District Clinical Specialist Teams in South Africa

Ministerial Task Team Report to the Honourable Minister of Health, Dr Aaron Motsoaledi
# TABLE OF CONTENTS

EXECUTIVE SUMMARY ........................................................................................................ 1

1. INTRODUCTION ........................................................................................................... 1

2. THE DISTRICT CLINICAL SPECIALIST TEAMS ......................................................... 1
   2.1. COMPOSITION .......................................................................................................... 1
   2.2. ROLES ...................................................................................................................... 1
   2.3. IDEAL MODEL FOR DISTRICT SPECIALIST TEAMS ........................................... 3
   2.4. REPORTING LINES ................................................................................................. 4
   2.5. LOCATION ............................................................................................................... 4
   2.6. PROVINCIAL SPECIALISTS .................................................................................... 5
   2.7. MINIMUM TEAM COMPOSITION ........................................................................... 5
   2.8. ALTERNATIVE MODELS .......................................................................................... 7

3. APPOINTMENT OF STAFF ............................................................................................ 8

4. COSTS ............................................................................................................................ 8

5. INDUCTION AND ORIENTATION .................................................................................. 9
   5.1. CHARACTERISTICS OF PARTICIPANTS ................................................................. 9
   5.2. NUMBER OF PARTICIPANTS .................................................................................... 10
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.8</td>
<td>HUMAN RESOURCES FOR HEALTH IN RURAL AREAS</td>
<td>40</td>
</tr>
<tr>
<td>11.9</td>
<td>RISKS AND CHALLENGES</td>
<td>41</td>
</tr>
<tr>
<td>11.10</td>
<td>THE WAY FORWARD</td>
<td>41</td>
</tr>
<tr>
<td>12</td>
<td>ANNEXURES</td>
<td>43</td>
</tr>
<tr>
<td>12.1</td>
<td>TERMS OF REFERENCE FOR A MINISTERIAL TASK TEAM TO ADVISE ON ‘DISTRICT SPECIALIST TEAMS’</td>
<td>43</td>
</tr>
<tr>
<td>12.2</td>
<td>MTT MEMBERS, SECRETARIAT AND ADVISORS</td>
<td>46</td>
</tr>
<tr>
<td>12.3</td>
<td>STAKEHOLDER CONSULTATIONS</td>
<td>47</td>
</tr>
<tr>
<td>12.4</td>
<td>PROVINCIAL CONSULTATIONS</td>
<td>59</td>
</tr>
<tr>
<td>12.5</td>
<td>PRESENTATION TO THE NATIONAL HEALTH COUNCIL (4 AUGUST AND 2 DECEMBER 2011)</td>
<td>71</td>
</tr>
<tr>
<td>12.6</td>
<td>DISTRICT CLINICAL SPECIALIST TEAM COSTING MODEL</td>
<td>77</td>
</tr>
<tr>
<td>12.7</td>
<td>ATTRACTION AND RETENTION DISCUSSION PAPER</td>
<td>79</td>
</tr>
<tr>
<td>12.8</td>
<td>DCST JOB DESCRIPTIONS – GENERIC AND SPECIFIC ROLES</td>
<td>85</td>
</tr>
<tr>
<td>12.9</td>
<td>DCST SELECTION PROCESS GUIDELINES</td>
<td>106</td>
</tr>
<tr>
<td>12.10</td>
<td>DCS INDUCTION AND ORIENTATION GUIDELINES</td>
<td>109</td>
</tr>
<tr>
<td>ACRONYMS</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>--------------------------</td>
<td>--------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>AHA</td>
<td>Area Health Authority</td>
<td></td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
<td></td>
</tr>
<tr>
<td>BANC</td>
<td>Basic Antenatal Care</td>
<td></td>
</tr>
<tr>
<td>BIC</td>
<td>Basic Intrapartum Care</td>
<td></td>
</tr>
<tr>
<td>CARMMA</td>
<td>Campaign on Accelerated Reduction of Maternal Mortality in Africa</td>
<td></td>
</tr>
<tr>
<td>CEOs</td>
<td>Chief Executive Officers</td>
<td></td>
</tr>
<tr>
<td>CFO</td>
<td>Chief Financial Officers</td>
<td></td>
</tr>
<tr>
<td>COPC</td>
<td>Community Oriented Primary Care</td>
<td></td>
</tr>
<tr>
<td>DCSTs</td>
<td>District Clinical Specialist Teams</td>
<td></td>
</tr>
<tr>
<td>DMT</td>
<td>District Management Team</td>
<td></td>
</tr>
<tr>
<td>DFID</td>
<td>Department for International Development (UK)</td>
<td></td>
</tr>
<tr>
<td>DHA</td>
<td>District Health Authority</td>
<td></td>
</tr>
<tr>
<td>DHIS</td>
<td>District Health Information Systems</td>
<td></td>
</tr>
<tr>
<td>EPOC</td>
<td>Essential Post Natal Care</td>
<td></td>
</tr>
<tr>
<td>ESMOE</td>
<td>Essential Steps in Managing Obstetric Emergencies</td>
<td></td>
</tr>
<tr>
<td>GPs</td>
<td>General Practitioners</td>
<td></td>
</tr>
<tr>
<td>HODs</td>
<td>Heads of Departments</td>
<td></td>
</tr>
<tr>
<td>HR</td>
<td>Human Resources</td>
<td></td>
</tr>
<tr>
<td>IMCI</td>
<td>Integrated Management of Childhood Illnesses</td>
<td></td>
</tr>
<tr>
<td>KPAs</td>
<td>Key Performance Areas</td>
<td></td>
</tr>
<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
<td></td>
</tr>
<tr>
<td>MECs</td>
<td>Members of Executive Committee</td>
<td></td>
</tr>
<tr>
<td>MNCWH</td>
<td>Maternal, Neonatal, Child and Women's Health</td>
<td></td>
</tr>
<tr>
<td>MTEF</td>
<td>Medium-term expenditure framework</td>
<td></td>
</tr>
<tr>
<td>MTT</td>
<td>Ministerial Task Team</td>
<td></td>
</tr>
<tr>
<td>NDOH</td>
<td>National Department of Health</td>
<td></td>
</tr>
<tr>
<td>NHC</td>
<td>National Health Council</td>
<td></td>
</tr>
<tr>
<td>NHI</td>
<td>National Health Insurance</td>
<td></td>
</tr>
<tr>
<td>NSDA</td>
<td>Negotiated Service Delivery Agreement for Health</td>
<td></td>
</tr>
<tr>
<td>OHSC</td>
<td>Office of Health Standards Compliance</td>
<td></td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
<td></td>
</tr>
<tr>
<td>RWOPS</td>
<td>Remuneration Work Outside the Public Service</td>
<td></td>
</tr>
<tr>
<td>SACOMD</td>
<td>South African Committee of Medical Deans</td>
<td></td>
</tr>
</tbody>
</table>
Executive Summary
South Africa is failing in its efforts to reach the Millennium Development Goals (MDGs) for maternal health and child mortality. As a result, the National Minister of Health has set targets for strengthening health system effectiveness in the Negotiated Service Delivery Agreement for Health. As part of the government’s plans to fortify the health system, the Minister has outlined a Primary Health Care (PHC) approach, with three streams, namely:

- District based Clinical Specialist Teams (DCSTs) for the support of priority health programmes;
- School based Primary Health Care services; and
- Municipal ward based Primary Health Care Agents.

The purpose of the District Clinical Specialist Teams is to improve both the quality of health care and health outcomes for mothers, newborns and children—i.e. the core component of strengthening the district health system. DCST members are to function first as a team, and second as individuals within their respective disciplines.

Ministerial Task Teams were established to work with the National Department of Health to assist in establishing the three PHC initiatives. This report has been prepared by all members of the Ministerial Task Team (MTT) on District Clinical Specialist Teams. It provides a synopsis on progress against the original terms of reference and a series of recommendations to help guide the National and Provincial Departments of Health in their implementation of the Primary Health Care Re-engineering process and the DCSTs.

The MTT on DCSTs comprises experts in the following clinical disciplines: Obstetrics and Gynaecology, Paediatrics, Nursing, Family Medicine, Public Health as well as the Chairperson of the South African Committee of Medical Deans (SACOMD). The MTT was assisted in its functions by a number of experts (see Annexure 12.2).

The Terms of Reference (TORs) for the Task Team were set by the Minister, and are provided in Annexure 12.1. Extensive consultative meetings were held with experts in the field and relevant stakeholders to get input regarding the work of the MTT.

Consultative visits or workshops were also undertaken by members of the MTT in individual provinces to meet with MECs, heads of departments (HODs), District Managers, CFOs, CEOs of hospitals, heads of the relevant academic departments of universities, senior clinicians and other staff to obtain input regarding the role, function and composition of the DCSTs.
Following agreement on job descriptions for members of the DCSTs, advertisements were placed by NDOH in national newspapers, appropriate websites and widely-read international medical journals. The framework for short-listing and the interview process was presented at the National Health Council on 2 December 2011. This process was led by the National Department of Health with assistance from the MTT as required.

**MTT Recommendations**

Ten recommendations are made by the MTT to the Minister of Health.

1. **Composition**

   1.1. A DCST should be located in each district of South Africa and consist of a family physician, a primary health care nurse, an obstetrician and gynaecologist, an advanced midwife, a paediatrician and a paediatric nurse. An anaesthetist should be included in a role that is expanded to oversee emergency medical and peri-operative care.

   1.2. Given that a full team will not be possible in all districts in the short term, a minimum team would be necessary, consisting of one of two options:

      - A nurse-doctor dyad from a single discipline (i.e. family physician and PHC nurse; OR obstetrician and gynaecologist, and advanced midwife; OR paediatrician and paediatric nurse). The presence of any dyad constitutes a minimal team but a team must have both a doctor and a nurse from the same discipline. This option is preferred and feasible when both the nurse and doctor in a single discipline can be appointed within a district.

      - A family physician and PHC nurse, plus advanced midwife or paediatric nurse on site in the district, and an obstetrician or paediatrician providing support from a DCST in an adjacent district. When a district has the option to appoint a midwife or paediatric nurse without an obstetrician or paediatrician this is only considered feasible where medical support for the nurse is available both from a family practitioner within the district and an obstetrician or paediatrician respectively from outside the district.

   1.3. If a minimum DCST team is in place, then vacant positions can be filled through sessional appointments until such time as full-time staff can be contracted. If a minimum team is not in place, then session work should not be allowed, given the poor past record in the country of hiring specialists on these terms.
1.4. Specialist family physicians should be appointed at all community health centres and district hospitals as the most senior clinician. The family physician in the District Clinical Specialist Team is appointed at a higher head-of-unit level, with a greater responsibility for issues of clinical governance and capacity building, and a primary focus on maternal and child health care.

2. Roles

2.1. In each district the DCST will be responsible for the following areas of work, which will form the basis of annual performance assessments: quality of clinical services; clinical training; monitoring, evaluation and improving clinical services; supporting district level organisational activities; supporting health systems and logistics; collaboration, communication and reporting; and teaching and research activities.

2.2. The authority of persons occupying DCST posts will arise partially from the posts themselves but more so from their individual credibility based on their knowledge and experience. It is therefore important to recognise the value of appointing senior members of the profession to these posts.

3. Reporting Lines

Given the diverse arrangements in each province, the exact reporting arrangements and lines of accountability will be defined province by province, but in principle the MTT recommends that the DCST should report both to:

▶ The district: for ensuring their work is included in district planning and budgeting processes; that national standards are being adhered to; and that service or facility-specific improvement plans are agreed and acted on as problems or constraints are identified; and
▶ The province: for ensuring discipline-specific standards are defined and adhered to; and to ensure equity across the province.

All provinces should consider creating posts for, and appointing, discipline-specific provincial specialists. However the MTT recognises that if there are insufficient specialists, then preference may be given to filling positions in districts rather than to the new provincial specialist positions.

4. Location

Provinces have different views on how they want to locate the teams—ranging from co-location with district management, to location of specialists in regional hospitals. Some provinces prefer an independent site for the whole team. This variation is acceptable but
it is crucial that the DCST works as a team, and is encouraged to do so with face-to-face meetings at least once a month, and progress reports prepared jointly.

5. Training / Resource Centres

Each district should have a training/resource centre available and fully equipped for the DCST to carry out required training activities. Resources should be provided by the National Department of Health under its infrastructure budget.

6. Salary and Benefits

The salary and benefits for the DCST team members should be compatible with that of heads of clinical unit and with the nursing management cadre in order to attract experienced health professionals in South Africa.

7. Financing Arrangements

The MTT strongly recommends that the government establish a conditional grant to cover maternal and child services that includes a line item covering DCSTs, to ensure sustained public sector funding and to allow monitoring of expenditure during the MTEF period and beyond.

8. Human Resources for Health in Rural Areas

The National Department of Health should revisit existing human resource policies to improve rural retention and consider the options for improving coverage of specialists in rural areas. This could include a requirement for community service for specialist registration, rotation as part of registrar training and periods of specialist deployment in regional hospitals in underserved areas.

9. Risks and Challenges

Ongoing recruitment for DCST members must be allocated to a specific unit or persons in each Provincial Department of Health.

An evaluation of success and lessons learnt must be done regularly and a draft plan for this be prepared by the personnel or unit mentioned above.

Finally it is suggested that community service for specialists be considered in order to strengthen clinical services in regional hospitals, to facilitate clinical outreach programmes and to cover any clinical shortfalls in the event of a migration of senior clinicians from hospital service to the DCSTs.
10. Recommendations on the way forward

10.1. Performance agreements: A performance agreement should be signed between the province/designated official and the members of the DCSTs. A baseline assessment, as well as quarterly performance assessments, should be carried out according to standardised national guidelines.

