in one local service area in the Eastern Cape, with the objective of developing competence among HR planners and other health managers. Nearly ten years on, a concern has been raised as to whether the project is having the anticipated impact in terms of improved job performance of the target group.

The aim of this study is to conduct a situational assessment of HR planning in Mnquma, with the objective of finding out what the key obstacles are, as perceived by the target group, after almost ten years of relatively intensive capacity- and competence-building.

Using a qualitative methodology, six key informants were interviewed in order to gain an understanding of the problems and to be able to develop recommendations regarding the improvement of capacity-building programs for rural HR health planners.

The findings from this study confirm that there has been a significant shift in responsibility away from the central level as a consequence of decentralisation, resulting in additional skill requirements at the local level. The study has identified weaknesses in the design of the capacity-building program, both on the part of the recipient and of the supporting agency, resulting in the omission of crucial elements from the training syllabus.

April 2005

DECLARATION

I declare that *A Situational Assessment of Human Resources Planning in the Mnquma Local Service Area of the Eastern Cape Province, South Africa* is my own work, that it has not been submitted before for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged as complete references.

Bastiaan Leendert Remmelzwaal April 26, 2005

Signed: ……

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ABBREVIATIONS

CIDA	Canadian International Development Agency
CPO	Chief Personnel Officer
DFID	Department for International Development (UK)
DOH	Department of Health
EC	European Commission
ECDOH	Eastern Cape Department of Health
ECP	Eastern Cape Province
HR	Human Resources
HRD	Human Resources Development
HRM	Human Resources Management
HRP	Human Resources Planning
ILO	International Labour Organisation
LD	Luxembourg Development
LSA	Local Service Area
MTR	Mid-Term Review
PERSAL	Personnel Administration System
PHC	Primary Health Care
RSA	Republic of South Africa
SIPU	Swedish Institute for Public Administration
TNA	Training Needs Assessment
UNDP	United Nations Development Program
WHO	World Health Organization

CHAPTER 1. INTRODUCTION

1.1 Background

1.1.1 Introduction to Mnquma

The focal point of this study is the health office in the Mnquma local service area (LSA) in the Eastern Cape Province. Mnquma LSA covers an area of 3,500 km^2 and has a population of around 330,000. The LSA is divided into three areas, namely Centane, with a population of 85,000, Butterworth, with 135,000 and Nqamakwe, with 110,000 inhabitants. There are 124 villages, 12 townships, and 3 informal settlements. The communities in the area are provided with comprehensive and integrated health care, comprising primary, community and acute services.

In terms of health infrastructure, the Mnquma LSA comprises one district hospital (Butterworth) and one community hospital (Tafalofefe) that together form a so-called 'hospital cluster' (of which there are 17 in the Province). In addition, there is a Community Health Centre at Nqamakwe, as well as 25 entry-level clinics that form a network of PHC facilities. Mnquma is one of 21 LSAs in Eastern Cape Province.

Whereas the hospitals are managed by a Cluster Management Unit, the Mnquma LSA office has the responsibility for the management of the Community Health Centre and the PHC clinics. One of the areas of responsibility of the Mnquma Health Office is the planning of human resources.

1.1.2 HR planning in Mnquma

For nearly a decade, HR planners and other health managers at the Mnquma LSA Health Office in the Eastern Cape have undergone a relatively extensive program of training and upgrading. This capacity-building program took place partly as the result of the Department of Health's deliberate efforts to build management capacity in rural areas. In addition, the donor agency, Lux-Development, has funded and implemented a variety of capacity-building initiatives, including seminars, workshops, short courses and distance learning courses for Mnquma managers.

Recently, and perhaps to some extent as a result of this research project, a concern has been raised among the different stakeholders as to whether the capacity-building program in Mnquma is having the anticipated impact in terms of improved job performance and job satisfaction. After almost ten years of intensive training and capacity building, the fact of the matter is that HR planning in Mnquma is still a haphazard process, giving the impression that the planning process is hampered by a lack of knowledge and competence among the responsible managers. Considering the efforts made by all parties, in terms of capacity building, this poses questions as to what causes this less-than-optimal performance among local HR planners.

The existing literature on the subject of capacity building for HR planners in the context of decentralisation suggests that training in specific technical skills, including management and finance, is essential for successful adoption of new roles and responsibilities. This being the case, the question arises as to why HR planners in rural areas, at least in the locality under investigation, appear not to be as effective as anticipated, even after training and re-training has taken place. Something appears to be at fault with the competence-building programs, either in the way they are designed or in the way they are implemented, supervised or supported. This thesis aims to investigate these suspicions and explore possible causative factors.

1.2 The problem addressed

The problem addressed by this study is that the decision to decentralise some of the HR planning and management functions in health has brought with it an element of confusion among local health managers, including HR planners, in that they appear ill-equipped to take on additional responsibilities. It is suspected that rural HR planners may not always have the appropriate knowledge and skills at their disposal that could assist them in carrying out their duties effectively.

1.3 The wider context of the problem

The problem of poor HR planning, and the associated lack of capacity and competence among health planners at the local level, is to be regarded within the context of health-sector decentralisation. Decentralisation of responsibility from the central government

to lower levels of government has become an increasingly common strategy for improving the performance of health systems in developing countries (Rondinelli et al., 1999). Designers and implementers of decentralisation and other reform measures, however, have focused their attention on financial and structural reform measures, while ignoring their human resource implications (Kolehmainen-Aitken, 2004).

South Africa is no exception to the general trend toward decentralisation as the government has adopted it as the model for both governance and management. Whereas the post-apartheid government of South Africa inherited a centralised and highly fragmented health system, the present government seeks to increase equity, efficiency, and community involvement by creating a unified, decentralised national health system, based on the district health system model (Kolehmainen-Aitken, 2004).

HR planning within the health sector of South Africa was traditionally done primarily by planners at national and, to a limited extent, at provincial and regional level. In recent years, however, a shift is said to have taken place, whereby some of the HR planning functions have been decentralised from the national to the provincial and from the provincial to the local level.

While, by its very nature, decentralisation brings with it a greater degree of responsibility for HR planners at the sub-national level, evidence from a recent case study in a rural South African district supports the notion that the decentralisation of HR functions has broader and often problematic implications (Lux-Development, 2003). In order to explore this issue in more detail, this thesis focuses on a case study in one of the least developed provinces in South Africa: the Eastern Cape.

Determining HR requirements at the local level is a complex process, wherein planners face huge challenges. It is suspected that the effectiveness of HR planning at the local level is hampered by a number of factors, including lack of capacity and competence, resource constraints, lack of information, as well as certain human factors associated with organisational behaviour. The implications of not having the capability to plan effectively are severe as they can lead to distributional difficulties, training mismatches, inappropriate use of qualified staff and, ultimately, unproductive and demoralised staff.

1.4 Research aim and objectives

The aim of this study is to conduct a situational assessment of HR planning at one local health authority, in order to determine how decentralisation has impacted the effectiveness of HR planning.

The primary objective of this study is to find out, for one local health authority, what the key obstacles to effective HR planning currently are, after almost ten years of concerted effort in terms of capacity building.

The broader objective of this study is to contribute to the literature which addresses required competencies for human resource planning concerning health, within the context of decentralisation.

1.5 Research questions

In order to fulfill the aims and objectives of this research, the development of this study will centre on a number of basic research questions:

a. How are the HR planning functions distributed between national, provincial, district / local level?
b. To what extent has the decentralisation of some of the planning and management functions affected HR planning at the district and sub-district level?
c. What, according to HR planners, are the required skills for effective HR planning?
d. To what extent have provisions been made at these levels, in terms of skill development and competence building, in order for HR planners to be effective?

1.6 Research design and method: an overview

In order to develop an understanding of the HR planning process and the problems associated with it, an exploratory qualitative case study was undertaken in a rural locality: the Mnquma Local Service Area in the Eastern Cape Province. A qualitative

methodology was chosen, as it was expected to elicit the desired information from the study population. It also allowed for a more flexible investigation of the various issues and enabled the researcher to acquire insight into a diversity of, at times unforeseen, experiences and viewpoints expressed by the key informants. The framework of HR planning functions, resulting from the literature review, was used for guiding the interviews and subsequent analysis of the findings.

1.7 Structure of this thesis

After this introduction, the development of the thesis starts with a comprehensive review of the existing literature in Chapter 2, which explores the context in which the study takes place; this being health-sector reform and decentralisation. It then considers what, according to the existing literature, the implications of these reforms are for HR planners, particularly at the local level. The literature review includes an exploration of the concepts of capacity and competence. It results in a framework of HR planning functions which is used in subsequent chapters. Chapter 3 describes the methodology used for the case study and the subsequent analysis of the results. Chapter 4 presents analyses and discusses the results from the case study. The last part of this thesis, Chapter 5, presents the main conclusions and recommendations. In addition to summarising the main findings, Chapter 5 is concerned with exploring some of the wider implications of the research findings. It concludes by suggesting a number of areas for further research.

CHAPTER 2. LITERATURE REVIEW

2.1 Study boundaries

There are many factors that determine or influence the behaviour and performance of health-sector managers. These determinants include social, cultural and motivational aspects of inter-human dynamics and organisational behaviour.

In order to make this study both practical and feasible, a clear contextual boundary was introduced in that it is concerned specifically with the immediate context surrounding its core concern, i.e. considerations related to competence and performance of HR planners at the local level.

Furthermore, due to the nature of this study, any conclusions and recommendations arising from it will have relevance primarily to rural South Africa, in particular to the Eastern Cape Province. It is hoped, however, that some of its findings and recommendations will have applicability to a wider audience.

One could argue that the topic of this mini-thesis falls, to some extent, between the disciplines of public health and behavioral science and thus ought to give cognisance to both bodies of literature. The decision was taken, however, to approach the subject matter primarily from a public health perspective.

2.2 Health-Sector Reform

2.2.1 Decentralisation

Health-sector reform aims to improve the performance of the health sector through a conscious process of setting sectoral priorities and policies (Kolehmainen-Aitken, 1997). Although each country's reform process has its own specificity, there are common trends, such as the pursuit of better outcomes using the same or fewer resources (Rigoli & Dussault, 2003).

Decentralisation of political and administrative power is becoming a prevalent component of health-sector reform in many developing countries. The concept implies the shift of power, authority and functions away from the central level. Decentralisation is seen as a mechanism to achieve greater equity and efficiency, as well as a greater involvement of the community. Decentralisation aims to reduce the size of the bureaucracy which is far removed from the target group being served. Key objectives of health-sector decentralisation are improved efficiency, accessibility, equity, community participation and health status (Hutchinson & LaFond, 2004). The decision to decentralise usually arises outside the health sector and is often political or economic (Cassels, 1995).

The concept *deconcentration* is regarded as the weakest form of decentralisation which takes place within one and the same government department (e.g. Health). *Devolution* involves the transfer of responsibilities from a central government to lower levels of government that have been empowered by statutory or constitutional provisions. *Delegation* involves the transfer of responsibilities from central agencies to semi-autonomous entities operating independently or semi-independently from government (Brinkerhoff & Leighton, 2002).

South Africa is no exception to the trend towards health-sector decentralisation, as evidenced by the shift in funding from national-level to provincial-level programmes. In order to strengthen the health sector and to intensify a range of programmes, provincial health expenditure has increased steadily over recent years: nationally from R33.2 billion in 2002/03 to R36.9 billion in 2003/04, and an expected rise to R42.9 billion by 2005/06 (IFR, 2003). The key features of the provincial health budgets are:

a. Substantial increases for previously disadvantaged provinces;
b. Large increases in the Hospital Revitalisation Programme;
c. Increases for the Integrated Nutrition Programme;
d. Strengthening of the Enhanced Response to the HIV/AIDS Strategy; and
e. R500 million rising to R1 billion additional funding annually for a new system of rural incentives and a scarce-skills strategy.

Strong growth rates for health budgets apply specifically to some of the most disadvantaged provinces; the Eastern Cape, for example, has seen a rate of increase from 2003/04 to 2004/05 of almost 16.9 percent, in comparison to a national provincial average of 10.9 percent. It is expected that the rapid growth in health budgets of historically disadvantaged provinces is set to continue for some years to come.

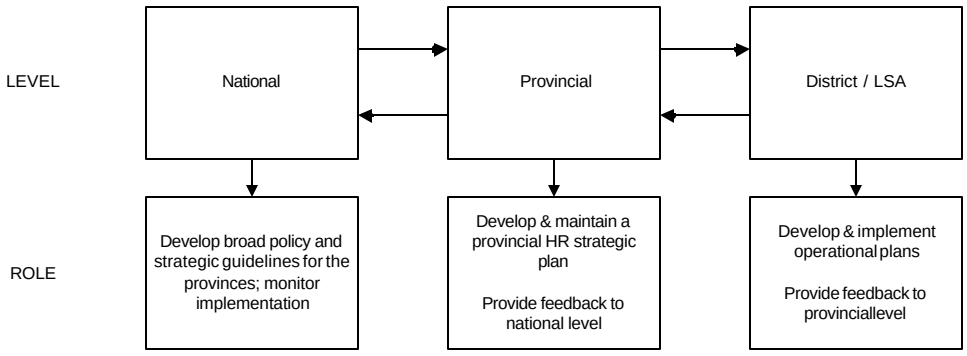
The implementation of the resulting strategies and programs related to decentralisation has major human resource implications. The impact of health-sector reform has modified critical aspects of the health workforce, including labour conditions, degree of decentralisation of management, required skills and the entire system of wages and incentives (Rigoli & Dussault, 2003). Recent studies in selected developing countries suggest that designers and implementers of decentralisation and other reform measures appear to have focused on financial and structural reform measures, while ignoring the human resource implications of such measures (Kolehmainen-Aitken, 2004).

2.2.2 Functional delegation

Hutchinson and LaFond classify decentralisation by the *types of responsibilities* devolved and by the level of autonomy granted to the local authorities (Hutchinson & LaFond, 2004). A common taxonomy classifies decentralisation by three categories of devolved responsibilities: political, administrative and fiscal. This research concentrates mainly on the administrative aspects of decentralisation, which have been delineated by Rondinelli (1999:2) as "the transfer of responsibility for planning, financing and managing certain public functions from the central government and its agencies, subordinate units or levels of government, semi-autonomous public authorities or corporations, or areawide, regional or functional authorities".

Whereas the National Department of Health in South Africa aims to focus mainly on issues related to policy, legislation, national programmes and international liaison, the chief responsibility for the delivery of health services now rests firmly with provinces and districts. The following diagram depicts the functional division between the different levels:

Fig. 1 HRP: Roles at the different levels



Bossert, in this respect, points out that central- or national-level officials require skills in policy making and monitoring, while lower-level officials need more operational and entrepreneurial skills (Bossert, 1996).

2.3 Human Resources Planning

2.3.1 Introduction

Human Resources Planning (HRP) is an important function within general health-sector planning. HRP refers primarily to the estimation of the required workforce, both in quantity and quality, needed to deliver a package of health services to the population. HRP is typically concerned with medium- and long-term needs for personnel, while ensuring that their skills and knowledge will match anticipated health service needs. The existing literature invariably emphasises the importance of systematic planning, whereby planning of human resource requirements is based on a cyclical process, referred to as the *planning cycle*.

The web-based WHO Toolkit (hrhtoolkit.forumone.com) describes human resources development (HRD) as involving planning, production, and management functions. These functions can be seen as comprising distinct tasks, each of which requires specific knowledge and skills. The Toolkit describes HR planning as consisting of the following tasks:

a. Describe the health workforce supply;
b. Describe the health workforce distribution;

c. Forecast health workforce requirements;
d. Set job requirements;
e. Compose job descriptions;
f. Describe staffing patterns and standards; and
g. Design supervisory structure.

The following section elaborates on the components of this framework.

2.3.2 HR planning functions

a. Describe the health workforce supply

Describing the workforce supply is concerned with estimating the present and future supply of each cadre of health workers. Firstly, one needs to undertake an analysis of the existing human resources. The HR division must profile existing staff according to number, age, competency, training needs, race, gender, disability, occupational category, organisational component and grade (SIPU, 2005). This profiling is greatly facilitated by an effective and updated system of human resources records. Secondly, the HR division needs to make an estimation of likely changes in resources, losses to the organisation (e.g. retirement, impact of HIV/AIDS, etc.), improvements in staff performance, programmes for staff development and external environmental factors.

The supply of personnel is essentially a function of a number of variables: (i) the current number working and their productivity, (ii) those in other occupations or unemployed, (iii) shifts in trained staff into and out of the health sector, (iv) emigration and immigration, (v) supply from training schools, and (vi) losses due to death and retirement.

b. Describe the health workforce distribution

The description of the current and desired distribution of the health workforce is concerned both with the geographic and the institutional distribution of personnel. Relevant issues to consider include: (i) shortages of skilled

personnel in rural areas, and associated with this (ii) inappropriate concentration in urban health facilities, which leads to shortages elsewhere.

c. Forecast health workforce requirements

Forecasting the demand is linked to anticipating staff requirements necessary to implement the strategic, operational or business plan of the health institution(s) concerned. The desired organogram of the organisation/institution will reflect the outcome of the forecasting exercise. Forecasting relates to estimating the demand or requirements for each different professional group for each year over the projection period.

There are various methods for assessing demand based on (i) likely future health service utilization, (ii) health needs, i.e. demographic and epidemiological projections, (iii) personnel to population ratios, and (iv) setting of specific service targets and then estimating personnel requirements to accomplish these (Green, 1992).

d. Set job requirements

In order to determine job requirements, HR staff first of all need to gain an understanding of the nature and purpose of the organisation; in this case, health-care delivery. Within this context, one needs to determine the required knowledge, skills and abilities to carry out a spectrum of individual jobs. Setting job requirements feeds into the process of defining initial education and further on-the-job training and upgrading of staff.

e. Compose job descriptions

Job descriptions define the work to be done by each cadre of health personnel. They act as a reference for both employer and employee and facilitate the provision of clear and precise objectives for training programs.

f. Describe staffing patterns and standards

The starting points for developing staffing patterns and standards are the current staffing densities or patterns observed in a given locality or health facility. These patterns can be adjusted up or down, depending on informed opinion about emerging health needs, potential measures to improve staff productivity, likely budget realities, evolving technology, and other considerations. There is no completely 'scientific' way for developing standards since, ultimately, they depend on past experience, good judgment, and societal values as well as on political, financial, administrative and other realities.

g. Design supervisory structure

Supervision aims to facilitate the work of individual employees or employee teams, so they can effectively perform their job responsibilities. The design and implementation of supervisory structures can be broken down into the following sub-tasks:

- Describe all supervisory roles;
- Ensure that all supervisors and employees are aware of systems put in place and associated procedures;
- Clearly define performance objectives with desired results and outcomes;
- Train supervisors; and
- Provide adequate time and resources for supervisors and supervisees to meet and work together.

The above categorisation of HRP functions will serve as a guide for the remainder of this study, including the individual interviews and focus-group discussion envisaged in the course of this research project. This framework will also be used for the analysis of the results of the case study. The framework of HR-planning functions in matrix form is given in Annexure 1.

2.3.3 Required skills for HR planning

This research project explores the required skills, i.e. capacity and competence for HR-planning staff at the local level, which enables them to cope with a changing set of responsibilities and to carry out their duties effectively.

The existing literature uses the terms *capacity* and *competence* interchangeably to denote the ability on the part of individuals or institutions to perform according to predefined standards. A definition by the ILO links competence to capability by referring to competence as the productive capability of an individual (ILO, 1993).

In terms of required competencies for HR staff, Filerman (2003:3) maintains that *managerial competence* is of utmost importance. He adds that "each position, at every level must be analysed to identify the specific management competencies required to meet the objectives of the position. The analysis will produce up-to-date position descriptions and identify the skills that need improvement".

However, in the same publication, Filerman states that when assessing competency needs, one ought to focus rather on *practical skills* that are essential to everyday experience, thus avoiding the complex, culturally limited concepts of managerial and organisational behaviour that dominate contemporary managerial literature as "there is little evidence that they work…" (2003:4).

Cohen is of the opinion that management training for local-level health managers often consists of a set of uncoordinated, theoretical courses, workshops and seminars, which do not provide practical skills and management tools (Cohen et al., 1995).

As for the skills and competencies, Kolehmainen-Aitken advocates the need for the development of human capabilities, both managerial and technical, in particular at the local level. She promotes the need for a concerted effort by all role-players. She falls short, however, of defining the required human skills and competencies in more detail, nor does she indicate how precisely these competencies can be determined. She does, however, suggest that they should be "wide in scope, including financial, HR and logistical management skills, as well as competence in advocacy and negotiation" (1997:14).

2.3.4 Implications of decentralisation

Good intentions notwithstanding, evidence suggests that managers at local levels are ill-prepared to take on the new responsibilities devolved to them, especially where this occurred in a context of decentralisation without adequate financial resources and appropriate tools (Bógus et al., 1995). A number of studies have focused on the changes in attitudes and efforts of health managers in response to the demands imposed by the new rules created by the decentralisation process (Adams, 2001; Cavanagh, 1996; Bennett, 1999). The extent to which managers accept and share the proposed institutional changes appears to affect their motivation. A number of authors comment on the motivation and morale of health staff who are, understandably, anxious about the impact of the reform measures (e.g. Kolehmainen-Aitken, 1997).