10.2. Induction and orientation: An intensive one-year induction and orientation programme should be undertaken by the newly selected DCSTs. This should be centrally managed for the first wave of appointments to ensure consistent implementation of the initial teams, alignment with their intended purpose, equity, initial monitoring of progress and cross-provincial learning. The Provincial Departments of Health should then be responsible for taking this forward and continuing with induction and orientation of new staff.

10.3. Monitoring and evaluation: Monitoring of progress will rely on data regarding appointments, feedback from the orientation programme and a quarterly report from each DCST using a predefined template developed by the MTT. Evaluation of the effectiveness of the DCST in the medium term will depend on reporting against a set of routinely collected indicators related to their activities and derived mainly from the District Health Information Systems (DHIS). These indicators have been defined by the MTT along with another set of indicators for the longer-term contribution of the DCST to maternal and child health. A baseline and annual evaluation of progress should be commissioned by National and Provincial Departments of Health to complement the national surveys and routine DHIS.

10.4. National oversight: A national oversight committee should monitor and advise on the DCST work for at least a two-year period. This committee should be chaired by the Director-General or a designated Deputy Director-General and be responsible for reporting to the National Health Council on progress in setting up the DCSTs and on their effectiveness within their allocated districts.

10.5. Future replacement/recruitment: The National Department of Health should be responsible for recruitment and selection of members of the DCSTs to ensure equity in responses across provinces. Once the initial round of selections has been completed, the responsibility for further recruitment and replacement of staff will revert to the Provincial Departments of Health.
District Clinical Specialist Teams in South Africa
Ministerial Task Team Report
1. Introduction

The Minister of Health has set up this Ministerial Task Team (MTT) on District Clinical Specialist Teams (DCSTs) to guide him on the composition, structure and functions of the district teams. The MTT comprises a multidisciplinary team of experts in the disciplines of Obstetrics and Gynaecology, Paediatrics, Nursing, Family Medicine and Public Health. Its work is linked with other national health initiatives such as the Human Resources for Health Strategy.

2. The District Clinical Specialist Teams

The aim of the District Clinical Specialist Teams is to strengthen the South African district health system in order to improve the quality of health care for mothers, newborns and children, reduce mortality and improve health outcomes in these groups.

2.1. Composition

To achieve the above objective a multidisciplinary team comprising the following seven highly experienced members is proposed:

- Family physician;
- Primary health care nurse;
- Anaesthetist in an expanded role;
- Obstetrician and Gynaecologist;
- Advanced midwife;
- Paediatrician; and
- Paediatric nurse.

The family physician is a new cadre of specialist trained specifically to work in the district health system as a generalist in primary care and the district hospital.

2.2. Roles

Although individuals in the team have a primary responsibility regarding their discipline they will also act collectively. It is anticipated that improved clinical governance will result in improved systems and better quality care across all disciplines and not merely those catering for mothers, newborns and children.
The focus of the DCSTs activities must be on facilitation, integration and coordination of staff, services, programmes and packages of care as well as surveillance, monitoring and evaluation. The actual implementation of these activities remains the responsibility of the relevant management, staff or structures in each facility. The primary role of the district clinical specialist is thus supportive supervision and clinical governance and not the direct delivery of clinical services. However, participation in clinical care is essential in order that DCST members maintain their clinical competence, remain cognisant of the context in which services are delivered and retain their individual credibility and authority in the field.

In undertaking these tasks each member of the DCST has four target audiences with whom they need to engage:

a) The primary audience for the DCST is aligned to individual specialities. The family physician and primary health care nurse in the DCST should target the non-hospital district level services in community health centres (CHC), primary health care (PHC) clinics and PHC ward based outreach teams. The anaesthetist, obstetrician and gynaecologist, advanced midwife, paediatrician and paediatric nurse should engage with the family physicians, medical officers and nurse specialists in their respective disciplines at the district hospitals to achieve the following:

- Anaesthetist: improve peri-operative care and emergency services for adults, pregnant women, newborns and children;
- Obstetrician and Gynaecologist, and advanced midwife: enhance the quality of maternity services; and
- Paediatrician and paediatric nurse: improve neonatal, paediatric and child health services.

b) A secondary audience for the domain specialists is to support the DCST family physician and primary health care nurse in addressing the needs of their disciplines in non-hospital and community based services. For the family physician and primary health care nurse a secondary audience will be their colleagues in the district hospitals.

c) DCST members must also engage with facility based specialists in their discipline in order to develop a partnership to strengthen specialist services in their discipline and clinical support to the referring institution and the catchment population.

d) The fourth audience is the district office management and programme teams regarding surveillance, monitoring and evaluation, improving administrative and logistical support and the mobilisation of resources for any subsequent intervention.
2.3. Ideal model for district specialist teams

The ideal model for the DCST assumes that the following facility based services are functional:

- A family physician is present in each district hospital and community health centre (CHC) with responsibility for all clinical services in the facility and coordination of outreach programmes to support PHC clinics in their respective catchment areas;
- Paediatricians, obstetricians and gynaecologists and anaesthetists are present in all regional and tertiary hospitals where they provide inpatient, outpatient and outreach services relevant to their discipline; and
- An active outreach programme exists in each discipline for the support of clinical services in all facilities throughout the catchment area of their institution. The focus of this outreach programme should be clinical care and supportive supervision around individual patient care.

The components of a multifaceted outreach programme will have to be shared between DCST and facility based specialists. Clinical care must remain the primary focus of facility based specialist outreach activities. Clinical governance will be the domain of the DCST.

Supportive supervision and mentorship by the DCST must be shared with the facility based specialists and must focus on informal teaching and mentoring around individual patients and formal teaching and mentorship around systems and programmes.

One DCST is required for each geographic area. There are three options for defining these geographic areas:

a) The health district, which is an administrative unit with a defined geographic area. There is little uniformity between districts in terms of geographic size, population number and the number and range of health facilities. All districts have PHC clinics and district hospitals but only some have community health centres and regional hospitals and even fewer have tertiary hospitals.

b) The catchment area of a regional hospital, which is aligned to the referral pathway for clinical care.

c) On the basis of population, with one team allocated for every 1, 2 million people.
The local context in each province should determine the most appropriate basis for determining the number of teams required as well as the most appropriate alignment of teams i.e. with a district office or regional hospital.

Regardless of how one defines the geographic area of each DCST, the roles and responsibilities will be similar with regular on-site support to hospitals, CHCs and PHC clinics. The frequency of visits must be defined in the annual performance agreement of each member of the team.

2.4. Reporting lines

The line function and reporting structure needs to consider both the individual specialist as well as the team and should cater for both clinical and administrative functions. It is therefore suggested that the DCST should have a clinical reporting line to the provincial specialist and administrative reporting line and accountability to the district manager.

The provincial specialist is responsible for service delivery related to their discipline at both the facility and community level in order to:

- Address issues around equity within the province;
- Provide mentorship, support and ongoing development of “weaker” district specialists; and
- Manage alternative or interim models in areas where it is not possible to appoint a DCST.

Some provinces are currently in the process of advertising or appointing provincial specialists in three disciplines, namely Paediatrics, Obstetrics and Gynaecology and Family Medicine.

2.5. Location

The team should be based in one location in order to enhance its functioning. This location needs to recognise the local context and should adopt the most appropriate of three possibilities for each team:

- A district or regional hospital;
- The district office; or
- An independent site such as a training or resource centre.

The choice of option needs to consider the need for DCST members to maintain their clinical relevance and acumen, which are critical to the credibility of the individual
specialist and his/her authority, and to avoid the risk of isolation from the clinical context and their peers. Furthermore, all options pose a challenge in ensuring that the district clinical specialists retain their primary function and are not absorbed into the functions of the institution in which they are accommodated.

2.6. Provincial specialists

A provincial specialist is required for each of the major clinical disciplines. Their role is to represent clinical services in the senior management structure of each province; to promote equity in the distribution of resources and access to services related to their discipline; and to oversee the delivery of an appropriate standard of care in their discipline throughout the province.

The roles and responsibilities of the provincial specialists also include oversight of his/her discipline throughout the province to ensure:

› An appropriate continuum of care throughout the health service from the home to the central hospital;
› Equity in the distribution of services and resources;
› Integration of primary health care and hospital services;
› Effective and appropriate access to the required level of care; and
› Uniform systems, norms and standards at all levels and facilities in the province;

Additional roles include the following:

› Mentorship and support of DCST members and hospital based heads of clinical departments/units;
› Surveillance, monitoring and evaluation of programmes and services related to their discipline in all facilities and districts in the province;
› Collaboration with district managers and provincial programme managers; and
› Representation of the province in national forums related to their discipline.

Provincial specialists will report to an appropriate structure in the relevant Provincial Department of Health.

2.7. Minimum team composition

The primary focus of the DCST is to work closely with the district management team, the ward based PHC teams and the Integrated School Health Programme to improve maternal and child health and to reduce maternal, newborn and child mortality. This means that for maximal impact interventions have to:
Span the full range of promotive, preventive, curative and rehabilitative services;
Encompass all activities from the home, through the PHC clinics to the district hospital;
Facilitate a change in lifestyle and health seeking behaviour in all communities;
Integrate activities occurring at each of the above sites; and
Coordinate the above activities to ensure full and equitable coverage of the population.

Although a complete team will consist of seven members it is unlikely that this ideal will be achieved in many districts. It is therefore necessary to define what constitutes a minimal effective team. Experience in the implementation of programmes embracing both doctors and nurses, such as the Integrated Management of Childhood Illnesses (IMCI), has shown that implementation is enhanced when the nurse and the doctor are trained, mentored and supported as a team rather than individually. In light of this it is suggested that in defining a minimum team the following principles are adopted:

A single member cannot constitute a team;
For all disciplines, except anaesthesiology, a nurse-doctor pair is required;
One doctor could possibly work with and support two nurses;
A family physician & PHC nurse pairing is the minimum requirement to establish a team; and
One anaesthetist can cover more than one district.

The following constitute the options for a minimum effective team:

**Preferred option**: A nurse-doctor dyad from a single discipline i.e.:

- Family physician & PHC nurse; or
- Obstetrician and Gynaecologist, and advanced midwife; or
- Paediatrician & paediatric nurse.

This option is preferred and feasible when both the nurse and doctor in a single discipline can be appointed within the district.

**Alternative option**: A family physician & PHC nurse supported by an advanced midwife or paediatric nurse on site in the district as well as an obstetrician and gynaecologist or paediatrician providing support from a DCST in an adjacent district.

Where a district has the option to appoint a midwife or paediatric nurse without an obstetrician or paediatrician this is only considered feasible where medical support for
the nurse is available from both a family physician within the district and an obstetrician or paediatrician respectively from outside the district.

2.8. Alternative models

The following models for the deployment and functioning of DCSTs are proposed as options for Provincial Departments of Health to consider as interim measures in circumstances where they are unable to recruit teams.

2.8.1. “Consolidated” Model

The consolidated model envisages a single team serving a larger geographic area or multiple teams operating out of a single base to serve adjacent districts. This model requires the following elements:

- The identification of a fully functional clinical site located in a social environment which is more likely to support the recruitment and retention of specialist staff;
- The temporary deployment of the DCST posts for each district to the functional site to facilitate the appointment of team members; and
- The intensity of support throughout the consolidated area being identical to that envisaged to the ideal model.

2.8.2. “Contractual” Model

The contractual model is an interim measure which ensures some services to those districts that have not acquired a DCST, or components of the team, through the ideal or consolidated models.

Simplistically, this model is an agreement between an underserved district and a well-resourced service provider (public sector hospital, academic department or group practice) for the provision of the DCST functions—namely clinical care, clinical governance and the development and supportive supervision of staff—to the district.

The essential components of the agreement are:

- The district provides a funded DCST post to the service provider for the period of the agreement;
- The service provider fills this post in order to supplement their existing specialist staff; and
- Additional staff numbers ensure that the service provider has the capacity to fulfil the function of the DCST.
The delivery of the functions of the DCST are the collective responsibility of the service provider and can be provided either by one person at a time on rotation for a limited period or by a number of people sharing the roles.

3. Appointment of staff

Ideally, appointment to a DCST should be limited to senior nursing and medical specialists in order to ensure their credibility with clinical and administrative staff at all levels in the health system. However the shortage of senior specialists may necessitate the appointment of less experienced specialists, experienced medical officers or the use of contracted staff.

The appointment of staff in either alternative model must support the linking of an individual specialist with a dedicated facility for weekly support to foster a sound relationship, ensure continuity of care and lessen the burden of travel. This can be achieved by:

- Sharing the responsibilities of the DCST member between members of the clinical department so that select members of the department are linked to their own facility; and/or
- The appointment of staff—be they retired clinicians, medical officers, GPs or specialists in private practice—on a sessional basis to fulfil the roles and responsibilities of the DCST with respect to a single facility. One post could be shared between five sessional staff with each supporting one hospital or a defined number of PHC clinics thereby ensuring reasonable cover throughout the geographic area.

4. Costs

Suggestions on the salary and benefit packages to be provided to members of the DCSTs were informed by discussions at the National Health Committee (NHC) Technical Committee and the NHC. The MTT recommended that these should be competitive with the packages for heads of clinical units and with the nursing management cadre in order to attract highly experienced professionals (See Annexure 12.6).

Additionally the maximum allowable rural allowance based on the basic portion of the remuneration package (70%) is proposed as an incentive for the appointment of these teams to districts. Additionally consideration should be given to commuted overtime which should be optional for the medical specialist members of the DCSTs.
The provinces will be responsible for the salaries, benefits and incentives covering:

- Accommodation;
- Transport;
- Communication needs;
- Joint appointment benefits where applicable; and
- Relocation costs.

The MTT strongly recommend that the government establish a conditional grant to cover maternal and child health services that includes a line item covering DCSTs to ensure sustained public sector funding and to allow monitoring of expenditure during the MTEF period and beyond.