In her paper on the implications and impact of decentralisation of human resources, Kolehmainen-Aitken (1997) analyses the impact of decentralisation on human resource development. Two major human resource issues are considered, namely (i) those that emerge as a part of the process of delegating power to lower-management levels, and (ii) identification of the most important areas of HR where problems arise as a result of the way in which decentralised management systems are structured.

Kolehmainen-Aitken summarises her findings by saying that the impact of decentralisation is influenced by five distinct factors, these being (i) the degree to which political and administrative power is transferred, (ii) how the new roles are defined, (iii) what skills are available at the local level, (iv) what administrative linkages exist between the different management levels and between the central health authority, and (v) the degree of political will to make decentralisation work. According to Kolehmainen-Aitken, the process of devolution brings with it four important HR issues, namely:

a. Access to information on HR (timely and up-to-date);
b. The complexity of transferring HR (resistance to change);
c. The impact of professional associations, unions and registration bodies (labour relations); and
d. The morale and motivation of staff (uncertainty, anxiety).

From her case studies in a number of developing countries, she identifies five human resource areas where problems arise due to decentralisation:

a. Organisational structures, roles and responsibilities, which are said to be generally poorly defined;
b. Coordinated HRD, referring to the availability of reliable data on the numbers, skills and geographic distribution of health personnel and the capacity to use these data for HRP;
c. Sustained appropriate training capacity, referring to ownership of responsibility for training programs;
d. Technical and managerial competence, associated with a potential shortage of skilled staff; and
e. Performance conditions, meaning the availability of adequate resources for staff to enable them to carry out their duties.

Solter (1999) agrees that decentralisation brings with it considerable need for new skills, particularly in management competencies. Local managers' capacity to respond to these and other performance gaps through training is, however, thought to be restricted. They lack funds to pay for such training, and often have little or no capacity to plan and implement in-service training programs at the local level.

2.4 Capacity and competence

2.4.1 Capacity building

For decades, capacity building was seen as providing practical assistance to local institutions in developing nations, primarily by providing funding and equipment and strengthening technical skills. The existing literature on this subject provides many examples of short-term and limited-impact programs in which capacity building has followed a typically narrow and short-term approach, not taking into account the wider environment and support systems of the target group (for example: Teskey, 2000).

During the mid-1990s the international donor community became increasingly aware of the limited impact of technical cooperation. It was during that time that a new

approach to capacity building was promoted, the so-called *framework of levels and dimensions* (EC, 2000). This framework supported the notion that capacity building of individuals had to be seen as part of a wider system by 'zooming out' to the outer levels, or layers, to find the root causes for capacity constraints. Poor performance of individuals was thought to have root causes both at the level of the individual and within the surrounding layers or levels. This concept implied fundamental consequences on how capacity gaps were to be identified and how capacity-building strategies were to be designed.

Following this realisation of the late 1990s, the term *capacity* was re-defined as being the "ability of individuals, organisations or systems to perform appropriate functions effectively, efficiently and sustainably" (UNDP, 1998:5). The same source describes capacity building essentially as an internal process, which may be accelerated by outside assistance, rather than dictated. The performance and the capacity of an individual or group of individuals is said to be influenced by factors both within the primary focus area as well as by external factors in the broader environment (Milèn, 2001).

Many development agencies have thus come to realise that to define capacity-building (or -strengthening or -development) simply as training, skill development or even increasing knowledge of individuals would be too narrow a perspective. Neither can capacity building any longer be regarded as static, as the concept denotes a continuous renewal in terms of a steady process of improvement.

Capacity building has many dimensions. Traditionally the major issue of capacity building tended to focus on the general assumption that policy and programme development are the responsibility of government and that it is therefore the national level that ought to be equipped. In other words, one of the preconditions for successful reform is capacity at the national level to plan and manage change (Sein, 2000). However, HR planning capacity, even at the national level, is usually weak, particularly so in developing countries. Furthermore, planning has often focussed quite narrowly on certain occupations only (Bach, 2001).

Kolehmainen-Aitken, considering the ongoing reform process in the health sector, is especially concerned with the peripheral level and argues that planning skills, particularly human resources skills, are generally weak in most developing countries. To confound the problem among rural health managers, higher levels of government often transfer responsibilities to those managers without providing them with adequate skills for their newly acquired roles (Kolehmainen-Aitken, 2004).

2.4.2 Components of competence

The research questions posed in this thesis are closely related to job performance of individuals. Performance is associated with capacity, ability and competence. Competence has been defined as the ability to perform a specific task in a manner that yields desirable outcomes (Kak et al., 2001). Competence is thought to be associated with a person's underlying characteristics that are causally related to job performance (Boyatzis, 1982).

For the purpose of this study, the term *competence* will be used when referring to the ability to perform a task in a satisfactory manner. It is further relevant to divide the concept of competence into its four components, as proposed by Kak et al. (2001). Competence of an individual, i.e. the ability to perform a task, is defined in the context of particular *knowledge, skills, ability* and *traits.* These *components of competence* can be acquired in a variety of ways, as summarised in the following Table:

Table 1. Components of Competence

COMPONENT	DESCRIPTION	HOW ACQUIRED	EXAMPLES OF COMPETENCIES (District Health)
Knowledge	The understanding of facts and procedures	Pre-service education In-service training Continuing education	Basic epidemiology Health economics Stock control Transport management Waste management
Skills	The capacity of an individual to perform specific actions; actions that an individual performs in a competent way in order to achieve a goal	Hands-on training Role play	Accounting, budgeting Procurement Contract management Computer skills Reporting Procedures Data handling
Ability	The capacity to act or to do something; attributes that an individual has acquired through previous experience	Developed over time Work experience	Leadership Management, planning Quality assurance Labour relations Ethical behaviour Evaluation, monitoring Group facilitation Staff motivation
Traits	Personality characteristics that predispose a person to behave or respond in a certain way; distinguishing characteristics or qualities especially of a personal nature	Personal attributes which are slow to change or even permanent	Presentation skills Self confidence Public speaking Dealing with authority Dealing with conflict Stress management Time management Chairing meetings

[Source: Adapted from Kak et al., 2001; Boyatzis, 1982; Landy, 1985; Ericsson, 1996]

This classification of components of competence will be referred to when analysing the findings from the case study.

2.4.3 Mentoring and supervision

An important element of *the wider layers* to which the existing literature refers (EC, 2000; Milèn, 2001) is the immediate management support for capacity-building programs, in particular for the mentoring and supervision of the target group of individuals. Considering the fact that the development of competence is now generally regarded as an ongoing process, one should consider carefully the follow-up to any training activity, whether it applies to an individual or to a group of individuals. The

monitoring and evaluation of the training provided is equally as important as the question as to what happens to the individuals after a specific training activity has been completed. Milèn emphasises the fact that monitoring and evaluation of capacity-building programs has generally been neglected and that measurable outcome and process indicators are required (Milèn, 2001).

2.5 Summary

The study of the existing literature related to HR planning at the local level within the context of health-sector decentralisation has brought to light a number of gaps in the following areas:

a. Distribution of HR planning functions before and after decentralisation

It was found that the existing literature tends to make rather general statements on this subject. By having a closer look at one specific rural locality, this study intends to shed light on the perceived responsibilities of HR planners before and after decentralisation. This study aims to generate detailed information which will lend itself to further analysis and possible refinement of some points made in the literature.

b. Impact of decentralisation on required skills for HR planners

Once the new responsibilities for HR planners have been identified as an outcome of the case study, it will be possible to deduce specific skill areas which were not relevant before decentralisation. The existing literature suggests that the effectiveness of HR planning at the local level is hampered by a lack of *managerial* and *technical* competence as well as by constraints in terms of *financial resources*. With regard to specific competencies required by HR planners at the local level, it was found that the literature falls short of providing concrete guidance as it tends to generalise and use broad and all-embracing terminology. The results from this study will be used to test the consensus of the literature and possibly add a refining element to it.

c. Process of determining required competencies

There is consensus in the literature regarding the disorganised nature of many competence-building programs. Cohen argues that training for local-level managers often consists of theoretical courses which are chosen rather haphazardly and are essentially uncoordinated, thus failing to provide the practical skills required (Cohen et al., 1995). Kolehmainen-Aitken (1997) falls short of defining the required skills and competencies in some detail, and does not indicate how precisely these competencies can be determined in a given situation for a specific target group. This study intends to propose or refine a model for a systematic and transparent process of determining competence gaps among managers.

d. Components of competence

The classification by Kak et al. (2001) of components of competence will be used to have a closer look at the competence-building programs that have taken place and are taking place at the chosen study location. In particular, it will be relevant to determine whether some aspects of competence may perhaps have been overlooked.

CHAPTER 3. RESEARCH DESIGN AND METHODOLOGY

3.1 Aim and objective of the study

The aim of this study is to conduct a situational assessment of HR planning in the Mnquma Local Service Area (LSA), with the objective of finding out what the key obstacles are to effective HR planning. The empirical part of this study will focus on the following key questions:

a. How are the HR planning functions distributed between national, provincial, and district/local levels?
b. To what extent has the decentralisation of some of the planning and management functions affected HR planning at the district and sub-district levels?
c. What, according to HR planners, are the required skills for effective HR planning?
d. To what extent have provisions been made at these levels, in terms of skill development and competence building, in order for HR planners to be effective?

It is anticipated that by finding answers to these questions, the aims and objectives of this study can be met.

3.2 Study design

In order to gain a better understanding of the HR planning processes at the sub-provincial level, a case study was undertaken in a rural sub-district, i.e. the Mnquma Local Service Area (LSA) in the Eastern Cape Province. The research took the form of an exploratory, qualitative study. A qualitative methodology was deemed appropriate as it was expected to elicit the desired information from the study population. It would also allow for a more flexible investigation of the various issues and enable the researcher to acquire insight into a diversity of, at times unforeseen, experiences and viewpoints expressed by the key informants.

The main study instrument used was the *non-scheduled semi-structured interview*, whereby the researcher met with key informants (Bowling, 2002; Bless & Higson-Smith, 1997). Questionnaires in the form of structured lists of probing questions were developed for this purpose. The reason for choosing this type of interview was that it would allow the interviewer (i.e. the main researcher) and the interviewees to expand on topics as they saw fit, to focus on particular aspects, to relate to their own experiences, and so on. The task of the interviewer was to direct the flow of ideas, to intervene when needed and to ask probing questions. The basis for the formulation of guiding questions for the interviews was the analytical framework for HR planning derived from the literature study.

Following on from the individual interviews, the interviewer convened a *focus-group discussion*, attended by all interviewees. The focus-group session enabled the interviewees to share individual viewpoints and, to some extent, reach a degree of consensus.

3.3 Study population

The focal point for this research was the health office in the Mnquma LSA of the Eastern Cape Province. The reason for choosing the Mnquma locality was that the main researcher had easy access to that area as he had already worked with some of the staff on related issues within the spheres of activity of the development agency by whom he is employed.