5. Induction and orientation

Induction refers to the initial introduction of the members of the district specialist teams to their new roles and orientation to the longer term capacity and team building required to enable them to fulfil these roles and impact on maternal and child health at the district level.

5.1. Characteristics of participants

The specialist family physician’s initial training is fully orientated towards functioning as a specialist across the whole district platform, however training for the new speciality only began in 2008 and most family physicians currently practicing will have been trained in older less comprehensive programmes. The other medical specialists will have previously been working in regional or tertiary hospitals and will therefore require significant re-orientation to their new roles. The primary care nurses and midwives have been trained for specific tasks within the district health system, but not necessarily for their roles in the district specialist teams in terms of broader functions such as clinical governance.

Team members will come from different professional groups, with different prior learning and experience and different levels of higher education.

All members of the team therefore will require not only induction, but longer term capacity building for their new roles. Time must also be spent in building team work and functioning.
5.2. **Number of participants**

It is assumed that the centralised training will focus on the first wave of appointments to the 12 NHI pilot districts and be expanded to 25 districts prioritised by the NHC on the basis of their high maternal, perinatal and child mortality.

If all teams are complete there will be 70 participants in the initial phase. After the first phase of induction and orientation for the 12 NHI districts, subsequent district teams will be the responsibility of the provinces. It is expected therefore that each province will send two representatives to the initial centralised training programme and representatives from the regional training centres with the specific task of preparing to duplicate the programme in their own provinces. It is also expected that the 10 district managers will attend part of the first induction workshop, bringing the number to 96 participants.

5.3. **Learning outcomes**

The specific focus of the DCST is maternal and child health (MCH) and all learning outcomes should be interpreted in terms of this focus. By the end of the induction and orientation programme team members should be able to:

- Describe their vision and specific goals for the work of the team in their specific district;
- Use a range of methods to improve the quality of clinical care;
- Provide effective education and clinical training to individuals, small and large groups;
- Identify weaknesses and improve the performance of the health system;
- Support the development and implementation of community-based interventions;
- Support district and facility level management activities;
- Function effectively as a team; and
- Evaluate and report on their work.

By the end of their induction, district managers should be able to identify how the DCSTs will fit into their district structures and how they will relate to and engage with each other. By this time provincial representatives will be able to replicate the induction and orientation programme in their own provinces.
5.4. Outline of course content

5.4.1. Vision and goals

- Describe their vision and specific goals for the work of the team in their specific district include:
  - Critical reflection on situational analysis; and
  - Rational planning cycle.

5.4.2. Q I methodology

Use a range of methods to improve the quality of clinical care includes the following skills:

- How to develop, disseminate, implement and evaluate evidence-based clinical guidelines;
- How to facilitate a quality improvement cycle;
- How to conduct a critical event audit (mortality & morbidity review);
- How to conduct a clinical outreach visit; and
- Knowledge of the specific programmes/guidelines relating to MCH (see table below)
Table 1 - Linkages between levels of care and stages of life cycle in MCH

<table>
<thead>
<tr>
<th>District Hospital / Subdistrict</th>
<th>Health Centre / Clinic</th>
<th>Home/Community-based / ward-based team</th>
</tr>
</thead>
<tbody>
<tr>
<td>School health services</td>
<td>Referral level antenatal care</td>
<td>Basic antenatal care (BANC)</td>
</tr>
<tr>
<td>Family planning</td>
<td>Basic Intrapartum Care (BIC)</td>
<td>Neonatal resuscitation</td>
</tr>
<tr>
<td></td>
<td>Basic and comprehensive emergency care (ESMOE)</td>
<td>Basic intrapartum care</td>
</tr>
<tr>
<td></td>
<td>Basic neonatal care</td>
<td>ESMOE</td>
</tr>
<tr>
<td></td>
<td>Kangaroo mother care</td>
<td>Postnatal care (FPOC)</td>
</tr>
<tr>
<td></td>
<td>PMTCT-Plus</td>
<td>PMTCT-Plus</td>
</tr>
<tr>
<td></td>
<td>Hospital IMCI / in-patient care</td>
<td>IMCI and preventative Care (EP, growth monitoring, vitamin A, deworming)</td>
</tr>
<tr>
<td></td>
<td>Integrated school health services</td>
<td>PMTCT Plus and HIV services</td>
</tr>
<tr>
<td></td>
<td>Emergency care ETAT</td>
<td>Chronic care</td>
</tr>
<tr>
<td></td>
<td>IYCF and WHO “10 Steps”</td>
<td>Post rape care</td>
</tr>
</tbody>
</table>

5.4.3. Education and training

Provide effective education and clinical training to individuals, small and large groups include the following skills:

- Designing educational activities;
- Giving presentations;
- Facilitating small group learning/workshops;
- Educational interactions during clinical outreach visits; and
- Stimulating self-directed learning.

5.4.4. Health system performance

Identify weaknesses and improve the performance of the health system includes:

- Understanding the policy framework and functioning of SA district health system;
Understanding the evidence base for effective characteristics of district / primary health care systems;
Understanding the six domains within the National Core Standards for health establishments in terms of MCH and the critical areas for improving patient-centred care;
Understanding the district health information system for MCH; and
Understanding the National Strategic Plan for Maternal, Neonatal, Child and Women’s Health and Nutrition in South Africa.

5.4.5. Support district and facility level management activities

This includes the following:
Understanding results of national audit of facilities and work of facility improvement teams that relate to their own district;
Understanding relevant district management structures and processes for clinical support services, operational management (i.e. human resources, finances, staff welfare, supply chain) and management of facilities; and,
Understanding relevant district’s organisational culture and values.

5.4.6. Support the development and implementation of community-based interventions

This includes the following:
Understanding the other district level interventions in the PHC re-engineering process—ward based primary care teams, school health;
Understanding the concept of community orientated primary care; and
Understanding the evidence base for effective MCH community based interventions e.g. early child development.

5.4.7. 5.4.6 Function effectively as a team

This includes:
Effective team functioning (clear goals, roles, interaction, decision making, conflict management, availability, mutual support, leadership); and
Personal learning and problem solving styles.

5.4.8. Evaluate and report on the work of the team

This includes understanding responsibilities in relation to reporting on the teams activities.
5.5. Learning methods and style

The fundamental learning approach is one of action-reflection. At the workshops, teams will be expected to critically reflect on their district and team activities, learn from their experience and each other, and plan their activities for the period before the next workshop. Workshops will also provide the teams with new knowledge and skills that can be immediately applied in their work. Training will be interdisciplinary and inter-professional to a large extent, with nurses and doctors participating together in their teams.

The values and behaviours that are embedded in the style of training should be congruent with the values and behaviours that the team are expected to demonstrate in the districts and encourage in the district health services; for example collaboration, critical reflection, innovation and creativity, respect.

More didactic aspects of training can be conducted as a large group (80-100 people) but the major part will be in small groups—such as the district teams themselves, practitioners working in primary care, practitioners working in district hospitals etc... During the small group learning we suggest that district teams be twinned with a different team at each workshop in order to share experiences and learn from each other. The number of groups will be too many to enable sharing between all groups at each workshop. Facilitators may need to identify specific learning that should be shared with everyone.

The training plan should be open to revision and modification in the light of experience and feedback.

At times the learning needs of the provincial representatives will need to be taken care of in separate sessions at the workshops. They must think through the educational issues and the organisational challenges of replicating the programme in their own settings.

Provincial representatives with the required skills may also be able to visit teams between workshops to supervise and re-enforce messages to strengthen educational and clinical governance skills. This may not be feasible in all provinces.

5.6. Training programme

Workshops should be scheduled at six-week intervals. District managers should attend the last two days of Workshop 1 and engage with their DCSTs.
With the exception of Workshop 1, they are all three-day workshops and should cover the content outlined below.

**WORKSHOP 1: INDUCTION (5 DAYS)**
- Introduction to national policy on revitalising primary care, specifically the DCSTs;
- Introduction to the induction and orientation programme;
- Introduction to each other, initial team formation and exploration of personal learning styles;
- Content related to identifying weaknesses and performance of the district health system; and
- Planning of situational analysis and how to introduce themselves to key stakeholders in the province and district when they start work.

**WORKSHOP 2**
- Finalise situational analysis report, present to twin team, prioritise goals for the year;
- Session on content related to implementation of evidence based guidelines, quality improvement cycles and critical event reviews;
- Session on educational and clinical training skills;
- Session on how to report on team activities; and
- Planning of activities for the next six weeks.

**WORKSHOP 3**
- Feedback and critical reflection on activities;
- Content on community-based interventions (COPC, evidence);
- Selected content on home/community level guidelines (see Table 4); and
- Planning of activities for next six weeks.

**WORKSHOP 4**
- Feedback and critical reflection on activities;
- Session on educational and clinical training skills;
- Selected content on primary care level guidelines (see Table 5); and
- Planning of activities for next six weeks.

**WORKSHOP 5**
- Feedback and critical reflection on activities;
- Reflection on team functioning;
- Selected content on district level guidelines, including reflection on referral hospital services (see Table 6); and
- Planning of activities for next six weeks.
WORKSHOP 6
- Feedback and critical reflection on activities;
- Session on educational and clinical training skills;
- Remaining content on home/community level guidelines (see Table 4); and
- Planning of activities for next six weeks.

WORKSHOP 7
- Feedback and critical reflection on activities;
- Session on educational and clinical training issues;
- Remaining content on primary care level guidelines (see Table 5); and
- Planning of activities for next six weeks.

WORKSHOP 8
- Feedback and critical reflection on activities;
- Critical reflection on team functioning;
- Remaining content on district level guidelines (see Table 6); and
- Closure and way forward.

5.7. Resources

5.7.1. Materials

The appointed training team will need to finalise the materials. Essential “must read” materials should be provided in hard copy. Optional and extra materials should be provided at each workshop on a CDROM. All materials should also be made available on a website for easy access by team members. Materials will at least include:

- All guidelines as per Table 1;
- National Core Standards documents;
- National documents on ward-based teams and school health;
- Reports of the three Ministerial Committees on mothers, newborns and children (Department of Health publications);
- Saving Babies (PPIP) and Saving Children (Child PIP) reports;
- Materials on PHC and DHS key principles and effective characteristics;
- Strategic plans from NDOH e.g. MNCWH, CARMMA;
- Operational management guidelines for DHS;
- Overview of DCST;
- Health Systems Trust Review;
- Child Health Gauge;
- Material on adult education and clinical training;
Material on teamwork and functioning;
Material on personal learning styles, leadership and personality;
Material on organisational values and culture;
Reporting template;
Situational analysis guide;
Materials on methods to improve quality of care;
Material on community orientated primary care and
CARMMA.

5.7.2. Trainers

The induction and orientation programme will need three full-time staff for one year to prepare and co-ordinate training:

- Principal trainer / co-ordinator of team learning;
- Co-trainer / co-ordinator of provincial representative learning; and
- Administrator.

These full-time trainers must have a background and expertise in health science education and familiarity with MCH issues. Additional experience with action-learning, DHS, PHC, public health or leadership/management issues is recommended. Initial preparation of this plan should also involve consultation with content experts.

In addition, 5-10 small group facilitators will be needed during the workshops themselves. They will need some preparation before each workshop. Each workshop will require the participation of ad hoc content experts.

5.7.3. New resources

The following materials will need to be developed:

- Internet site for electronic access to materials;
- Selection and collation of materials in hardcopy for each workshop; and
- Copying of Caroms with additional materials for each workshop.

6. Engagement with provinces

The MTT invited all provinces, through the NDOH, to attend consultative sessions to discuss implementation measures that are relevant and appropriate for the particular province. Matters discussed at the sessions included the following:
- Proposed roles of teams;
- Proposed tasks required to improve quality of clinical care within health districts;
- Relationships and reporting lines;
- Alternatives for placement of teams;
- Alternative delivery models;
- Possible content for orientation programme; and
- Other relevant developing themes/ issues.

The outcomes of the provincial visits are reflected in Annexure 12.4.

7. The recruitment process

The recruitment and selection process for DCSTs was led by the NDOH with assistance, as required, from members of the MTT. The response to the advertisements was mixed, with the greatest response from nursing professionals. As expected, there were insufficient medical specialists to fill the positions across the country, or even in all of the prioritised districts that have been selected as NHI pilot districts. As of April 2012 only 42% (86 out of the 208 required nationally) of medical specialist positions were filled, despite offering competitive salaries and benefits. The recruitment process must therefore continue, including attracting specialists from overseas, whilst in the long term, more South African trained medical specialists are required.

Table 2 - Total number of applications per province and discipline

<table>
<thead>
<tr>
<th>Province</th>
<th>Nursing Professional</th>
<th>Medical Specialist</th>
<th>Medical Officer</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Cape</td>
<td>146</td>
<td>28</td>
<td>8</td>
<td>182</td>
</tr>
<tr>
<td>Free state</td>
<td>205</td>
<td>11</td>
<td>8</td>
<td>224</td>
</tr>
<tr>
<td>Gauteng</td>
<td>504</td>
<td>86</td>
<td>92</td>
<td>682</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>260</td>
<td>77</td>
<td>16</td>
<td>353</td>
</tr>
<tr>
<td>Limpopo</td>
<td>502</td>
<td>19</td>
<td>15</td>
<td>536</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>172</td>
<td>25</td>
<td>11</td>
<td>208</td>
</tr>
<tr>
<td>Province</td>
<td>Nursing Professional</td>
<td>Medical Specialist</td>
<td>Medical Officer</td>
<td>Total</td>
</tr>
<tr>
<td>-----------------</td>
<td>----------------------</td>
<td>--------------------</td>
<td>----------------</td>
<td>-------</td>
</tr>
<tr>
<td>North West</td>
<td>160</td>
<td>14</td>
<td>6</td>
<td>180</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>98</td>
<td>14</td>
<td>2</td>
<td>114</td>
</tr>
<tr>
<td>Western Cape</td>
<td>109</td>
<td>50</td>
<td>27</td>
<td>186</td>
</tr>
</tbody>
</table>

**Figure 1- Total number of applications per province and discipline**

The screening and short listing process for the medical specialists and medical doctors was completed by the third week of December 2011. This involved assessment according to appointment requirements, competencies and the key performance areas.

The screening and short listing process for nursing professionals commenced in the second week of January 2012.
The following is the number of short listed candidates per specialist discipline and per province.

Table 3 - Short listed Candidates by Province and Specialty

<table>
<thead>
<tr>
<th>PROVINCE</th>
<th>SPECIALTY</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Paediatrics</td>
<td>Obs &amp; Gynae</td>
<td>Anaesthesia</td>
<td>Family Medicine</td>
<td>Medical Officers</td>
<td></td>
</tr>
<tr>
<td>Northern Cape</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Limpopo</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>5</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>7</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Free State</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Gauteng</td>
<td>9</td>
<td>7</td>
<td>1</td>
<td>7</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>4</td>
<td>6</td>
<td>1</td>
<td>9</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Western Cape</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>North-West</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>6</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

8. Risk management

The MTT identified and discussed a number of factors that may limit or impact on the success of the initiative to establish DCSTs and considered how to mitigate their impact.

8.1. Availability of medical specialists

While the DCSTs offer career progression and attractive salary packages, the number of medical specialists available to create a DCST in each district is limited. Family medicine is a new specialty and the number of specialists at a head-of-unit level, as currently defined, is small. Nevertheless approximately 60-70 new family physicians are qualifying each year and the overall pool of these specialists is increasing. Other medical specialists are not orientated by their training and historical roles to work
primarily in the district and many are taken up in the private sector. These risks are mitigated by a variety of models for the DCST, maximising the appointment of available medical specialists, and consideration of community service for specialists.

8.2. Co-ordination with ward based PHC teams and the Integrated School Health Programme

If the national re-engineering of PHC in South Africa is to succeed it is crucially important for the DCSTs to work closely with the other two streams of PHC re-engineering—the ward based PHC teams and the Integrated School Health Programme. The DCSTs will need to be proactive in this regard, and help the district management team develop its oversight and management function.

8.3. Orientation of medical specialists

The family physician is the only medical specialist specifically trained to work in the district health services. The other specialists (obstetricians and gynaecologists, paediatricians, anaesthetists) are trained to work clinically in regional and tertiary hospitals. Placement of these specialists in the DCST therefore requires them to assume different roles (e.g. district leadership, change agents, clinical governance, educators) in a completely different context and this is why the induction and orientation programme is so extensive.

8.4. Accountability

The DCST should be accountable to the provincial specialist clinically, with administrative accountability to district management teams for their work. These management teams will need to be strengthened to ensure that they have sufficient capacity to provide supervision and oversight, and part of the role of the DCSTs will be to help build this district capacity. In some areas the DCST may serve more than one district and guidelines in terms of administrative support will therefore be required.

9. Monitoring and evaluation

This section outlines the strategy for monitoring and evaluation of the DCSTs. Monitoring and evaluation will be relevant to district management, provincial management and the National Department of Health.
Monitoring of the implementation and activities of the DCSTs will utilise three sources of information:

- National and provincial human resource information on the number and location of appointments to the DCSTs. This will enable reporting on the percentage of districts with a DCST and the composition of the teams;
- Quarterly reports on the DCSTs activities and progress, which will be submitted by the teams themselves. (An outline of the report contents is given in 9.1 below.)
- Reports on strengths, weaknesses, opportunities and threats to the functioning of the teams from the reflection and feedback obtained at the orientation programme. These will be available during the first year only, as part of the training workshops (see section on induction and orientation, above).

Evaluation of the effectiveness of the DCSTs will be based on a set of indicators related to changes in service delivery at the community, primary care and district hospital levels, as well as in the health system itself. These indicators are defined in 9.1 below and are mostly part of the existing routinely reported dataset. Evaluation of changes in progress against these indicators over time and from baseline will be possible.

Evaluation of the impact of the DCSTs will be based on a set of “upstream” indicators that represent health outcomes that should be improved in the longer term. The DCSTs should make an important contribution to the improvements against these indicators.

### 9.1. Monitoring of DCSTs activities

The DCSTs are expected to report quarterly to the district management, provincial management and National Department of Health on their activities, providing the information listed below.

#### 9.1.1. Situational analysis at baseline and annually:

- Evaluation of the range of services offered at primary care facilities / district hospitals vs. expected package of care;
- Evaluation of percentage of staff trained in core clinical guidelines (i.e. IMCI, BANC, BIC, EPOC, Post-rape, childhood emergencies, severe malnutrition, ESMOE);
- Evaluation of the percentage of facilities utilising the appropriate guidelines (i.e. IMCI, BANC, BIC, EPOC, Post-rape, childhood emergencies, severe malnutrition, ESMOE);
- Evaluation of staffing levels and competencies for MCH;
- Evaluation of adolescent friendly services at primary care facilities;
- Evaluation of emergency medical services for MCH;
Collation of all indicators listed below; and
Some indicators may be needed at the sub-district level for district management.

9.1.2. Continuous quality improvement:

- Number of quality improvement cycles completed / in progress;
- Clinical topics covered by the quality improvement cycles;
- Percentage of all facilities included in the quality improvement process;
- Reporting on selected indicators for evaluation of effectiveness that are derived from periodic clinical audit as part of the quality improvement cycles;
- Percentage of district hospitals with regular critical event review for maternal and perinatal deaths;
- Percentage of district hospitals with regular critical event review for childhood deaths; and
- Percentage of primary care facilities participating in regular critical event review for maternal, perinatal and childhood deaths.

9.1.3. Education and training of health workers:

- Report on training events, topics covered, numbers of health workers trained, type of health workers trained; and
- Report on evaluations of competency for health workers in the district.

9.1.4. Engagement with district management teams (DMT):

Report on the quality of the relationship with the DMT, key topics/problems raised and how they are being dealt with.

9.1.5. Clinical outreach visits to facilities:

- Percentage of primary care facilities visited monthly by primary care subgroup in last quarter;
- Percentage of district hospitals visited monthly by paediatric subgroup in last quarter;
- Percentage of district hospitals visited on a two weeks basis by obstetric subgroup in last quarter; and
- Percentage of district hospitals visited by anaesthetist in last quarter.
9.1.6. Teamwork:

- Report on self-evaluation questionnaire on teamwork and plans to address any problems raised.

9.1.7. Conclusions:

- Summary of the key strengths, weaknesses, opportunities and threats experienced by the DCST in the last quarter.

9.2. Evaluation of effectiveness of the DCSTs

The following tables represent a model of how the activities of the DCSTs relate to the key objectives defined in the Strategic Plan for Maternal, Neonatal, Child and Women’s Health and Nutrition in South Africa 2012-2016. A set of indicators to evaluate the effectiveness of these activities are then identified as well as the sources of these indicators.

The tables (4—7) are organised in terms of the community, primary care and district hospital levels as well as broader health system related issues.
<table>
<thead>
<tr>
<th>Activities</th>
<th>Objectives</th>
<th>Indicators</th>
<th>Source</th>
</tr>
</thead>
</table>
| Engage with the ward based PHC teams and provide appropriate education and training e.g. immunisations, breastfeeding, uptake of postnatal care, uptake of antenatal care, nutrition, vitamin A, de-worming, oral dehydration, childhood danger signs, care seeking behaviour | Ensure that ward based PHC teams engage with effective health promotion and disease prevention activities for MCH and if necessary collect additional MCH health information | % of mothers and babies who receive post-natal care within 6 days of delivery  
% of HIV exposed infants who are tested for HIV (using PCR) at six weeks  
% of eligible mothers still taking ART at six weeks  
% of pregnant women who book before 20 weeks gestation  
% of children fully immunised by 1 yr  
% of children fully immunised by 1 year  
% of children age 1 to 5 years who receive at least one dose of Vitamin A per year  
Women year protection rates for family planning | DHIS  
DHIS  
DHIS  
DHIS  
DHIS  
SADHS |
| Engagement with district management teams, ward based primary health care teams, school health services on key risk factors and social determinants of health | Running health promotion campaigns on specific MCH issues | Implementation of health promotion campaigns | DCST reports |
| Support for including key reproductive and adolescent health messages in school health services  
Engagement with school health initiative | Provision of school health services to targeted learners | Delivery rate for women <18 years  
TOP rate for women <18 years  
Women year protection rates for family planning | DHIS  
DHIS  
SADHS |
Table 5 - Support service delivery in the community

<table>
<thead>
<tr>
<th>Activities</th>
<th>Objectives</th>
<th>Indicators</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Situational analysis</td>
<td>Identify gaps in PHC level services and expand the range of services to provide the defined package of care</td>
<td>% of children with diarrhoea who receive zinc</td>
<td>QIC (clinical audit)</td>
</tr>
<tr>
<td>Quality improvement cycles (IMCI)</td>
<td></td>
<td>Coverage with Pneumococcal and rotavirus vaccines</td>
<td>DHIS</td>
</tr>
<tr>
<td>Education and training of PHC providers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engagement with district/facility management team</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical outreach visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality improvement cycles (25 item checklist for BANC)</td>
<td>Effective implementation of BANC in primary care facilities</td>
<td>% of PHC facilities effectively implementing BANC</td>
<td>QIC (clinical audit)</td>
</tr>
<tr>
<td>Implementation of BANC guidelines</td>
<td></td>
<td>Cervical cancer screening coverage</td>
<td>DHIS</td>
</tr>
<tr>
<td>Education and training of PHC providers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical outreach visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support for messaging at PHC level on early uptake of ANC</td>
<td>Increase uptake of ANC before 20 weeks</td>
<td>% of women attending ANC</td>
<td>DHIS</td>
</tr>
<tr>
<td>Education and training of PHC providers</td>
<td></td>
<td>% of pregnant women who initiate ANC before 20 weeks gestation</td>
<td>DHIS</td>
</tr>
<tr>
<td>Activities</td>
<td>Objectives</td>
<td>Indicators</td>
<td>Source</td>
</tr>
<tr>
<td>------------</td>
<td>------------</td>
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</tr>
</tbody>
</table>
| Quality improvement cycle (PMTCT)  
  Implementation of PMTCT guidelines  
  Education and training of PHC providers  
  Clinical outreach visits | Effective implementation of the PMTCT programme | % of eligible antenatal clients initiated on ART  
% of eligible antenatal clients initiated on AZT on time during antenatal care | DHIS  
DHIS |
| Quality improvement cycle (EPOC)  
  Implementation of EPOC guidelines  
  Education and training of PHC providers  
  Clinical outreach visits | Effective implementation of EPOC | % of mothers and babies who receive post-natal care within 6 days of delivery  
% of facilities offering family planning | DHIS  
DHIS |
| Support for health promotion at PHC level  
  Quality improvement cycle (criteria for mother baby friendly hospital initiative)  
  Education and training of PHC providers  
  Engagement with district/facility management | Promotion of early and exclusive breastfeeding including ensuring that breastfeeding is made as safe as possible for HIV-exposed infants | % of PHC facilities that meet criteria for MBFHI | QIC (clinical audit) |
<table>
<thead>
<tr>
<th>Activities</th>
<th>Objectives</th>
<th>Indicators</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Situational analysis</td>
<td>Ensure that all PHC providers are IMCI trained</td>
<td>% of PHC facilities in which 60% of PHC providers are IMCI trained</td>
<td>DCST report</td>
</tr>
<tr>
<td>Collaborate with existing IMCI training programmes or ensure that such</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>programmes are initiated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality improvement cycle (IMCI)</td>
<td>Ensure coverage of EPI package</td>
<td>% of children fully immunised by 1 year</td>
<td>DHIS</td>
</tr>
<tr>
<td>Implementation of IMCI guidelines</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical outreach visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality improvement cycle (IMCI)</td>
<td>Provision of vitamin A supplementation 1-5 years</td>
<td>% of children age 1 to 5 years who receive at least one dose of Vitamin A per year</td>
<td>QIC (clinical audit)</td>
</tr>
<tr>
<td>Implementation of IMCI guidelines</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical outreach visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality improvement cycle (Paediatric HIV)</td>
<td>Effective implementation of HIV care for children</td>
<td>% of HIV exposed infants who are tested for HIV (using PCR) at six weeks</td>
<td>QIC (clinical audit)</td>
</tr>
<tr>
<td>Implementation of guidelines for paediatric HIV</td>
<td></td>
<td>% of eligible children initiated on ART</td>
<td>DHIS</td>
</tr>
<tr>
<td>Education and training of PHC providers</td>
<td></td>
<td>% of eligible children initiated on ART</td>
<td>QIC (clinical audit)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>% of HIV exposed and infected children who receive Cotrimoxazole prophylaxis</td>
<td></td>
</tr>
</tbody>
</table>
## Table 6 - Support service delivery at district hospital level