3.4 Study sample

The primary target group at Mnquma consisted of three persons, namely the LSA Office Manager, the Chief Personnel Officer and the Senior Administrative Officer. For the reason that this group primarily deals with a range of HR issues, they were regarded as key informants. Secondary interviews were conducted with some of the other members of staff, in particular those who have, at some point, acted as managers.

In order to assist the main researcher with his understanding of the research issues and to put HR planning in Mnquma in context, formal interviews were also conducted with

HR planners at provincial level (in the provincial capital, Bhisho, where the main researcher is based and to which he, therefore, has easy access). The target group of interviewees at the provincial level consisted of three persons: the Director of Human Resources Planning, her Deputy Director and his assistant. The researcher also interviewed a representative of the Swedish development agency SIPU.

3.5 Data collection

In-depth, semi-structured interviews were conducted with four persons at LSA level and also with four persons at provincial level during the period October, 2004 to February, 2005. In preparation for these encounters, the main researcher drew up interview schedules and questionnaires. The researcher conveyed the purpose of the research to the informants and always made sure that individuals were willing to take part in the interview sessions. Prior to approaching subordinate office staff members, the researcher obtained approval from the Office Manager to conduct the interviews.

All interviews were conducted in English and took place on location, i.e. at the Mnquma Health Office or at the provincial HQ in Bhisho. Interviews were either recorded on tape or in else in writing, for transcription and analytical purposes.

The focus-group discussion took place after the interviews with individuals. The meeting was attended by all key informants, as well as by several additional staff members of the Mnquma LSA office. By providing informants with the opportunity to discuss their individual viewpoints and opinions concerning issues pertaining to competence and performance, the researcher was able, at least to some extent, to assess the degree of consistency among the participants. A problem was encountered during the focus-group discussion, in that subordinates tended to withhold the verbal expression of their opinion in the presence of the superior Office Manager.

The non-scheduled, semi-structured interview process and the focus-group discussion produced rich qualitative data in the form of transcribed viewpoints, experiences and opinions from key informants.

3.6 Reliability and validity

Reliability has been defined as the extent to which the observable (or empirical) measures that represent a theoretical concept are accurate and stable when used for the concept in several studies (Bless & Higson-Smith, 1997). By its nature, however, this study could only offer an exploration of the viewpoints of one target group, i.e. one set of people in one situation. While the researcher sought areas of consensus among key informants and explored the applicability of the findings to a broader group, the interpretation of the results will primarily pertain to the target group in question.

Furthermore, data collection methods based on non-scheduled, semi-structured interviews carry with them an intrinsic element of subjectivity and potential exposure to critique from the scientific community. Any interview is likely to be influenced by the skills, characteristics and personalities of both parties. The interviewer was aware of the risk that interviewees might refrain from expressing their real opinions and true feelings. Much depended on the objectivity and personal attributes of the interviewer.

In order to improve the validity of the findings, the researcher made use of a process of triangulation (Patton, 1987; Bless & Higson-Smith, 1997). This means that the findings from the interviews and focus-group discussions were matched against the findings from the study of other sources. Other sources of information included existing documents issued by the ECDOH and supporting agencies, reports and opinions expressed by HR consultants pertaining to the Eastern Cape Province and a recently conducted business case for Mnquma LSA, in which a number of HR issues were raised.

As an additional validation strategy, the conclusions and recommendations from this research were fed back to the key informants in order to verify whether they regarded the outcome as a reasonable reflection of their viewpoints (Mays & Pope, 1995).

3.7 Data analysis

The interviews and subsequent focus-group discussion with key informants yielded rich qualitative data. The accounts given by individuals were content analysed for

coherence, common ground and patterns that emerged. The analytical framework for HR planning, derived from the literature study, served as a guide to structuring and categorising the information received.

The analysis of the qualitative information was verified and enhanced by making use of the services of a second researcher on location. A second researcher was available given the fact that the main researcher is a member of a four-person team of consultants involved in capacity-building and training activities in the Mnquma LSA. The second researcher had no objection to taking part in the process of triangulation as he had carried out several management- and administration-related studies and interviews in and around the Mnquma Health Office in recent years.

3.8 Ethics

The main researcher is a member of a team of foreign consultants operating in the Eastern Cape Province. The collaboration project between the government of South Africa and the Grand Duchy of Luxembourg, Project RSA/005, aims to build health management competence in the Mnquma LSA. The project is now in its third three-year phase, and the staff of the Luxembourg team are fully integrated into and accepted by the Mnquma target group of health managers and planners.

The researcher is aware of the fact that as a white male foreigner he is in a privileged position to be integrated in the Mnquma LSA situation. Capacity-building elements of the project are accompanied by direct investments, in terms of buildings and equipment for Mnquma LSA, to the amount of R10m during 2004 only. Although there was a ready willingness on the part of the Mnquma staff to fully cooperate with any project-related studies, the researcher remained sensitive to local issues and to interpersonal realities and perceptions. The researcher did not encounter any problems with regard to access to sites, conducting meetings, or with obtaining permission to interview health personnel.

The main researcher has conducted similar research before; he has successfully completed a Ph.D. at the University of Sussex in the United Kingdom, with field studies in the health sector of several developing countries.

The pilot study in Mnquma LSA had the support and approval of the Eastern Cape Department of Health (ECDOH), as formally outlined and agreed upon by all parties concerned in the RSA/005 Project Document. It is the intention of the main researcher to forward the results from the study to the ECDOH, prior to submitting them to a popular or accredited journal, or sharing any of the research findings with other stakeholders.

As mentioned earlier, participation in interviews by the informants was on a voluntary basis, while participants could withdraw from the research process at any point. The researcher remained aware of the fact that issues related to human ability and competence can be rather sensitive. For this reason he ensured that the key informants were fully involved in the research process and endeavoured to ensure that any findings from the study would have the full backing and consent of the target group, prior to formal publication of the report.

CHAPTER 4. RESULTS: PRESENTATION AND DISCUSSION

4.1 Introduction

In order to be able to answer the research questions, interviews were conducted with HR planners at the Mnquma health office and also at the provincial health office in the Eastern Cape's capital, Bhisho. The interviews shed light both on some of the general constraints impinging on staff performance as team members as well as on issues hampering effective HR planning.

4.2 General staff constraints at Mnquma

4.2.1 Staff structure and vacancies

The management team at Mnquma is comprised of the LSA Health Office Manager, program managers and managers and coordinators in the areas of human resources, provisioning, skills development, health promotion, nutrition, clinic supervision and program coordination. In total, the Mnquma LSA office has 29 approved posts of which only 14 are presently filled. The following information was gathered from the interviews:

a. The post of Assistant Director in charge of the administration (human resources as well) no longer exists, nor does the one for Chief Personnel Officer (CPO);
b. The post of Transport Officer is not filled; however, there is an acting officer in place at the moment;
c. The posts that are traditionally under the Assistant Director/Admin., i.e. Senior Admin. Officer/Provisioning, registry clerks, transport officer, switchboard operator, and cleaner are presently floating and have no official linkage with the organogram. This inadequacy is one of the consequences of the cancellation of the Assistant Director/Admin. post in the LSA organogram; and

d. The post of Finance Controller appears to be missing in the organogram: the financial operations are carried out by the Senior Administrative Officer in charge of Provisioning.

In the opinion of some of the interviewees, the many vacancies result, at least to some extent, in a non-functional organisational structure. Several reasons were given for the relatively large number of vacancies at the Mnquma District Office:

a. Professionals are reluctant to work in rural areas, in particular, doctors, physiotherapists, speech therapists, psychologists, social workers, dentists, dental therapists and occupational therapists;
b. Remuneration levels of the public health sector are not attractive;
c. Professional nurses move to institutions where scarce skills are paid for;
d. There are limited career opportunities and no proper career pathing;
e. Incentives are lacking; and
f. There are lengthy recruitment procedures.

During the interviews, it became apparent that a number of individuals were stressed and overworked because of having too many functions and responsibilities. When faced with additional tasks and time constraints, managers tend to delegate some of their tasks to junior employees. This, in turn, creates problems, since the junior employees often do not have the skills and experience to carry out managerial duties.

Although staff absenteeism is not recognized as a major issue at this LSA office, absenteeism levels are not regularly monitored. Absenteeism, when it happens, is dealt with on an individual basis through a lengthy, cautious, and hesitant disciplinary process. It is common knowledge that health workers who are frequently absent are subjected to the early stages of the disciplinary action but rarely go through to the final stage of the process.

A clear and established policy for administration of the disciplinary and grievance procedure/mechanism is not in place. Lack of established processes in this area and lack of willingness to use the available procedures are said to be notorious in the health facilities, particularly in the hospital cluster.

As a result of a transparent process of selection of human resources at the time of recruitment and staff upgrading, forces of nepotism are generally thought not to play a significant role. Likewise, at the level of the District Office, the 'brain drain' phenomenon is not seen as a major factor being responsible for the many vacancies. None of the staff interviewed could give any recent examples of brain drain.

4.2.2 Job descriptions

From the interviews, it appeared that there is no comprehensive approach to determining health system-related needs and associated job descriptions for staff. As a result, there exist, generally speaking, no job descriptions with clearly defined areas of responsibility for individuals. The lack of job descriptions is generally regarded as a major obstacle to effective planning and management. For a number of posts there are, as yet, no job descriptions available; for example, for Information Officer and Logistics Support Officer.

4.2.3 Staff qualification

Persons interviewed were of the opinion that the levels of knowledge and skill of the staff were not of the necessary standard. Managers generally expressed the view that the key skills and competencies needed to enable them to perform their daily activities effectively were lacking. Priority areas of concern, in terms of required competencies, were given as: (i) human resources management, (ii) financial management, (iii) communication, and (iii) use of health information.

4.2.4 Staff support and development

At the LSA office, the Training Coordinator is responsible for assessing the training needs for the staff in the Mnquma health facilities. As yet, however, there is no comprehensive training plan for the staff at any of these facilities. The Training Coordinator claims to encounter various obstacles, such as the problems in collecting timely information to assess staff training needs, lack of identification of persons officially responsible for training issues in the health facilities, and shortage of working tools (such as a proper filing system for information received from the facilities and a

working computer). The absence of an established system for the periodic training and upgrading of staff is regarded as having a negative effect on staff morale and staff effectiveness.

With regard to performance assessment, there are no formal and/or systematic performance appraisal processes in place for staff evaluation. Some of the interviewees reported that nurses and other staff at different levels in the LSA cite a lack of recognition or praise for their hard work as an important cause for low morale among them.

4.3 HR planning issues

4.3.1 Introduction

Interviewees were asked about the effect of decentralisation on perceived responsibilities for HR planners and also about constraints impinging on HR planning at the LSA level. Several themes emerged from these interviews. They have been grouped into four categories: (i) distribution of HR planning functions, (ii) skills shortages, (iii) strategic planning, and (iv) liaison with the provincial office.