<table>
<thead>
<tr>
<th>Activities</th>
<th>Objectives</th>
<th>Indicators</th>
<th>Source</th>
</tr>
</thead>
</table>
| Situational analysis  
Engagement with district/facility management team  
Education and training of staff | Identify gaps in DH level services and expand the range of services to provide the defined package of care | % of sub districts providing TOP service  
% of hospitals providing high risk antenatal care  
Provision of lodging facilities for pregnant women awaiting onset of labour where appropriate  
% of hospitals providing KMC  
% of hospitals accredited for MBFHI | DCST report  
CST report  
DCST report  
DCST report |
| Situational analysis  
Quality improvement cycle (BIC, ESMOE)  
Implementation of BIC and ESMOE guidelines  
Education and training of staff  
Critical event review  
Clinical outreach visits | Effective implementation of BIC guidelines  
Effective implementation of ESMOE | % of hospitals which achieve a score of 80% on the BIC checklist for intrapartum care (based on use of the partogram)  
% of hospitals where all staff who supervise deliveries are trained in obstetric emergency care, neonatal resuscitation and new-born care (ESMOE)  
% of mothers and babies receiving 6 hour postnatal check  
% of babies born to HIV positive mothers initiating ARVs | QIC (clinical audit)  
DCST report  
QIC (clinical audit)  
QIC (clinical audit)  
QIC (clinical audit) |
<table>
<thead>
<tr>
<th>Activities</th>
<th>Objectives</th>
<th>Indicators</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Situational analysis</td>
<td>Effective in-patient management of children</td>
<td>% of all nursing staff on the paediatric ward and all doctors trained to provide emergency care to children&lt;br&gt;In-hospital case fatality rate for children (U5) with diarrhea&lt;br&gt;In-hospital case fatality rate for children (U5) with pneumonia</td>
<td>DCST report</td>
</tr>
<tr>
<td>Quality improvement cycle (diarrhoea, RTI, emergencies, Child PIP)</td>
<td></td>
<td></td>
<td>ChildPIP</td>
</tr>
<tr>
<td>Critical event review (Child PIP)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guideline implementation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education and clinical training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical outreach visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Situational analysis</td>
<td>Effective management of severe malnutrition</td>
<td>In-hospital case fatality rate for children (U5) with severe malnutrition</td>
<td>ChildPIP</td>
</tr>
<tr>
<td>Quality improvement cycle (malnutrition, WHO 10 steps)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Critical event review (ChildPIP)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guideline implementation (WHO 10 Steps)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education and clinical training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical outreach visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Situational analysis</td>
<td>Effective management of rape survivors</td>
<td>% of hospitals with designated staff with specific training in comprehensive post-rape care&lt;br&gt;% of rape survivors receiving comprehensive care</td>
<td>DCST report</td>
</tr>
<tr>
<td>Quality improvement cycle (post-rape care)</td>
<td></td>
<td></td>
<td>QIC (clinical audit)</td>
</tr>
<tr>
<td>Guideline implementation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education and clinical training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical outreach visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activities</td>
<td>Objectives</td>
<td>Indicators</td>
<td>Source</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Critical event reviews</td>
<td>Implementation of critical event reviews for maternal, perinatal and child deaths</td>
<td>% of hospitals which regularly review maternal and perinatal deaths / child deaths</td>
<td>DCST reports</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PIPP</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ChildPIP</td>
</tr>
</tbody>
</table>

**Table 7 – Strengthening the capacity of the health system to support quality MCH care**

<table>
<thead>
<tr>
<th>Activities</th>
<th>Objectives</th>
<th>Indicators</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly reporting to district, province and national levels</td>
<td>Regular reporting on progress and activities of DCST</td>
<td>% of quarterly reports received for the year on time</td>
<td>SADHS</td>
</tr>
<tr>
<td>Situational analysis</td>
<td>Ensure sufficient staffing levels to provide quality MCH</td>
<td>Gap between staffing norms and current staffing situation</td>
<td>DCST report</td>
</tr>
<tr>
<td>Engagement with district management team</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluation of staff knowledge, skills and attitudes vs. clinical guidelines e.g. IMCI, ESMOE</td>
<td>Ensure competency of clinical staff</td>
<td>Report on evaluations done and outcomes</td>
<td>DCST report</td>
</tr>
<tr>
<td>Structural criteria in quality improvement cycles</td>
<td>Ensure adequate clinical support services (medication, diagnostic services and health technology, blood, sterilisation) as per EDL and national core standards</td>
<td>National survey of core standards at PHC facilities and hospitals: clinical support services for MCH</td>
<td>NDOH</td>
</tr>
<tr>
<td>Engagement with district/facility management team</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activities</td>
<td>Objectives</td>
<td>Indicators</td>
<td>Source</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Structural criteria in quality improvement cycles</td>
<td>Ensure adequate infrastructure to support quality MCH services (buildings, utilities, safety, security, cleanliness, waste, laundry, food)</td>
<td>National survey of core standards at PHC facilities and hospitals: facilities and infrastructure</td>
<td>NDOH</td>
</tr>
<tr>
<td>Engagement with district/facility management team</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Situational analysis</td>
<td>Improve the quality of EMS for pregnant women, new-borns and children</td>
<td>Report on the situational analysis and quality improvement process</td>
<td>DCST report</td>
</tr>
<tr>
<td>Quality improvement cycle (EMS)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engagement with district management team</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Auditing the accuracy of data within the DHIS, ensuring feedback on results and assisting health workers to interpret results, revising the dataset.</td>
<td>Effective functioning of the routine health information systems for MCH</td>
<td>Report on activities to improve routine health system and data accuracy per facility</td>
<td>DCST report</td>
</tr>
<tr>
<td>Engagement with district management team</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
9.3. Evaluation of the impact of DCSTs

The following up stream indicators can be used in the longer term to monitor the contribution and impact of DCSTs.

Table 8 - Impact indicators with data sources

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>DATA SOURCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Mortality Ratio</td>
<td>MRC/NDACC</td>
</tr>
<tr>
<td>Neonatal Mortality Rate (Early / late)</td>
<td>MRC/NDACC</td>
</tr>
<tr>
<td>Infant mortality rate</td>
<td>MRC/NDACC</td>
</tr>
<tr>
<td>Under-5 mortality rate</td>
<td>MRC/NDACC</td>
</tr>
<tr>
<td>Prevalence of underweight amongst children &lt; 60 months</td>
<td>HSRC</td>
</tr>
<tr>
<td>Prevalence of stunting amongst children &lt; 60 months</td>
<td>HSRC</td>
</tr>
<tr>
<td>% of births supervised by skilled attendants</td>
<td>DHIS, SADHS</td>
</tr>
<tr>
<td>Mother-to-child transmission of HIV</td>
<td>NSP</td>
</tr>
<tr>
<td>Stillbirth rate</td>
<td>DHIS, PPIP data, other surveys</td>
</tr>
<tr>
<td>Low-birth weight rate</td>
<td>DHIS, PPIP data</td>
</tr>
<tr>
<td>% of infants (0-6 months) who are exclusively breastfed</td>
<td>Population-based surveys</td>
</tr>
<tr>
<td>Contraceptive prevalence rate</td>
<td>SADHS</td>
</tr>
<tr>
<td>% of rape victims seen by trained care providers</td>
<td>DHIS</td>
</tr>
<tr>
<td>Prevalence of HIV infection in women 15 - 24 years</td>
<td>NSP</td>
</tr>
</tbody>
</table>
9.4. Feedback and Evaluation of the Training

Feedback from participants will be obtained at the end of each workshop on the training process and organisation of the workshops.

A report should be submitted to NDOH at the end of each workshop by the principal trainer on progress made and any key strengths, weaknesses, opportunities and threats raised by the DCSTs in their reflections and feedback. This will inform reporting to the NHC on progress and obstacles.

An evaluation of the effectiveness of training will be reflected in the M&E plan.

9.5. Conclusion

The monitoring data can be collated into six-weekly feedback reports to the NHC on progress with implementation of the DCST. Once initial evaluation data is available on the effect of the teams at community, primary care and district level then selected indicators can be used to communicate the effect to the general public. The MTT provisionally suggested the following indicators for this purpose:

- The percentage of pregnant women who initiate ANC before 20 weeks gestation;
- The percentage of hospitals where all staff who supervise deliveries are trained in obstetric emergency care, neonatal resuscitation and new-born care (ESMOE);
- The percentage of mothers and babies who receive post-natal care within 6 days of delivery; and
- The in-hospital case fatality rate for children (U5) with diarrhoea, pneumonia or severe malnutrition

Progress against these indicators and the impact indicators should be vigorously communicated within the health sector and to the general public.

10. The way forward

10.1. Prioritising placement

The MTT spent considerable time deliberating and consulting on the placement of the DCSTs within the districts. It was agreed that a flexible approach should be followed for the placement with the options discussed during the provincial visits of the MTT, viz. placement at the district office, separate offices within the district, regional hospitals, etc.
In addition discussions focused on the prioritisation of the districts. This prioritisation is to be aligned with the priority districts for the NHI and the ESMOE-EOST programme districts, e.g. the Phase 1 Districts for the DFID Scale-up of ESMOE-EOST programme:

**Table 9 - Pilot districts**

<table>
<thead>
<tr>
<th>Province</th>
<th>Districts</th>
</tr>
</thead>
<tbody>
<tr>
<td>EC</td>
<td>Amathole DM</td>
</tr>
<tr>
<td>FS</td>
<td>Lejweleputswa DM</td>
</tr>
<tr>
<td>FS</td>
<td>T Mofutsanyane DM</td>
</tr>
<tr>
<td>FS</td>
<td>Fezile Dabi DM</td>
</tr>
<tr>
<td>KZN</td>
<td>Ugu DM</td>
</tr>
<tr>
<td>KZN</td>
<td>Uthungulu DM</td>
</tr>
<tr>
<td>KZN</td>
<td>uMgungundlovu DM</td>
</tr>
<tr>
<td>GP</td>
<td>Ekurhuleni MM</td>
</tr>
<tr>
<td>LIM</td>
<td>Waterberg DM</td>
</tr>
<tr>
<td>MPU</td>
<td>G Sibande DM</td>
</tr>
<tr>
<td>NC</td>
<td>Frances Baard DM</td>
</tr>
<tr>
<td>NW</td>
<td>Bojanala Platinum DM</td>
</tr>
<tr>
<td><strong>Districts with Medical Schools</strong></td>
<td></td>
</tr>
<tr>
<td>EC</td>
<td>O Tambo DM</td>
</tr>
<tr>
<td>LIM</td>
<td>Capricorn DM</td>
</tr>
<tr>
<td>FS</td>
<td>Motheo DM</td>
</tr>
</tbody>
</table>
10.2. Working with the private sector

The private sector has a key role to play in supporting the success of the DCSTs. In particular, some districts would benefit from private providers being contracted to provide support to the DCSTs where direct recruitment of DCST specialists has not been possible, as outlined in the ‘contractual’ model earlier. Also groups such as the South African Society of Obstetricians (SASOG) could assist in mobilising specialists to work on a long term, voluntary basis to improve service delivery in under-served areas.

10.2.1. District health workforce

The HR task team has defined the optimal ratio of health workers to population required for the ward-based, school-based and district-based services. Each health district should perform a gap analysis and indicate HR deficits / excesses.

Major deficits within and/or faced by the DCST and/or district workforce in the public sector are likely and may be minimised by involving the private sector. These deficits may include the following:

- Incomplete DCST: part-time professionals may be contracted;
- Vacancies in the district workforce: part-time professionals will be contracted; and/or
- Inadequate infra-structure at district level: private facilities may be contracted.

Where excess capacity is identified the following options may be applicable:

- Redeployment of staff;
- Extending outreach and contractual agreements to other health districts; and/or
- Extending services (by providing staff, patients and goods) to under-utilised facilities (private and public). The latter would be a useful option to negate the adverse effects of remunerated work outside the public service (RWOPS).

Adherence to the following principles (governance and economics) underlying the structure of NHI is fundamental in the contractual engagement with the private sector:

- Adherence to providing a comprehensive package of care underpinned within the district-based primary health care framework;
- Due accreditation and certification of staff and facilities by the OHSC;
Due contractual agreement with the District Health Authority (DHA). This will include agreement to regular monitoring and evaluation and re-imbursement based on a capitated/global fee structure;

- A remuneration structure adequate to keep personnel in the public sector and to involve private practitioners in NHI; and

- A uniform remuneration package that applies to all personnel. The DHA should be enabled to renew or cancel all contractual agreements with all health personnel.

A model for full-time remuneration would be subject to specific service requirements met in the public sector including number of patients treated and managed per week, number of ward rounds performed each week, number of hours allocated to management meetings, teaching, training and research each week.

Additional remuneration may be agreed to at selected outreach sites in the health district/service cluster. Again specific service outputs indicated above would be contracted. Where the outreach site is a private sector facility the DHA and/or Area Health Authority (AHA) will contact the facility to provide beds, operating time, clinic space etc. The doctor will be remunerated by the DHA and/or current institution and the patients directed to the facility as per the DHA.

10.3. Role of the academic institutions

The Minister of Health appointed two deans from the South African Committee of Medical Deans (SACOMD) to the MTT.

The role of the academic institutions on the District Clinical Specialist Teams initiative includes the following:

- To facilitate the expansion of the existing Clinical Training Platform to include district hospitals;

- To disseminate the advertisements for the appointment of DCSTs as widely as possible and encourage qualifying persons to apply, especially where there is a poor response to the advertisements;

- To seek funding for extra posts from the Department of Health, so as to release appropriate and willing academic clinical staff to be part of the DCSTs on rotational basis for periods of six months to a year, in cases where no appointments have been made;

- To seek to achieve good working relationships between the universities and the Provincial Departments of Health in this initiative to ensure sustainability of this initiative; and
To assist the Department of Health in joint monitoring and evaluation of this initiative, the Academic Institutions, through the SACOMD, would therefore like to affirm their support to the transformational agenda that the Minister is driving so passionately, and hope that, within the near future, acceptable health outcomes for this country will be achieved.