4.3.2 Distribution of HR planning functions

With reference to the framework of HR planning functions, identified in the literature study section of this thesis, interviewees at local and provincial level were asked about functions and tasks within HR planning, with particular emphasis on increased responsibility for them as a result of decentralisation. The structure of the interview questions followed the framework of HR planning functions (refer to Annexure 1). The results of the interviews are as follow:

a. Describe the health workforce supply

Interviewees at the local level concerned with this aspect of HR planning regarded themselves as fully responsible for describing the present and future anticipated workforce supply. Before decentralisation, this was said not to have been the case. However, there are some problem areas. The list of existing

staff in the health institutions, kept by a HR practitioner, is not integrated into the computerised PERSAL system. Another frustration is that field staff, particularly nurses, move between health institutions without informing the local health office. The list kept by the HR practitioner is not extensive in that detail is limited to name, age, sex, location and basic occupational data (salary, grade).

Provincial-level staff members confirmed that their role was one of rendering advice and support to the LSAs, who are primarily responsible for this aspect of HR planning. In the past, the province (in conjunction with the national level) had been fully responsible for describing the health workforce supply. The concept of *regions* within the province has, in hindsight, been an intermediate stage in the process towards decentralisation.

Whereas the national level used to determine the national workforce supply without significant input from the provinces, they now typically monitor and interpret statistical information related to current and future workforce supply for the purpose of informing national policies and guidelines which they develop.

b. Describe the health workforce distribution

In the past, the LSA office collected this information for its own internal use, whereby the information was not entered into a computerised system linked to the provincial and national levels. Nowadays, the LSA is responsible for collecting and maintaining this information, linked to the PERSAL system.

The provincial office sees itself as the 'custodian of the organisational structures' and, as such, fulfils a monitoring role in this respect; work-study officers carry out inspections and verifications during visits to the LSA offices. The province renders support to those LSAs which are lacking the capacity to implement this function.

Statistics on current and future workforce distribution is monitored and interpreted at the national level, which informs the development of policies and guidelines.

c. Forecast health workforce requirements

After decentralisation, the local level became responsible for the preparation of the localised HR strategic plan, which is linked to future workforce requirements. As described elsewhere in this study, the development of the LSA-specific HR StratPlan is recently becoming an interactive process between the provincial level and LSA offices.

The provincial office typically renders assistance to the LSA office; the LSA office is presented with a generic plan, which can be tailored to a specific LSA. The advantage of this system is that national and/or provincial common strategies (e.g. ARV roll-out, implementation of national *Equity Plan*) are incorporated in the StratPlans of all LSAs. In the past, the provincial office was responsible for forecasting the workforce requirements without significant input or feedback from the LSAs.

The national office informs the provinces on countrywide programs and initiatives. In addition, it monitors and interprets statistics on health workforce requirements. In the past, there was little interaction between the provincial and national levels, with the national level typically prescribing the anticipated workforce to the provinces.

d. Set job requirements

Whereas in the past the LSA office was not held responsible for providing the provincial office with detailed job requirements, it now prepares lists of tasks associated with existing jobs and submits these to the province for evaluation. One of the HR practitioners interviewed confessed that his lack of understanding of 'medical jobs' was hindering his effectiveness as a HR planner.

The province typically takes 'a broader view' and re-evaluates the objectives of the jobs before determining detailed job requirements. The resulting task lists are the basis for required competencies associated with each job.

The national office informs the provinces, through policies and guidelines, on the broader objectives and functions at the provincial and local levels. In the past, it issued generic job categories to the provincial offices, with requirements and salary scales.

e. Compose job descriptions

The local-level staff do not regard themselves as responsible for composing job descriptions. Interviewees confirmed a dependency on 'job profiles' prepared at the provincial level. The job profiles are used to formulate advertisements for recruitment. The LSA office is being given a degree of freedom in amending job requirements, depending on limitations, i.e. lack of skills in the local labour market. Depending on local circumstances, the LSA office can request a quantity for a particular post which deviates from the 'provincial standard' for that post.

Job analysts and work-study officers at the provincial office are currently busy developing comprehensive job profiles for all cadres, stipulating required knowledge and competencies. The resulting profiles are a crucial resource for the LSAs.

In the past, the national office prescribed job descriptions to the provinces, so-called occupational classes, through the Department of Public Service and Administration (DPSA). In an attempt to streamline job descriptions nationwide, it still gives guidance to the provinces by making templates available as the basis for province-specific job profiles. National codes of remuneration (grades) list all occupational classes, indicating the overall responsibilities associated with posts.

f. Describe staffing patterns and standards

While not having any responsibility for this function in the past, the LSA office has now begun to assist the provincial offices by informing them about the distribution and emerging patterns of human resources. One interviewee commented on the fact that access to PERSAL was limited to extracting information mainly on salary scales of staff. At provincial level, the level of access was thought to be less limited.

The provincial level traditionally relied on the guidelines from national level. Nowadays they are responsible for describing provincial HR patterns and setting norms and standards in close collaboration with the LSAs. These descriptions inform the generic provincial StratPlan.

Whereas in the past, the national HR planning office determined staffing patterns and standards without significant input from the provinces, it now increasingly relies on information received from the provinces for the purpose of monitoring and setting out national policies and guidelines.

g. Design supervisory structure

In contrast with the past, the LSA office is now fully responsible for the design and implementation of a supervisory structure in support of its health workers. The LSA office generally organises training and upgrading, although this has been haphazard up to now.

In the past, the provincial office did not have a significant role to play; in fact, supervisory and mentoring functions were largely marginalized. This has now begun to change, partly as a result of decentralisation. The provincial office now renders support to the LSA office, but only if needed. General training activities are organised by the provincial office. Recent examples are 'job analysis' and 'office management'. The role of the provincial office is to empower the LSA office staff, in order for them to take on an increasing level of responsibility.

As for the provincial level, mentoring and supervision was traditionally not a priority for the national level. Presently the national level ensures, through the issuing of national guidelines, that provincial and local levels jointly put supervisory structures in place.

Interviews with HR planners, both at LSA and provincial level, thus provided valuable insight into the problem area. The information obtained was structured into a matrix, and the result is given in Annexure 2.

4.3.3 Skill shortages

As with general skills shortages, echoed by all interviewees, several of them gave the lack of specific skills as a reason for less-than-optimal performance in the area of HR planning:

"We don't have the skills to do HR planning… staff is put in positions, often in acting capacity, without having the necessary skills to do the job… we need more training."

"Even basic training is missing; for example, using the PERSAL[1] system, which runs on two of the computers here…there is a lack of capacity in computer skills and besides, not everybody has a User ID to gain access to PERSAL."

"What we need is a training needs assessment. For example, what I need is training on is how to chair and facilitate meetings. Most of us need skills to be better team members and to learn how to get the most out of people."

"Most of the training that we have received has to do with management and finance…what seems to be missing is training more at the level of personal development, especially self-confidence and verbal communication skills."

[1] PERSAL = Personnel Administration System

One interviewee mentioned the importance of team building, as well as labour relations, which includes basic conditions of employment, staff discipline, negotiation skills, etc. Another interviewee pointed out the importance of presentation skills, leadership, and the ability to delegate tasks.

Another interviewee commented on issues related to leadership and authority. Apparently, the dynamics of working in a relatively small office brings with it issues to do with inter-personal relations and behaviour towards persons in authority or persons of relative seniority. The question arose of whether training could be made available to deal with these issues. Some of these elements of human behaviour were thought to be cultural.

4.3.4 Strategic planning

From the interviews with HR planners at the Mnquma LSA office, it became clear that HR planning was a haphazard activity. Although the interviewees were aware of the various aspects of HR planning, there was no strategic framework in place as the basis for an operational plan for the HR planning section. As one interviewee remarked:

> "What is missing is a comprehensive list of tasks with a clear division of responsibilities among us… I guess we do a lot of HR planning but, to be frank, it is all rather chaotic…"

One interviewee commented on the fact that planning had not always been the responsibility of the LSA office:

> "I think that national and provincial-level staff are historically more used to planning exercises… here at the LSA level these kind of skills were not really needed… in the past, they basically told us what to do and we did it. It seems that this is now gradually changing, but that means more work for us…"

It became clear that the HR planners at the LSA office would benefit from a systematic and comprehensive list of tasks for HR planning. However, none of them had thus far attempted to draw up such a framework.

4.3.5 Liaison between LSA and province

Within the context of decentralisation, district managers at the district level are supposed to provide the link between the provincial and the local levels. In reality, however, the LSA office managers deal directly with their provincial-level counterparts. This not only applies to Mnquma, but also to other LSAs in the province. It is anticipated that, in the future, the districts will play a more significant role in this respect.

The LSA interviewees were of the opinion that although communication with the provincial office (in Bhisho) on issues related to HR planning did take place, there was a lot left to be desired. The interviewees expressed several concerns:

a. Support from the provincial office is weak;
b. Absence of a clear organisational structure;
c. No clarity about who the contact persons are at the provincial office;
d. No telephone numbers available for provincial office-based functions; and
e. No clarity over appropriate times to visit the provincial office with queries.

One interviewee commented on the fact that communication between the LSA office and the provincial HR office was far from ideal:

> "The present organisational structures do not encourage direct liaison, at least at the technical level, between LSA and provincial-level counterparts."

The expectation of the LSA office was that the provincial office would supply them with a strategic plan for HR planning, mainly due to the fact that the capacity to carry out strategic planning at the LSA level was sorely missing. Interviewees confirmed that, recently, the provincial office had approached the LSA office for this purpose and progress was now being made in this respect.

4.4 The provincial level perspective

In order to render support to HR planners throughout the province, the Eastern Cape Department of Health (ECDOH) has recently created a unit for HR planning, being an off-shoot of the existing HR management unit. The move to create such a unit was recommended to the provinces by the national level HR Development unit. In view of this study, several interviews were conducted with provincial-level HR planners.

As well as supporting the LSAs in the province, this relatively new unit at provincial level has been tasked with developing staffing norms and terms of reference for work studies. In order to carry out its tasks, the provincial HR planning unit requires feedback from the various LSAs. The case study at Mnquma took place at an opportune time, when the provincial HR planning unit presented a *draft strategic planning framework* (StratPlan) to the Mnquma LSA office for the purpose of obtaining feedback (ECPA, 2004). The provincial HR planning unit receives assistance from the Office of the Premier in the provincial capital, Bhisho. The Office of the Premier receives technical/advisory support from the Swedish aid agency SIPU (Swedish Institute for Public Administration) for the benefit of several service sectors, including health.

From the interviews with individual provincial HR planners, it became clear that the lack of strategic planning capacity on the part of the LSA staff had been acknowledged. It was for this reason that the province had decided to assist the LSAs by developing a generic strategic plan to promote and accelerate HR planning activity at the LSA level. The idea being that each LSA would be able to adapt such a generic provincial StratPlan to their specific needs and circumstances. As one provincial representative commented:

> "We have sketched an organogram for LSA staff requirements. Now we want to know whether this organogram matches the needs of the LSAs as perceived by the current LSA staff. The LSAs must now carry out a gap-analysis, in order to determine whether our organogram corresponds with their specific requirements, bearing in mind anticipated supply and demand. We are aware of the fact that not all LSAs will have exactly the same needs."

HR planners at Mnquma LSA welcomed this provincial initiative, and a meeting was held between the two parties in October, 2004, attended by the main researcher of this study. The framework for the StratPlan proposed by the province was discussed and input was obtained from the participants of the meeting. The comments provided by the LSA HR planners were recorded by the provincial facilitators, who are currently incorporating them in a revised StratPlan for Mnquma LSA. The provincial health planners are currently busy repeating this process in each of the 21 LSAs throughout the province.

The need for this type of 'back-office support' for the LSAs is widely recognised. The ECDOH has recently introduced new sections at the provincial head office, named 'Corporate Services', to be headed by the so-called District Managers. This means that for each LSA a Corporate Service Office will be created in the provincial capital, which will manage everything except medical/clinical issues for the respective LSAs. The Corporate Service is said to work closely together with the respective municipal offices.

4.5 The donor agency perspective

Mnquma LSA receives advisory and technical support from the government of Luxembourg. As well as funding and implementing renovation projects for rural hospitals and clinics, the Lux-Development (LD) project in the Eastern Cape supports the provincial Department of Health with the development of management competence in Mnquma LSA. The LD project in Mnquma was launched in 1996 and has gone through a number of project phases, emphasising different aspects of strengthening rural health-care delivery.

In recent years, the emphasis of the LD project has increasingly been on competence-building activities, targeting specifically the managers at the Mnquma LSA office. LD-funded training courses for Mnquma LSA management staff, including HR planners, have predominantly been in aspects of management, finance and administration. Details of planned training courses for 2004-2006 are given in Annexure 3.

Following a mid-term review (MTR) of the current phase of the LD project, at the end of 2004, a realisation has emerged that, despite a high level of competence-building activity during recent years, the net result in terms of empowered HR planners is noticeably disappointing. The MTR report (unpublished) comments on the fact that, despite the fact that key HR planners have attended numerous training courses in management, finance and administration, there remains a distinct sense of underachievement in terms of effective HR planning at the LSA level.

The conclusion of the MTR team concurs with recent findings of a provincial task team of the ECDOH, who concluded that some of the HR planning functions are not effectively implemented at LSA level and should therefore be taken away from the LSA and institute d at the district or provincial level. From a health management point of view, however, the district level is currently not functional.

The question arises as to why the anticipated outcomes of the LD project, as set out in the original project documents (Lux-Development, 1996; 1998; 2002), have not materialised, despite the good intentions of the donor agency and the willingness of the local partners, including the HR planners, to collaborate.

4.6 Main results

First of all, from the interviews there emerged a number of general constraints pertaining to staff at the Mnquma office, which appear to affect not only HR planning, but also other functional areas within the LSA office. These constraints include:

a. Too many vacancies as a potential cause for stress;
b. No policy on disciplinary and grievance procedures;
c. No job descriptions in place;
d. Inadequate levels of knowledge and skills;
e. No comprehensive training plan; and
f. No performance-appraisal procedures in place.

Secondly, more specific to functions within HR planning, interviewees highlighted a number of additional tasks delegated to them as a result of the delegation of

responsibility. Interviewees were also asked about perceived 'missing competencies' for each of the HR planning functions. Detailed findings are given in Annexure 2 and summarised in the following Table:

Table 2. Result of interviews of HR planners at Mnquma

HR function/task	**Additional tasks due to decentralisation**	**Missing competencies related to additional tasks**
Describe the health workforce supply	Describe the present and future anticipated workforce supply	Ability to profile staff according to a range of parameters; information gathering and analysis; computer skills; knowledge of PERSAL
Describe the health workforce distribution	Systematically collect and maintain personnel data, using PERSAL	Ability to collect and compile personnel data; computer skills; knowledge of PERSAL
Forecast health workforce requirements	Prepare and operationalise HR StratPlan	Strategic planning; ability to translate StratPlan into operational plan, including HR requirements
Set job requirements	Inform province about job-specific tasks	Understand job content of all categories; communicate with provincial level; computer skills
Compose job descriptions	Develop localised job descriptions based on job profiles prepared by province	Interpret job profiles; analyse local labour market; determine required number of additional staff for all categories
Describe staffing patterns and standards	Assist the province by providing data on HR distribution and emerging patterns	Ability to interpret PERSAL; conduct research within the local labour market; apply HR standards
Design supervisory structure	Set up an effective supervisory structure for staff guidance and development	Understand physical, mental and emotional needs of staff; ability to recommend organisational improvements; communication skills

These findings confirm that there has been a significant shift in responsibility from national and provincial level to the local level as a consequence of decentralisation, resulting in additional skill requirements, in particular (i) research, (ii) data collection, (ii) data analysis, (iv) computer skills, (v) communication, (vi) strategic planning, (vii) knowledge of standards and norms, and (viii) understanding the content of various job categories, including those of clinical, administrative and support staff.

In addition to the above, most of the local health managers commented on other issues directly or indirectly related to HR planning:

a. There is a need for a comprehensive training needs assessment of staff at the Health Office, which has thus far not been carried out;
b. Strategic planning is typically done in a haphazard fashion and driven by deadlines;
c. Training thus far has omitted to address some of the more personal issues to do with group dynamics and personal skills; and
d. Communication skills, both within the LSA office, but also with regard to the liaison with the provincial office, need improvement.

From the interviews with provincial HR planners, it became clear that the lack of strategic planning capacity at the LSA level had been identified as being a problem. In order to stimulate and accelerate strategic planning in the LSAs, the province had recently decided to develop a generic StratPlan for all LSAs, who, in turn, could then adapt these plans to their specific needs. A second support initiative by the province for the benefit of the LSAs is the creation of a 'back-office-support' system, in the form of Bhisho-based managers dedicated to support and represent the respective LSAs in the province.

Interviews conducted with representatives of the supporting donor agency, Lux-Development, led to a realisation that the results of a multi-year, competence-building program, in terms of changed behaviour of health managers, had thus far proved disappointing.

4.7 Discussion

4.7.1 Introduction

This study has explored some of the key causal factors for the less-than-optimal performance of HR planners at the LSA level. What emerged from the series of interviews was a varied collection of insights into (i) constraints in general staff conditions, (ii) distribution of responsibilities for HR planning, (iii) skill shortages for

HR planners, and (iv) problems with communication between the local and the provincial support office. The following sections reflect on some of the key issues pertaining to the research questions posed by this study.

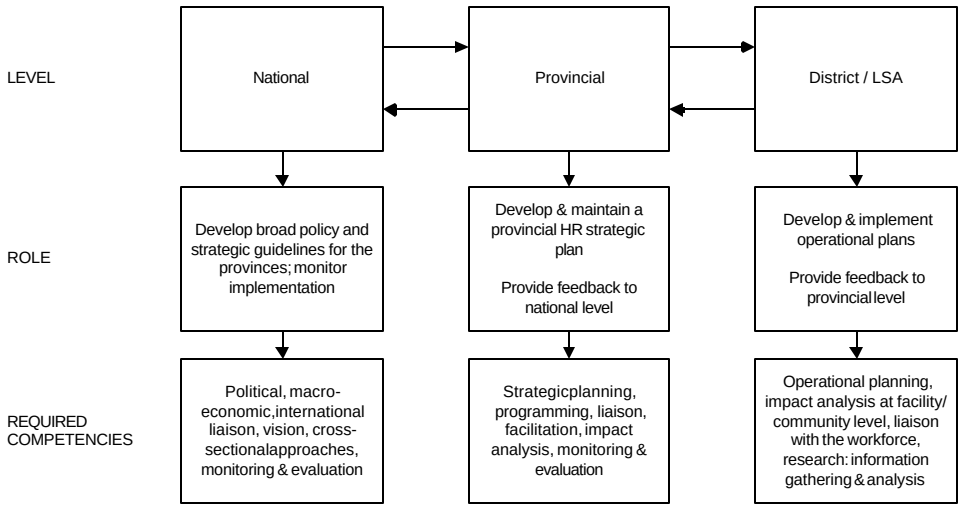
4.7.2 Role of the different levels of management

Following on from the diagram introduced in Chapter 2 (Fig 1.), the study findings confirm the assumptions regarding the division of labour outlined in the existing literature on decentralised health systems. The case study at Mnquma has shed some light on the actual division of roles and responsibilities between the provincial and local level.

An important finding is that the responsibility for certain aspects of the strategic planning functions appears to be shifted back from the LSA to the provincial level. The pendulum has clearly swung back as a result of apparent non-performance on the part of the LSA. Although it was the intention of the provincial HR planning unit to assist the LSA office in developing a StratPlan for medium-term planning purposes, in reality, the LSA team has been disempowered, since drafting the StratPlan is no longer their responsibility. Admittedly, inputs to the draft StratPlan made by the LSA will be incorporated into the final version of the StratPlan, which is important. However, the final editing and distribution is ultimately taken care of by the provincial office.

Assuming that the shifting back of some of the planning functions from the LSA to the province is indicative of a possible trend, Figure 2 presents a graphical representation of the required competencies at the different levels, based on the Mnquma experience, from the point of view of the provincial planning office.

Fig. 2 HR planning related roles and competencies after decentralisation



A further piece of evidence supporting the notion that LSAs are essentially regarded as not having the required capacity to implement certain managerial and planning activities is the recent decision of the province to create new posts for District Managers, to be situated at the provincial office. These District Managers will have the task of representing and supporting the LSAs with all managerial tasks, other than clinical, and they in fact will be responsible for reporting to the provincial office on LSA-related planning and management issues.

4.7.3 Identification of relevant competencies

The findings from the study in Mnquma suggest that efforts to bring about increased levels of managerial competence, resulting in better performance, have essentially concentrated on the development of technical skills of individuals related to management, finance and logistics/administration. Considering the disappointing net result, in terms of changed behaviour and better performance of individuals, the question arose as to whether HR planners have been trained in the right type of competencies. For this reason, it will be useful to compare the actual training programme which is currently being implemented at Mnquma with the classification of components of competence introduced in Chapter 2.