11. Recommendations to the Minister

The following is a summary of the recommendations of the Ministerial Task Team for District Clinical Specialist Teams (DCST) to the Minister of Health:

11.1. Composition

11.1.1 A DCST should be located in each district of South Africa and should ideally consist of a family physician; a primary health care nurse; an obstetrician and gynaecologist; an advanced midwife; a paediatrician and a paediatric nurse. An anaesthetist should be included in a role that is expanded to oversee emergency medical and peri-operative care.

(The family physician is a new cadre of specialist trained specifically to work in the district health system as a generalist in primary care and the district hospital.)

11.1.2 Given that a full team will not be possible in all districts in the short term, a minimum team would be necessary, consisting of one of two options:

> A nurse-doctor dyad from a single discipline (i.e. family physician and PHC nurse, or obstetrician and advanced midwife, or paediatrician and paediatric nurse). This option is preferred and feasible when both the nurse and doctor in a single discipline can be appointed within a district; or

> A family physician and PHC nurse plus an advanced midwife or a paediatric nurse on site in the district and an obstetrician or a paediatrician providing support from a DCST in an adjacent district. This option can be considered for the appointment of a nurse where no doctor from the same discipline can be appointed in their district but where support can be received from both a family physician in the district and a doctor in the same discipline who is appointed to a DCST in an adjacent district.

11.1.3 If a minimum DCST team is in place, then vacant positions can be filled through sessional appointments until such time as full-time staff can be
contracted. If a minimum team is not in place, then session work should not be allowed given the poor past record in the country of hiring specialists on these terms.

11.1.4 Family physicians: Specialist family physicians should be appointed at all community health centres and district hospitals as the most senior clinician. The family physician in the district clinical specialist team is appointed at a higher head-of-unit level, with a greater responsibility for issues of clinical governance and capacity building, and a primary focus on maternal and child health care.

11.2. Roles

11.2.1 In each district the DCST will be responsible for the following areas of work, which will form the basis of annual performance assessments: quality of clinical services; clinical training; monitoring, evaluation and improving clinical services; supporting district level organisational activities; supporting health systems and logistics; collaboration, communication and reporting; and teaching and research activities.

11.2.2 The authority of persons occupying DCST posts will arise partially from the posts themselves but more so from their individual credibility based on their knowledge, experience and track records. It is therefore important to recognise the value of appointing senior members of the profession to these posts.

11.3. Reporting lines

Given the diverse arrangements in each province, the exact reporting arrangements and lines of accountability will be defined province by province but in principle the MTT recommends that the DCST should report both to:

› The district for ensuring their work is included in district planning and budgeting process, that national standards are being adhered to, and that service or facility specific improvement plans are agreed and acted on as problems or constraints are identified; and
› The province, for ensuring discipline specific standards are defined and adhered to and to ensure equity across the province.

All provinces should consider creating posts for, and appointing discipline-specific provincial specialists. However the MTT recognises that where insufficient specialists
exist, then preference may be given to filling positions in districts rather than to new provincial specialist positions.

11.4. Location

Provinces have different views on how they want to locate the teams—ranging from co-location with district management to location of specialists in regional hospitals, while some prefer an independent site for the whole team. This variation is acceptable but it is crucial that the DCST works as a team, and is encouraged to do so with face to face meetings at least once a month, and progress reports prepared jointly.

11.5. Training / Resource Centres

Each district should have a training resource centre available and fully equipped in order for the DCST to carry out required training activities using resources. This should be provided by the National Department of Health under its infrastructure budget.

11.6. Salary and benefits

The salaries and benefits for the DCST team members should be compatible with those of heads of clinical units and with the nursing management cadre in order to attract members from amongst the experienced health professionals in South Africa.

11.7. Financing arrangements

The MTT strongly recommends that the government establish a conditional grant to cover maternal and child services that includes a line item covering DCST in order to ensure sustained public sector funding and to allow monitoring of expenditure during the MTEF period and beyond.

11.8. Human resources for health in rural areas

The National Department of Health should revisit existing human resource policies to improve rural retention, and consider the options for improving coverage of specialists in rural areas. This could include requirements for community service for specialist registration, rotation as part of registrar training and periods of specialist deployment in regional hospitals in underserved areas.
11.9. Risks and challenges

Ongoing recruitment will need to be allocated to specific persons or unit in each provincial Department of Health.

An evaluation of success and lessons learnt should be done periodically and a draft plan for this should be prepared by the recruitment persons mentioned above.

Finally it is suggested that community service for specialists be considered to strengthen clinical services in regional hospital, to facilitate clinical outreach programmes and to cover any clinical shortfalls in the event of a migration of senior clinicians from hospital service to the DCSTs.

11.10. The way forward

11.10.1 Performance agreements: A performance agreement should be signed between the province and each member of the DCSTs and baseline assessments and quarterly performance assessments carried out according to standardised national guidelines.

11.10.2 Induction and orientation: An intensive one year induction and orientation programme should be undertaken by the newly appointed DCST. This should be centrally managed for the first wave of appointments to ensure consistent implementation of the initial teams, alignment with their intended purpose, equity, initial monitoring of progress and cross-provincial learning. The Provincial Departments of Health should then be responsible for taking this forward and continuing with induction and orientation of new staff.

11.10.3 Monitoring and evaluation: Monitoring of progress will rely on data regarding appointments, feedback from the orientation programme and a quarterly report from each DCST using a predefined template developed by the MTT. Evaluation of the effectiveness of the DCST in the medium term will depend on reporting against a set of routinely collected indicators related to their activities and derived mainly from the DHIS. These indicators have been identified by the MTT. The MTT has also identified a set of indicators for the longer term contribution of the DCST to maternal and child health. A baseline and annual evaluation of progress should be commissioned by national and Provincial Departments of Health to complement the national surveys and routine District Health Information System.
11.10.4 National oversight: A national oversight committee should monitor and advise on the DCST work for at least a two-year period. This committee should be chaired by the Director-General or a designated Deputy Director-General and be responsible for reporting to the National Health Council on progress in setting up the DCSTs and on their effectiveness within their allocated districts.

11.10.5 Future replacement/recruitment: The National Department of Health should be responsible for recruitment and selection of members of the DCSTs to ensure equity in responses across provinces. Once the initial round of selections has been completed the responsibility for recruitment and replacement of staff will revert to the Provincial Departments of Health.
12. ANNEXURES

12.1. Terms of Reference for a Ministerial Task Team to advise on ‘District Specialist teams’

Background
South Africa is failing in its ability to reach the Millennium Development Goals for Maternal Health and Child Mortality. Consequently, the Minister of Health has set strategies to improve the health outcomes for maternal and child health. Ambitious targets for maternal and child health and strengthening health system effectiveness in the Negotiated Service Delivery Agreement for Health have been set. As part of the government’s plans to strengthen the health system, the Minister of Health has outlined three areas where major changes are required to improve primary health care services. These are:

1. Ward based Primary Health Care outreach teams composed of nurses and community health workers;
2. A strengthened school health service through increasing the role and number of school health nurses;
3. Specialist teams to strengthen clinical governance of district based MCH services.

Task Teams to develop the ward based PHC outreach programme as well as School health programmes have been established, this Task Team will draft proposals to design the third component. It was proposed by the Minister that there should be a District Specialist Team in every district.

District ‘specialist’ teams
These teams will consist of the following experts – a principal Paediatrician, principal Obstetrician/Gynaecologist, Principal Family Physician, Advanced Midwife, advanced Primary Care Nurse and a principal Anaesthetist.

Funds to establish these new teams have been made secured by the Minister of Health from National Treasury and provided to the Provinces. Consultations have begun with national experts and professional leaders in the field of maternal, peri-natal and child health including the deans and with the nursing profession during the recently completed national nursing summit. Given the urgency to combat the problems related to maternal and child health care in South Africa, the recruitment process for these specialist teams should start before the end of July 2011.

To advise the Department on the design of the District specialist teams, the Minister is establishing a Task Team of experts.
Task Team Terms of Reference
The key objective is to advise the Department on the design of district based specialist teams in line with the recommendations of the Minister, with adverts issued before end of July 2011 and a final set of recommendations on how these teams will function by October 2011. Specific Tasks to be completed are:

Develop the ‘District Specialist’ Work-plan: Prepare a six month work plan with key milestones and budget for the Task Team (TT), in agreement with the DG. This plan will include a consultation process with the relevant stakeholders. The TT will take into consideration work that is already underway such as the proposals being prepared following the recent national nursing summit, and the preliminary work done in some provinces and by the chairs of the national ministerial committees.

1. **Agree composition and terms of reference** for the District specialist teams and prepare job descriptions to clarify individual and collective roles and responsibilities including their mix of clinical, mentoring and public health responsibilities.
   
   In designing the terms of reference and job descriptions the task team should consider the variety of locations (urban, peri-urban and rural settings) that the district teams will work in as well as the availability of referral hospital support.

2. **Outline in some detail the tasks, authority and relationships that will be required of the individuals of the District Specialist Team, and the Teams themselves, to improve quality of clinical care within health districts**
   
   o Develop details on how the district team will assess and strengthen access to care and increase services that may be required based on the burden of disease etc.
   
   o Outline the team’s role in Continual Professional Development
   
   o Propose the process through which the team will conduct outcome Audits, including maternal, peri-natal and child mortality audits including how interventions will be recorded and audited.
   
   o Outline how safe, reliable anaesthetic and critical care during obstetric, neonatal and other forms of emergencies will be ensured.

4. **Clarity the reporting lines, accountability mechanisms and responsibilities** of the district specialist teams, taking into account the need for managerial accountability through district managers, who will be responsible for providing administrative support to the teams, and the need for professional and clinical accountability. The Task Team will recommend what structural changes are required so that lines of responsibility for the quality of clinical and public health services are clear.

5. **Suggest the contents of the orientation programme and ongoing support programmes** that teams will need to undergo to meet the job specifications.

6. **Consider the contract options and the salary and incentive packages** that will be offered to members of the teams, taking into consideration national and provincial HR policy, the
review of OSD currently underway, the need for retention in under-served areas, rotation of staff, career paths and encouraging the engagement of retired professional staff and those in private practice

7. **Clarify the financial and recruitment cost for establishing and sustaining the work of the District Specialist Teams including with relation to:** (a) resource implications by assessing the development and recurrent costs for establishing and sustaining the specialist teams including cost of personnel, material and equipment resources, programme delivery (i.e. transport, housing, etc.)

8. **Clarify the communications** necessary for establishing the teams, including notifying relevant professional bodies and district, provincial and national government agencies of the recruitment process.

9. **Work closely with other NDOH work streams** in particular those working on the development of the other two PHC related streams, Ward and School based and Primary Health Care.

10. **Prepare a detailed report for the Minister** on the process of establishing the district teams taking into account the specific areas outlined above, clarifying risks and how they will be managed, and mechanisms (especially indicators and targets) for monitoring and evaluation.

**Timetable**

- **June 3rd** - Invitations and agenda circulated for first Task Team meeting
- **June 10th** - First Task Team meeting (Location at OR Tambo tbc)
- **June 12/13** - Discussion at technical NHC (with HoDs)
- **June 22/23** - Presentation to NHC
- **3rd July** - Adverts issued
- **Oct 2011** - Final proposal to DG
- **Dec 2011** - First district specialist teams recruited

**Funding**

The team will funded as per normal NDOH guidance on Ministerial Task Teams, with Task Team support provided by DFID/HLSP.
12.2. MTT members, secretariat and advisors

Task Team members

<table>
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<tr>
<th>Name</th>
<th>Institution</th>
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<tr>
<td>Professor Jack Moodley</td>
<td>University of KwaZulu-Natal</td>
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<tr>
<td>Professor Jeff Wing</td>
<td>Wits School of Medicine</td>
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<tr>
<td>Dr Neil McKerrow</td>
<td>KwaZulu-Natal Department of Health</td>
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<tr>
<td>Professor Laetitia Rispel</td>
<td>Wits Centre for Health Policy</td>
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<td>Professor Marion Jacobs</td>
<td>University of Cape Town</td>
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<td>Professor Sthembiso Velaphi</td>
<td>University of Witwatersrand</td>
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<tr>
<td>Professor Khaya Mfenyana</td>
<td>Walter Sisulu University</td>
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<td>Professor Robert Mash</td>
<td>Stellenbosch University</td>
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Advisors

The Task Team was supported by:

- Secretariat led by Dr Kenny Jacobs
- Part-time support from public sector HR specialist (for Tasks 6, 7 & 10), Ms Elsje Greyling
- Adviser to MOH Dr Bob Fryatt (DFID)

The NDOH was represented at all Task Team meetings. NDOH focal persons are:

- Director-General
- DDG Strategic Health Programmes
- Cluster leader MCH
12.3. Stakeholder Consultations

12.3.1. Family Physicians Consultations

The group gave the following feedback:

Placing them at regional or tertiary hospitals risks them being drawn into the hospital environment and not coming out to the district. Consideration should be given to appointing them at the district office.

Specialists are not trained in a community-orientated way and as a whole do not have experience of district health services and the primary health care approach. Experience elsewhere suggests that many such specialists resist outreach into the district because they do not feel comfortable there. It is important therefore that they work as a team with the facility-based family physician and other district-based health workers.

The DCST will need careful orientation and training to their role and the skills required for their work in the district and community. Care must be taken that specialists do not fragment care by drawing the generalist health workers in the district into different vertically orientated directions along disciplinary lines. There is a need to build a continuum of care in an integrated way from community to district hospital and beyond with a generalist approach.

The family physician is already given specific responsibilities for clinical governance in their JDSs and also has a broader understanding of the district. The principal family physician in a district already has responsibility for clinical governance, which includes MCH the relationship of this team to the principal family physician at a district level needs careful thought. Clinical governance activities to raise the quality of care can only be successful if a certain minimum level of capacity is present in the district in terms of staff, equipment, medication and other resources such as transport and EMS.