The figures in the following Table have been derived from an analysis of the data contained in the Mnquma LSA Office Training Plan for 2004-2006 (Annexure 3). Referring to the classification of competencies in Chapter 2 and the examples provided therein, the Mnquma training courses were grouped by type of competence. The results of this analysis are as follows:

Table 3. Mnquma LSA Office: Planned Training 2004-2006 (Financial Years)

	person-hours (% of total)		
	Knowledge, skills	Personal traits	All training
LSA staff: HRM/HRD (2 persons)	55 (91.7%)	5 (8.3%)	60 (100%)
Other LSA staff (12 persons)	231 (96.7%)	8 (3.3%)	239 (100%)
Total (all LSA staff) 14 persons	286 (95.7%)	13 (4.3%)	299 (100%)

The following conclusions can be drawn from this analysis:

a. LSA office staff receive, on average, 21.4 hours of training over the two-year period, which translates into fewer than two training days per person per year;
b. Training for LSA office staff concentrates primarily on technical skills and to a far lesser extent on the development of personal traits which are deemed to be equally important (95.7% vs. 4.3%);
c. On average, HRM/HRD staff each receive 30 hours of training over a two-year period, which is about two days of training per person per year;
d. HRM/HRD staff are exposed to just 2.5 hours of personal development training each, over the two-year period;
e. A closer analysis of the training plan reveals that HR planners are trained purely in the planning, development and management of human resources and not at all in any of the other skill areas; and
f. Other LSA staff receive less than one hour of personal development training each, over the two-year period.

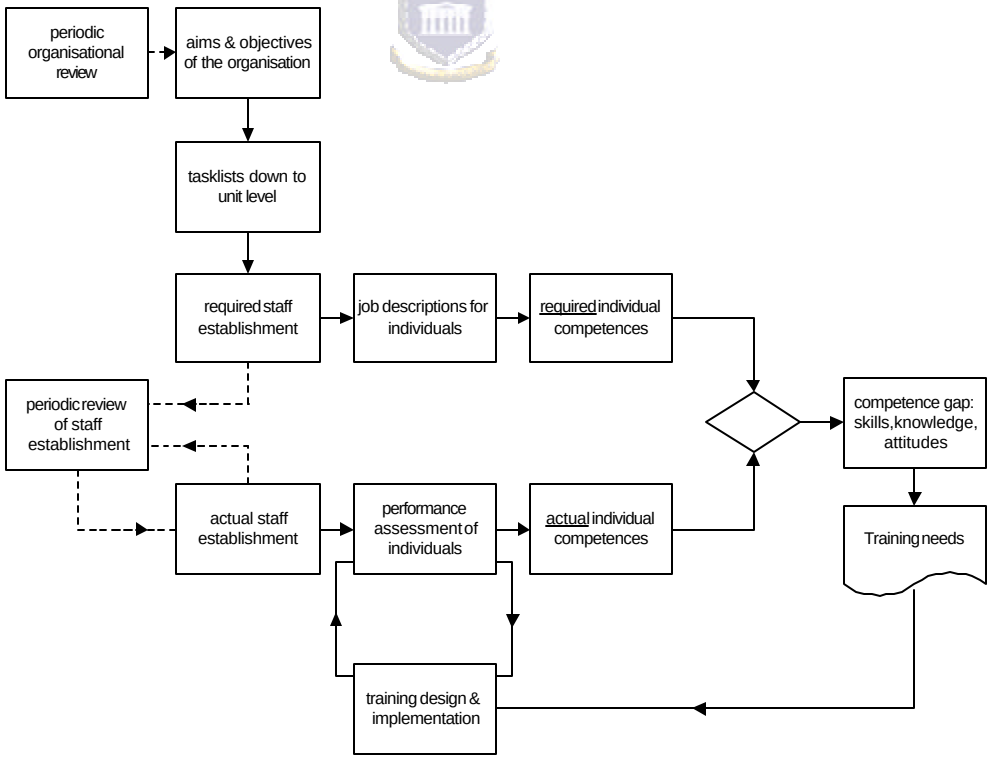
In carrying out the analysis, the assumption is made that the competence component 'ability' is gained through experience only and, as such, can not be addressed by short-term training.

4.7.4 Systemic approach to competence development

The absence of a training needs assessment in Mnquma was thought to be a contributing factor leading to poor performance. The existing literature suggests that effective capacity or competence building takes into consideration three distinct phases of implementation, namely, (i) needs assessment, (ii) defining strategies and actions, and (iii) monitoring and evaluation.

The following diagram suggests a methodology for determining competency gaps of staff members, but does require that job descriptions are in place:

Fig 3. The dynamic process of determining competence gaps and training needs



A methodical approach to determining competence gaps and training needs would include all of these elements. The findings of the case study suggest that training and skills development in Mnquma have generally been haphazard, meaning that training courses were made available to individuals without a proper training needs assessment having been carried out.

4.7.5 Management support to competence building programs

The existing literature refers to *the wider layers* as being the immediate management support for capacity-building programs, in particular of the mentoring and supervision of the target group. The monitoring and evaluation of the training provided is to be regarded as crucial, as well as the follow-up of the individuals after the training.

Given the haphazard nature of the training provided to Mnquma staff, it follows that insufficient attention has thus far been given to the monitoring and evaluation of training programs. From the interviews, it appears that there is no or little evidence of any follow-up to implemented training activities, whether it applies to an individual or to a group of individuals.

CHAPTER 5. CONCLUSIONS AND RECOMMENDATIONS

This study has attempted to examine the impact of health-sector decentralisation on HR planning at the local level. More specifically, it has aimed to gain a better understanding of additional tasks and functions, requiring additional skill requirements for HR planners. The research was based on interviews and group discussions with HR planners at local and provincial levels. This concluding chapter draws together the results of the study.

Prior to the study and the subsequent analysis of the data, a clear contextual study boundary was defined. Rather than embarking on a comprehensive interpretation of the social, cultural and motivational aspects of group dynamics and organisational behaviour, this study limited itself to the immediate context surrounding its core concern, i.e. considerations related to performance and competence of HR planners at the local level. The findings from this study, including the conclusions drawn and the various frameworks and models developed, will therefore have to be regarded as having particular significance within the boundaries of this specific context.

The development of this study is centered on the health office in the Mnquma Local Service Area of the Eastern Cape. The rationale for the choice of this locality was given in Chapter 3. Among the LSAs in the Amatola district in the Eastern Cape, the Mnquma Health Office must be regarded as a special case, considering the fact that it benefits from relatively intensive donor support for management development. In addition, the provincial HR planning unit of the Eastern Cape receives technical support, through the Office of the Premier, from the Swedish aid agency SIPU (Swedish Institute for Public Administration). This sets the Eastern Cape apart from other provinces. For these reasons, the observations made and conclusions drawn from this study have particular relevance to Mnquma. However, the applicability of the analytical framework and models developed will have significance beyond Mnquma, in particular to rural health managers having to deal with the implications of decentralisation.

Based on the findings from the study, a model was presented indicating the distribution of HR planning functions between national, provincial and local levels, including roles and required competencies. The findings from the study confirm a significant shift in responsibility from national and provincial levels to the local levels as a consequence of decentralisation of responsibilities, resulting in additional and significant skill requirements. This finding confirms the viewpoint of Kolehmainen-Aitken, who states that the re-allocation of roles and responsibilities always affects the health workforce and the way health is managed (Kolehmainen-Aitken, 2004).

Untrained managers are ill-equipped to cope with the added complexity that decentralisation brings to their work situations. This study has shown that managers, including HR planners, are, first of all, affected by a number of general constraints related to working conditions and resource restrictions, as identified by Kolehmainen-Aitken (2004) and many other authors. Secondly, HR planners in Mnquma are affected by factors related to the absence of a systematic and holistic approach to training and competence building. The training for managers that does take place is of a hit-and-miss nature and not based on a comprehensive and periodic training needs assessment, which is deemed crucial in a situation of changing responsibilities within the context of decentralisation. Competency assessment can determine the efficacy of training interventions in closing knowledge and skill gaps and in assessing and improving training (Kak et al., 2001). A model for a systematic approach to the identification of competence gaps and training needs has been proposed in the section of this study where its findings are discussed.

The study has examined the current training program for managers in Mnquma and compared it, in detail, against a framework of *components of competence* derived from the existing literature. It was found that, by and large, training in Mnquma has thus far concentrated on knowledge and technical skills, while omitting to address certain personal traits such as self-confidence, dealing with authority, time-, conflict- and stress-management, as well as the ability to organise and chair meetings. These competencies were seen by the interviewees as crucial for their proper functioning within a team in a relatively small office in a rural setting.

It was found that the competence to undertake *strategic planning* was virtually non-existent among the HR managers interviewed. At the time of this study, the provincial health office was in the process of putting measures in place to compensate for this shortcoming. It could be argued that national- and provincial-level staff are historically more used to planning exercises, whereas at the sub-provincial level, these skills were, until recently, neither required nor nurtured; planning was traditionally done top-down and local-level staff was mainly concerned with the implementation of decisions taken elsewhere. With the trend towards decentralisation, this is now changing. This process also creates problems to do with capacity and competence, such as those encountered in Mnquma.

In order to contribute to improving the performance of local HR health managers, the following recommendations are made, some of which may have a bearing on policies and strategies of the health department and supporting agencies:

a. It is crucial, at the local level, that a systematic approach to determining competence gaps and training needs is adopted and implemented. At present, training needs assessments in Mnquma are carried out rather superficially. A proper assessment would include the systematic analysis of knowledge, skills and attitudes as well the assessment of the degree of competence that job-holders have to meet those requirements.

b. As well as addressing managerial and technical skills, training at the local level must give adequate attention to the development of personal and inter-human traits, such as self-confidence, dealing with authority, time-, conflict- and stress-management, as well as the ability to organise and chair meetings.

c. Competence-building efforts have the potential to empower individuals and ensure greater levels of performance and job satisfaction. Feedback from individuals contributing to this study highlights a number of shortcomings; in particular, the need for a more systemic approach to training and skills development *with adequate buy-in from senior management*. It is recommended, therefore, that every effort is made to involve senior

management in all aspects of competence-building programs, including the design and implementation of the programs as well as the mentoring, supervision and follow-up of the target group. Clear lines of authority with mechanisms of accountability are crucial and applicable to all management functions.

d. In order for competence-building programs to be successful, it is imperative that a strong commitment is demonstrated by the partner organisation, not only at the level of the individuals targeted but also towards the 'surrounding layers' of the core group, meaning managerial and financial support systems for competence-building programs. It is equally important that external funding, advisory input, and so forth are used only as complementary to local resources, while the competence-building process is driven primarily by local managers and not by a donor agency. The donor agency still has an important role to play in providing information, support and facilitation.

e. Although the Mnquma LSA is fortunate, compared to most other LSAs in Eastern Cape Province, in that external assistance is available toward implementing competence-building programs, there is ample scope for improvement both on the part of the recipient and of the donor agency. Given the findings from this study, the donor agency clearly has the opportunity to facilitate a process of systematic training needs assessment at Mnquma and to introduce aspects of competence building that have thus far not been addressed.

f. Competence- or capacity building is a long-term process and therefore the long-term impact of any relatively short-term assistance program may prove disappointing. Development agencies, especially those concerned with competence building of health managers, need to adopt a critical look at the methods that have thus far been used to bring about improved and sustainable competence. A number of agencies have undertaken a process of self-assessment, for example, GTZ, DFID and CIDA. These agencies

have developed policies and strategies to give competence building a greater role and a new direction (refer, for instance, to GTZ, 1999).

Finally, it is suggested that further research in this area is undertaken, as follows:

a. Similar studies can be conducted in other LSAs in the Eastern Cape, or beyond. It will be interesting to conduct studies in 'successful' and 'less successful' LSAs, in terms of HR planning (e.g. in the opinion of the provincial office), so as to bring out a contrast of experiences, on which broader and more tested conclusions and recommendations can be based.

b. This study has limited itself primarily to the present situation in one LSA in the province. A greater awareness of those affected, and the ongoing discussion about the changing role of development agencies, justifies a *longitudinal study in time* of a representative sample of LSAs. A description of historical trends and the analysis of responsibilities, competence and performance may yield further insight into the problem area. Lessons may be learned from successful and less successful approaches and experiences, the discussion of which will be beneficial to all stakeholders.

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ANNEXURES

Annexure 1. Framework of HR planning functions

HR Function/Task	Description
a. Describe the health workforce supply	Profile the present supply of staff according to number, age, competency, training needs, race, gender, disability, occupational category, organisational component and grade; Future supply: Likely changes in resources; losses to the organisation (e.g. retirement, impact of HIV/AIDS, etc.), improvements in staff performance, programmes for staff development and external environmental factors
b. Describe the health workforce distribution	Geographic and institutional distribution. The relevant issues are: (i) shortages of skilled personnel in rural areas, and associated with this (ii) inappropriate concentration in urban health facilities, which leads to shortages elsewhere.
c. Forecast health workforce requirements	Forecast demand, linked to implementing the strategic, operational or business plan. There are various methods for assessing demand, based on (i) likely future health service utilisation, (ii) health needs, i.e. demographic and epidemiological projections, (iii) personnel to population ratios, and (iv) setting of specific service targets and then estimating personnel requirements to accomplish these.
d. Set job requirements	Determine the required knowledge, skills and abilities to carry out individual jobs.
e. Compose job descriptions	Determine in detail the work to be done by each cadre of health personnel.
f. Describe staffing patterns and standards	Describe the current staffing densities or patterns; then adjust these patterns up or down depending on informed opinion about emerging health needs, potential measures to improve staff productivity, likely budget realities, evolving technology, and other considerations. Standards ultimately depend on past experience, good judgment and societal values, as well as political, financial, administrative and other realities.
g. Design supervisory structure	Supervision aims to facilitate the work of individual employees or employee teams, so they can effectively perform their job responsibilities. Sub-tasks: • Describe all supervisory roles; • Ensure that all supervisors and employees are aware of systems put in place and associated procedures; • Clearly define performance objectives with desired results and outcomes; • Train supervisors; • Provide adequate time and resources for supervisors and supervisees to meet and work together.

Annexure 2. Responsibilities for HR planning before and after decentralisation

HR Function/ Task	Decentralisation	National level	Provincial level	Local level
a. Describe the health workforce supply	BEFORE	Determines the national workforce supply without significant input from the provinces	Responsible for giving input to the national level; the concept of regions was an intermediate stage towards decentralisation	Not responsible
	AFTER	Monitors and interprets statistics on current and future workforce supply informing national policies and guidelines	Renders support to the local level, as much as needed (capacity-related); Provide feedback to the national level	Fully responsible for describing the present and future anticipated workforce supply
b. Describe the health workforce distribution	BEFORE	Determines the national workforce distribution without significant input from the provinces	Responsible, without significant support from the local level	Collects and maintains this information for its own internal use; data not entered into a computerised system
	AFTER	Monitors and interprets statistics on current and future workforce distribution informing national policies and guidelines	Monitoring role; as 'custodians' of organisational structures receives all information from the local level; Work-study officers carry out inspections and verifications at the local level; recommendations made according to findings; supports the local level as much as needed	Responsible for collecting and maintaining this information (linked to PERSAL system)
c. Forecast health workforce requirements	BEFORE	Determines the national workforce requirements without significant input from the provinces	Responsible, without significant support from the local level	Not responsible
	AFTER	National policy and guidelines inform provinces on country-wide programs; Monitors and interprets statistics on future workforce requirements informing national policies and guidelines; National HR and equity plans give direction to provinces	Responsible, in close collaboration with the local level; Renders assistance to the local level in preparing a generic HR StratPlan as the basis for future HR requirements; local level is presented with a generic template for a StratPlan, which can be tailored to the LSA; Province-wide programs are common to all LSAs (e.g. ARV roll-out); province requires input from local level managers; Provides feedback to national level	Responsible for preparing a localised HR StratPlan, from which the required workforce can be determined; Interactive process: inform provincial level of locality specific issues; which can lead to adaptation of the 'generic' provincial HR plan
d. Set job requirements	BEFORE	Issues generic job categories, requirements and salary scales	Dependent on guidelines from national level	Not responsible
	AFTER	National policy and guidelines inform provinces on broader objectives and functions at provincial and local levels	Responsible, in close collaboration with the local level; Typically takes a broader view; re-evaluates objectives of the jobs, as the basis for tasks to be performed; Task list is basis for required competencies for the jobs	Provides provincial level with list of tasks pertaining to existing jobs; does not have competence to fill in the requirements for each job; Interactive process with province

Annexure 2 (Cont'd)

HR Function/ Task	Decentralisation	National level	Provincial level	Local level
e. Compose job descriptions	BEFORE	Prescribes job descriptions to provinces (occupational classes)	Develops job descriptions, largely based on generic templates issued by national level (through DPSA); job description typically consists of job content, i.e. list of tasks	Not responsible
	AFTER	In an attempt to streamline, gives some guidance to the provinces by making job description templates available as the basis for customised job profiles	Job analysts and work-study officers develop comprehensive job profiles for all cadres, stipulating required knowledge and competencies; national templates continue to be used as starting point for profiles; Advertising of LSA posts in local newspaper	Not responsible; uses job profiles, developed at provincial level, as the basis for recruitment procedures; Can request to deviate from recommended quantity of particular cadres depending on local circumstances; Can request to compromise on job requirements for a given job, depending on the local labour market
f. Describe staffing patterns and standards	BEFORE	Determines staffing patterns and standards without significant input from the provinces	Not responsible; depending on guidelines from national level	Not responsible
	AFTER	Monitors and interprets statistics on current and future staffing patterns informing national policies and guidelines related to HR-related standards	Responsible for describing HR patterns and setting norms and standards in close collaboration with the local level; Findings inform the generic StratPlan for the LSAs; Informs national level	Collaborates, to some extent, with the provincial level by informing them about HR distribution and emerging patterns
g. Design supervisory structure	BEFORE	No significant role to play; mentoring and supervision not regarded as a priority	No significant role to play; supervision and mentoring functions marginalised	Not responsible
	AFTER	Provides national guidelines on supervision and mentoring to provinces	Renders support to the local level, as much as needed; assists by organising and supervision of 'general' training courses for local managers	Fully responsible (the LSA office manager)

Annexure 3. Training Plan Mnquma LSA, 2004-2006

(Source: Lux-Development, 2003)

Planning and Management of Human Resources: o Day-to-day Human Resource Management (5 Days) o Human Resource Planning (5 Days) o Staff Motivation (5 Days) o Labor Relations (5 Days) o Dispute Resolution (5 Days) o Disciplinary and Incapacity procedures (5 Days) o Management of Staff Training and Development (5 Days)	LSA Office Manager (1); In-Charge of HR Dept. at LSA Office (1); CHC Middle Manager (1);CHC Administrator (1) **Total: 4**
Financial Management: o Budget Planning (5 Days) o Budget control/monitoring (5 Days) o Disbursement Procedures (5 Days) o Accounting of financial resources (5 Days)	LSA Office Manager (1); Finance Controller LSA Office (1); CHC Administrator (1) **Total: 3**
Health Information Management: o Data Collection/Organisation/Storage (2 Days) o Record Keeping, Management of Information, and Reporting (3 Days) o Use of data for Decision Making (1 Day)	LSA Health Information Manager(1); CHC Middle Managers (2) **Total: 3**
Waste Management o Refuse Collection (1 Day) o Medical Waste Collection and Handling (1 Day) o Waste Disposal (1/2 Day) o Waste Transportation (1/2 Day)	LSA Environment Health Officer (1); CHC Foreman (1); CHC Nurses (4); Clinic in-Charges (25) **Total: 31**
Organisation Development o Policy Formulation (3 Days) o Monitoring and Evaluation of Policy and Strategy (3 Days) o Organisation Development Planning (3 Days) o Management of Change (3 Days) o Organisation Re-engineering (3 Days)	LSA Office Manager (1) LSA Office Team Members (4); CHC Middle Managers (2); CHC Administrator (1) **Total: 8**
Provisioning and Stock Control: o Effective Provisioning Administration and Process (10 Days) o Transport/Fleet Management (3 Days) o Effective Store and Stock Management (3 Days)	LSA Financial Controller (1); LSA Office Store Manager/Keeper (1); LSA Office Transport Managers (1); CHC Administrator (1); CHC Dispenser (1); CHC Store Keeper (1) **Total: 6**
Leadership and Management Development o Leadership Management and Development (3 Days) o Supervision Management (3 Days) o Strategic Management (3 Days) o Project Management (3 Days) o Negotiation in the Health Sector (3 Days) o Teambuilding (3 Days)	LSA Office Manager (1); CHC In-Charge (1); CHC Administrator (1) **Total: 3**
Communication Management: o Effective Communication Development (3 Days) o Reporting System Development (1 Day) o Lobbying and Advocacy (3 Days)	LSA Office Manager (1); CHC Administrator (1); CHC In-Charge (1) **Total: 3**
Computer Skills Development o Introduction to Computer Software/Programs (5 Days) o Internet and E-Mail (1 Day)	LSA Office Manager (1); LSA Financial Controller (1); CHC Middle Manager (2); CHC Administrator (1) **Total: 5**
Customer Care Management o Patient Administration (2 Days) o Service Delivery Improvement (2 Days) o Quality Assurance Management (3 Days)	CHC Middle Managers (2); Clinic In-Charges (25) **Total: 27**
Human Resource Development o Training Management and Development (5 Days) o Evaluation of Human Resource Development (3 Days) o Moderator Training (2 Days)	LSA Office Training Coordinator (1); CHC Administrator (1); CHC Middle Manager (1). **Total: 3**