The DCST should have a mindset that sees their responsibility to the population at risk in the district and not only to specific facilities. The concept of provincial chief specialists was discussed, but there was not general support of this and a risk of them just becoming additional managers and administrators. It has not really worked in KZN as a model.

There is likelihood that urban areas will be more successful in attracting specialists to these teams and that this will once again increase inequity with rural areas.

The relationship between the mother and child and their health care worker is key.

There are possible implications for family medicine training. Revisit of their training programmes to
ensure they are preparing family physicians well in this area. Decentralising family medicine training to key nodal areas in the province may assist with the work of the team (where this is not already happening). There is a need to look at the current training capacity, outputs and required number of family physicians to support this model.

The MTT should understand that their work is not just about creating a proposal but also about how this proposal is disseminated, implemented and evaluated in an ongoing way over a significant period of time.

Family medicine is requesting that they have representation on the other ministerial task teams, particularly the team looking at ward based primary care teams. The role of the supporting doctor/family physician, as in the Brazilian model, is crucial to the success of these teams.

**12.3.2. Family Medicine consultative meeting input and projections on training:**

Family physicians are trained as generalists across ten clinical domains that include: general adult medicine, child health (paediatrics), women’s health (O&G), mental health, HIV/AIDS and TB, ENT/eyes/skin, emergency medicine, anaesthetics, surgery and orthopaedics. Their training in these domains is aligned with the burden of disease and the package of care that is required at primary care and district hospitals. The specific clinical skills have been identified through research at a national level.

Family physicians are trained to work independently at district hospitals in a comprehensive way across all services. They are intended to be the most senior and well-trained practitioner in the district hospital, who can raise the quality of care. The description of district hospitals as offering 4 basic areas (obstetrics and gynaecology, paediatrics and child health, general surgery and family medicine) is not congruent with the way family physicians are currently operating and being trained. We would see that the whole district hospital is the domain of family medicine and that family medicine is not just one domain within the district hospital.

Rural medicine is recognized as a component of family medicine by the HPCSA and this reinforces that family physicians are intended to work comprehensively across all clinical services offered by rural district hospitals. In these areas the workload and case mix does not warrant the appointment of a full-time obstetrician, paediatrician or surgeon. Family physicians are being specifically recruited from and trained in rural areas to maximize the likelihood that they will be retained.

Specialist family physicians cannot be exactly equated with other medical specialists in the proposed district specialist teams. Family physicians are specifically trained to understand and work within the district health system and to be appointed at all community health centres and district hospitals. They are trained to work in a comprehensive way that is not limited to a specific gender,
age group or group of diseases. The appointment of a principal family physician therefore within the district specialist team should not preclude the need to appoint other family physicians widely within the district.

Because family physicians are trained to work as generalists and in a comprehensive way it does not make sense for a principal family physician to only focus on maternal and child health. They have a unique contribution to make in terms of clinical governance, integrating and coordinating all services within the district and in terms of an “insider” understanding of how the district health system works.

**12.3.3. Municipal ward based primary health care**

Family medicine recognizes that the major gains in health will most likely come from a revitalized primary health care approach. The adoption of a team that is focused on a specific group of families in a geographic area and that takes health promotion and disease prevention seriously is welcomed.

As more family physicians are appointed within the district health system the opportunity for them to be part of, consult, support and mentor these primary care teams will increase even further. Family physicians are trained to promote the key principles of primary care such as being person-centred, comprehensive, family-orientated, community-orientated, integrated, and ensuring continuity and co-ordination of care. The contribution of family physicians to the services offered by these ward-based teams should not be overlooked.

Comments on training requirements are a shortfall of 307 family physicians currently which equates to 13 registrar posts at each of the 8 departments at the medical schools for the next 4 years.

**12.3.4. Paediatricians Consultation**

The following matters were discussed:

**Background:**

Background was provided on plans to restructure primary health care services and the 3 streams – ward based PHC outreach teams, school health services, District Specialist Teams.

Input from previous documents was shared with the participants, namely the Memorandum on improving maternal, perinatal and child care in SA, a Framework for the District Clinical Specialist Teams and the proposed Job descriptions for the members of the DCSTs.

**An overview of current outreach options / models was presented:**

- Generic / abstract model
Discussion focused primarily on the paediatric member of the specialist team but principles are applicable to all cadres:

**Composition of the team:**

- Midwife probably not able to contribute to neonatal care
- PHC nurse to focus on district level services outside the hospital
- Therefore need to supplement these two members with a nurse(s) to focus on nursing standards within the nurseries and children’s wards in the District Hospital

**Role:**

Various areas were considered and discussed:

- Clinical, Mentoring & Public Health
- Supportive supervision & Clinical governance
- Support child health programmes as a continuum from conception to adolescence
- Integrate clinical services with public health systems or programmes
- Development of “tools / resources” for clinical practice
- Clinical governance & advocacy including norms, standards & M&E
- Data management
- Facilitate development of an appropriate environment for delivery of clinical care – infrastructure, equipment, sundries, staff, skills etc…
- Support neonatal & child care in facilities
- Facilitate outreach
- Assist with strategic & operational planning in districts & institutions
- Participate in clinical work & overtime
- Time allocation of the members of the DCSTs:
  - 80% services in district
  - 10% clinical work in 2’ hospital
  - 10% university related

The above roles were aligned with the proposed job description.

**Packages for delivery**

Packages for delivery were discussed but no specific packages were identified, but preferences and themes were identified. The concept of themes to be promoted should be in line with:

- Promoting wellbeing
• Prevention
• Facilitate acute care
• Rehabilitation
• Growth & nutrition
• Development & disability
• Common killers
• HIV & TB
• Long term health conditions
• Newborn care
• Adolescent health especially reproductive & mental health
• Emergency care
• Promotion of the integration of “packages” as a continuum from home to hospital across services, sites & age spread

Relationships:
Success is dependent on authority & accountability of the DCSTs. Within the team “Leadership” should be determined by consensus or rotation. Conflict is to be managed at a local level – District Manager and the team member is to be disciplined by the provincial specialist who is to oversee & coordinate service within the discipline across all teams & 20 / 30 facilities. The provincial specialist will then report to the Head of Department of the Province. The provincial specialist should also:

• Serve as a two-way interaction with hospital based specialist
• Should access manpower to support district services & outreach (District Specialists to lead)
• Should contribute to hospital based clinical services (Facility based Specialist to lead)
• Team or members should engage directly with local outside bodies for intersectoral collaboration and with Academic institutions for personal development & exposure.

Delivery:
Should be at the district level, posts are to be placed in either District office or Regional hospital according to local context. Where there is difficulty with filling posts additional posts can be utilised in an adjacent or linked region with collective responsibility to support the “district” by a “host” department. Other proposals included the linking of geographic areas to major centres with posts & a “contract” to provide support on a rotational basis or alternative means of deployment, short term 1 – 2 week deployment of “volunteers”, North-South partnerships. Retired paediatricians or movement from private sector are welcomed but will require:

• Strong orientation programme
• Support from provincial specialist
• Ongoing development
• Rural rotation in the Registrar programmes should be explored.

12.3.5. Obstetricians and Gynaecologists, Anaesthetists and National
Ministerial Committees on Confidential enquiries into maternal and child
deaths

The same presentations were made as for the Paediatrician Consultations and comments and
concerns raised included the following;

• Training & Equipment were raised as a concern. It cannot be assumed that resources are
available, or delivery of service is optimal.
• The quality of training at midwifery level, condition of service and service delivery in
midwifery is an important concern. The 1 year midwifery program should be reinstituted,
urban areas are over developed and rural areas are lacking in resources and service
delivery.

Comments on the DCSTs included the following:

On the role of members of the DCSTs:

• Training, assistance with equipment, protocols, audits, ensuring that standard care is
met, infection control, disposal, facilitate and monitor, liaise with managers. Clear
description of their functions is necessary.
• Authority to function. Creditability. How do you give Post authority?
• Facilitate movement of patients
• Service providers referrals i.e. ambulance services
• Identify high risk situations
• That women and children are not forgotten, advocacy for resources
• The assumption is that we will have the resources which are required to do the work
• Co- ordination of service and care, supportive roles
• Treatment, capacity, appropriate environment, M&E (Quality)
• Appropriate systems

On the service packages:

• NHI is an important package
• List of packages – These need to be clear, comprehensive and outcomes based.

On relationships:

• Relationships with society
• Meeting with team to co-ordinate teams
• Who is the leader of the teams? Selection, rotation, authority appoint someone, team appoint, mutual agreement
• How the people work together will depend on how the departments work together
• Line function reporting: Provincial program is important work in conjunction and not undermine.
• What authority will team leader have?

On reporting lines:
• Clarity required on this. Do the specialist teams report to the DM

On Placement:
• Urban/ rural/ peri-urban/ district office/ regional hospital

On Alternative models:
• What alternatives are there? How will the alternatives be explored?

On Orientation:
• Need for orientation of specialists to be explored. Very few people will have all the skills required.

12.3.6. Nursing Professionals Consultation

The 3 models were presented and comments were:

• Patient behaviour needs to change and this needs to be addressed to make the model work.
• There is no ideal model but there needs to be a look at alterative models to meet the health needs of people.
  • The Task team consists largely of doctors. A: The Ministerial Task Team Chair and Dr. Yogan Pillay have been addressed regarding lack of Nurses on Task team. This is being addressed but agreed by both members.
• Problems – Work load of Nurses is too high, they are overburdened. Task teams need to work together.
• The possibility of more than one model in a Province must be investigated.
• How do we involve the health services in the country? The presentation needs to link back to the Brazilian model and the District Health Plan
• How is the team looking at resolving the problems in the country and provide service?
Will these small task teams actually resolve the problems we have in the country like shortage of staff and reduce Child mortality? Governance will not bring change. At facility level there are no midwives, shortage of nurses needs to be looked at.

How are the family Physicians going to actually assist in seeing the patients?

Two issues we need to be aware of are:

- Don't look at District Specialist teams in isolation to revitalise PHC and to improve on the implementation of programmes such as the recommendations on the confidential enquiries.
- There is need for an enabling alignment such as staff posts that would need to be filled and that there would need to be support for this.

Broader issues:

- Political commitment
- Decentralised management
- Financial commitment
- Different areas cannot use the same model, flexibility required

**Feedback from the Mother and Child Commission**

Roles

- Generic
- Nurse- supportive / facilitatory
- Doctors- authority
- Not mutually exclusive
- Team leader: perhaps chosen by the team
- Training
- Managerial supporting systems
- Clinical
- Reduce risk
- Improve quality and outcomes
- Provision of guidelines/standards
- Advocacy and standardisation
- Promote Functional systems
- Assess and advise
- Mentorship particularly in problem areas
- Capacity building
- Help prioritise planning/budgeting
- Maintain clinical competency of the team
Reporting lines

Facilitation of the training of existing personnel is required to achieve set standards. There is a need of an enabling environment to facilitate authority for:

- **Post**
- **Person**
- Accountability from service providers required by employer-KRAs. DST assesses and reports
- Report to CEO, district manager, HOD.
- Authority stems from head of health. DCSTs belong to the provinces, and not the districts...
- The members of the DCST must be senior to those they are supporting. There should be a channel to fast track issues to next level if normal channels do not respond timorously.
- The DCSTs must be monitored at national level – re. MDGs. Prioritised. Fast tracked performance agreements must be signed with the HOD’s because the number could be too large to ensure proper supervision?

Placement

- There is a need for flexibility in the placement - Split the physical location and functional level.
- At the District office - budgeting and Administration /managerial issues should be based here.
- At the Regional /tertiary facilities – The DCST members could get support and clinical input as they are clinically based and this is a more appealing place to be based – which should add to increased recruitment

Relationships

- Team members are not subordinates of each other and will have independent and interdependent functions. Remuneration should be at the appropriate level. This team should model the appropriate relationships between nurses and doctors.
- The Team leader should be elected by the team, be the appropriate person with respect to local health politics, support administrative support to the team, be a clinical specialist, maintain the context and facilitate effective communication.

Delivery

- Support is needed from academic sites. The Advanced midwife should be supported by an organised link with tertiary/regional based specialist.
Additional comments

- Community service for specialists should be investigated. Consolidated districts
- Districts could be consolidated
- Management – Advise and facilitate, not to do the managing

Feedback from Primary Health Care Commission

Roles and responsibility:

The DCST members are not managers but should be giving clinical support. Their other roles would be:

- Research for quality (generating evidence)
- Monitoring and evaluation
- Ensure implementation of protocols and clinical guidelines in practice
- Develop clinical protocols
- Monitoring and Evaluation – clinical mentoring
- PHC Nurse – shift in burden disease – is the PHC nurse equipped to provide to the PHC nurse who provides clinical care
- Identify gaps – e.g. the PHC nurse must be NIM-ART trained in order to provide support
- There must be clinical competence
- Intervene & support in the event of e.g. emergencies
- Division of time:
  - 80% clinical governance as in above
  - 10% of time on direct clinical work
  - 10% teaching and supervision
- Assist with clinical reporting

Relationships

There should be a relationship developed between province and university – with clear job descriptions, Memoranda of Agreement and guidelines which will clarify exactly what they should do.

Relationships within the team:

- Rotating Team leader – use schedule
- Annual rotation as minimum
- Team will decide by consensus
- Each team member to cost their activities
- Finance person in district office will manage the finance
  - Team members are equal partners in the team
  - Programmes – ensure synergy – not too many bosses (collegial relationship)
Reporting lines

- Clinical Specialist Team report to District Management Team
- Should be at the District office as a base
- Will be expected to be in the facilities all the time
- Ring fenced budget from the province
- Report to the District manager
- Reporting monthly M&M meetings and link with their disciplines/clinical forums
- Ensure nurses are involved
- Admin support should be provided
- Relationship with hospitals – institutionalise referral clusters meetings
- Programmes and synergise not too many bosses
- Report quarterly to District Health Team

Placement / Location

- Provincial needs should be taken into account. Placement of the Team should be in the DHS Office – they should have their own budget for their outreach work and the budget should be ring fenced – an annual business plan should be developed by the DCST. A need is expressed for flexibility to accommodate regional differences – to tailor needs for local needs. The rural areas have difficulty recruiting all the expertise for the team – therefore there might not be a standard team in districts.
- Joint appointment serves the doctor more than the patient as it provides a good salary – we should focus on the patient. These are honorary appointments. Signed Contracts must clearly state the time allocated to joint appointments. Use should be made of the existing resources e.g. MO who have done anaesthetics and build skills.

Models

- A balance should be achieved between different models. Consideration should be given to the geographical variances and alternative models should be explored. We could also look at the MOU model of the Western Cape.

Orientation

Orientation is required and the job description should inform on the content to ensure that practitioners are prepared for their roles and responsibilities.

The overall issues raised by the two groups but not discussed in detail were:

- Secretariat for team
- Data management and capturing – what do we need and are they collecting the appropriate information
Team must have the “means” i.e. access to laboratory services, x-ray, blood, etc and emergency care services

Each area has its own challenges

Training

HIS indicators, data management & collection, is the correct and relevant data being collected

Coordination between DST & current systems

Midwives vs. Neonatal Care

Need of additional people to support, where will they come from?

Secretariat for team

Teams must have the means e.g. Blood tests, radiology, x-rays, labs

EMS (Emergency)
  • It is critical that this is managed at provincial level to work

Target / focus of each group not discussed

Next steps

Need for a Public service act for advanced Midwives and Nurses.

Look where the gaps are. Medical specialists - there are posts, roles to be defined and orientation programme devised

District managers to be consulted

SA Nurses Council and District Managers need to be addressed.

Final comments

District Managers need to be professional health qualified persons and not just administrative persons
12.4. Provincial Consultations

12.4.1. Provincial Consultations Eastern Cape

Model

The ideal model is the preferred model but in the event this is not achieved initially they opted for a merging/clustering method of districts to achieve a minimum of 5 teams.

Priority Districts: Minimum - Chris Hani, Joe Gqabi, OR Tambo and Alfred Nzo clustered, Amathole and Buffalo City clustered, Nelson Mandela Metro & Cacadu districts to be clustered.

Placements

Considerations to be taken into account for placement of the DCSTs:

- Geographic - remoteness
- Existing Resources of the province
- Size of the populations of the districts
- Teaching platform of the province
- Burden of disease of the districts

Appointment, staffing, remuneration and incentives

The province will provide office furniture, office equipment, and other working tools. The appropriate medical equipment is to be available at the facilities. Equipment lists are to be finalised with inputs from the specialists. District managers are to identify the required infrastructure needs for structural changes (costed) – this is to be forwarded to NDOH urgently.

Relationships

DCSTs should have a relationship with an academic institution, the HOD of the particular discipline at the tertiary institution and ongoing relations with the District Manager. The Province will provide availability of space from where to work, provide means of transport and car subsidies.

Accountability and reporting

The contract is to be signed with the Provincial DOH. The National MCH/PHC Office is to provide umbrella oversight. There should be a direct line of reporting to the DDG Clinical / Provincial Specialist with a dotted line—indirect reporting—to the DDG MCWH. Administrative needs will be supplied in by the District Manager

The issue of team leader is still under discussion
12.4.2. 2. Provincial Consultations Northern Cape

Model

The ideal model is the preferred model but in the event this is not achieved initially they opted for a consolidated model with 2 teams to serve two areas.

The Alternative models

1 full-time local team in Kimberley with focus on 2 priority districts; 1 full-time team & 1 contracted team; 2 contracted teams.

Offices should preferably be in an independent unit attached to a training centre.

Reporting

Clinical reporting should be to the provincial specialist in the provincial office and administrative support should from the district manager.

Appointment and staffing

The appointments should be joint appointments with rural allowance and commuted overtime payable. Additionally arrangement will be made by the province to provide accommodation, School arrangements for children, transport and communication costs- laptop, Internet connection and cell phone. A resource centre in the districts will be the ideal.

12.4.3. 3. Provincial Consultations KwaZulu-Natal

Model

The only acceptable model will be the ideal.

Placements

Are to be decided taking into account population size, distances to be travelled, etc.

Accountability/ Line Reporting

Reporting should be to both the provincial specialist and the district manager with administrative support by the district manager. A process has been started to appoint provincial specialists who will have direct line of reporting with monitoring and provincial oversight.

Appointments

Should be joint appointments.
Confirmation of these proposals and others would have been taken at a smaller meeting of district managers to be held on 08 December 2011.

12.4.4. 4. Provincial Consultations Free State

Models
Mangaung Metro should support Xhariep with placement at Bloemfontein; the UFS should support Xhariep on a contractual basis. The other 4 districts each to have a full team; prioritisation should be determined by the health indicators.

Posts
DCST posts already created on the district staff establishments.

Accountability and line reporting
Clinically reporting will be to the Provincial Specialist and administratively to the District manager.

Appointment, staffing, remuneration and incentives
The appointments should be joint appointments with rural allowance and commuted overtime payable. Additionally arrangement will be made by the province to provide accommodation, School arrangements for children, transport and communication costs- laptop, Internet connection and cell phone.

A resource centre in the districts will be the ideal.

The province will look at its own budget and re-prioritize funds but support from the national office will be a bonus. The province though would not want to be not be stifled by the process. National should be responsible for salaries and some allowances. The province will create a small provincial team to research financing of the other incentives.

A recommendation was made to national to establish a ring-fenced grant to fund the DCSTs.

12.4.5. 5. Provincial Consultations Gauteng Province

Model
The aim is for 5 DCSTs – 1 team per District in Tshwane, West Rand, Johannesburg (Central Wits), Ekurhuleni and Sedibeng. Additionally advanced midwives should be added to the Metro teams. The province is to provide the additional funding.

Alternative model
4 Teams – in the 3 Metro’s & West Rand/Sedibeng (consolidated).
Consideration is to be given to linking Teams, Universities & Districts – 1 team with Medunsa, 2 teams with Pretoria University and 2 teams with the University of Witwatersrand.

**Placement**

The teams are to be based in the Districts; this was much debated and placement could be in the District Hospital or District Office. There should be flexibility with recognition of the local District context.

**Relationships**

With the current structures - district Family Physicians are not to be absorbed into the DCST due to the roles being different and this will leave a gap as current Family Physician focus is on PHC services vs. the focus of the DCST being on the MNCWH. The other Specialists within District hospitals are not to be absorbed into the DCSTs. Relationships – with the regional hospital will integrate hospital & PHC services and maintenance of clinical acumen of the DCST members; with the district office to facilitate integration with existing programmes; with the University – alignment to and integration with the existing MAU is important.

Support for other provinces - link to universities & build on existing relationships of Health Faculties with PDOH;

- Wits - North West/ Free State
- Pretoria - Mpumalanga
- Medunsa – Limpopo

**Reporting**

The DCSTs will have to interact with multiple role-players – Academic Hospital, Regional Hospital, District Manager, Provincial Specialist, HOD and District Manager. Technical (Clinical) accountability will be to the Provincial Specialist.

Coordination of team - options are to be identified on appointment and the team leader should be elected by the team members and rotated,

Ensure joint appointment with Universities & Nursing Colleges

**12.4.6. 6. Provincial Consultations North West Province**

The participants included the MEC, HOD & Senior Managers – Provincial, hospitals & District, Programme managers – Province and Family Physicians from each district.

The Province has a population of 3.2 million, 4 Districts (Bojanala / Dr Ruth Segomotso Mompati (RSM), Ngaka Moderi Molema (NMM), Dr Kenneth Kaunda (KK)).
The facilities:  
- PHC: 264  
- CHC: 47  
- DH: 17  
- RH: 3  
- TH: 0

Staffing:  
- 503 MOs (16 / 100,000 people)  
- 72 specialists (2 / 100,000 people)  
- 3,360 PN  
- >4,000 CCG

**Least** funded province/capita

- PHC utilization: 3.5
- LUSCS rate: 11%
- Immunisation coverage: 88.5%

**Facility case fatality rates:**

- Infant: 13.2%
- Child: 1.3%
- MMR: 229.5
- PNMR: 35

Has had District Specialists in the province for 17 years - family physicians plus O&G or paediatrician.

Standard practice of routine & planned periodic outreach visits though variable efficacy due to staff constraints

- NMM: Family physician & paediatrician
- Bojanala: Family physician, advanced midwife & outreach by hospital based paediatrician
- RSM: Family physician & outreach by hospital based paediatrician & obstetrician  
  Looking at placing family physicians in each sub-district
- KK: Family physician only with no outreach by hospital based specialists  
  All districts placing family physician at sub-district level
Preferred model:

Ideal model with 4 teams

Opportunistic appointment/recruitment

Prefer contractual model NOT consolidated model in following order:

1. Bojanala priority
2. Other Districts to be priorities in line with child mortality rates

Placement of offices

District Office

Resource centre

Regional Training Centres already exist in 3 Districts – limited office space

- Fully functional in Bojanala & NMM
- Partially functional in KK & RSM

Require funding to bring to full functionality

Need posts for “campus head & support staff” in each resource centre

Funding

Deliver as a conditional grant

Must explore long term sustainability of funding within the equitable share

Reporting lines

Through the District Office & to the Family Physician

Provincial Specialist

By default in each district the regional hospital specialist will head the discipline in the District

Will need to explore the feasibility of Provincial specialist posts based in Head Office

Relationships with existing structures

Family Physician in Districts will be absorbed into teams

No District MNCWH coordinator

Orientation

Adopt National framework
May need assistance with implementation

Additional matters:

Eligibility of current Family Physicians in terms of post requirements

Recruitment of specialist – only sure way is to “grow” one’s own specialists. Obtain training numbers from HPCSA, create registrar posts, appoint & pay registrars but deploy to another site for actual training with a contract to work year for year in the N West on completion of training.

12.4.7.7. Provincial Consultations Mpumalanga

Over 100 participants were present with the MEC & HOD both attended some sessions, Programme managers – Provincial & District, senior managers – Province & Districts, Hospital management – CEO & Nursing Managers and Clinicians.

Province:

Population 3.6 million (88% without medical aid

Districts: 3 Districts

Facilities

PHC 235
CHC 50
DH 23
RH 3
TH 2

Staff

563 doctors including 7 paediatricians & 3 Obstetricians
3706 nurses including 58 advanced midwives

Preferred model:

The preferred option is the ideal model with 3 teams – 1 per district

The 2nd choice is the consolidated model with 2 geographic area:

1. Ehlanzeni
2. Nkangala & Gert Sibande

The 3rd choice is to compliment the ideal or consolidated models with the contractual model
Placement of offices

Not in the District Office

Hospital based as follows:

- Ehlanzeni    Rob Ferreira
- Nkangala    Witbank – both the ideal & consolidated models
- Gert Sibande    Ermelo

Resource centre

Currently exists at Witbank Hospital

Regional Training Centres exist in Gert Sibande & Ehlanzeni District but need to be upgrades

The Revitalisation Programme will fund development of Resource Centres at Rob Ferreira, Ermelo & Themba Hospitals.

Reporting lines

Multiple reporting lines

1. Clinical issues    Provincial Specialist or Chief Specialist
   In absence of Chief Specialist – DDG Clinical Services
   Pending appointment of DDG Clinical Services the Chief Director Hospital Services

2. Administrative issues – District Manager

3. Individual post    Manager of component where the post is placed

EPMDS to be managed by Corporate Services

Provincial Specialist

Chief Specialist posts already exist for Anaesthetics and O&G. These will need to be created for Paediatrics & Family Medicine. Provincial Specialists will oversee both medical & nursing members of the District Clinical Specialist Teams

Relationships with University of Pretoria

Fairly weak at present, needs to be strengthened to support delivery and to create incentive for recruitment & retention.

Induction & Orientation

Adopt & adapt MTT framework.
Corporate Services & HRD to oversee provincial implementation, which may require appointment of 3rd party.

**Incentives**

Need to strengthen the provincial relationship with the University & explore the possibility of joint appointments.

Provide accommodation but recognise the tax implications of all incentives

**12.4.8.8. Provincial Consultations Limpopo**

The participants included the Programme managers – Provincial and District, senior managers – Province & Districts, the MEC & HOD both attended some sessions

**Province:**

Population 5.4 million (1,054,960 households)
Districts 5 (543 wards)
Facilities

- PHC 425
- CHC 28
- DH 32
- RH 5
- TH 2

**Preferred model:**

5 teams

Ideal model

Deploy to rural districts first

Implore NDOH to strengthen international recruitment efforts & facilitate easier registration processes

Incentives required attracting staff – graded to favour rural sites

Consolidated model with 3 geographic areas deployed in following order:

1. Sekhukhune & Waterberg
2. Vhembe & Mopani
3. Capricorn

If unable to appoint teams for consolidated model – combine this with contractual model in same order
Placement of offices

Not in the District Office

Preferably an independent unit attached to training centre

Regional hospital as interim measure as each District has a regional hospital

Resource centre

Library, skills lab, seminar rooms, offices with possible overnight accommodation

1 per District as independent structure

As interim measure consider using Multipurpose Centre in each District or expanding nursing campuses

Consider linking resource centre to DCST & PHC ward based teams – will need to add storage depot

Additional resources

Independent SCM

Transport

Researchers

Funding

Conditional grant modelled along lines of HIV/AIDS programme

Reporting lines

Dual reporting lines

Hospital component - Senior General Manager of Regional Hospitals

Community component - Senior General Manager District Health Systems and Integrated Primary Health Care Services

Provincial Specialist

2 heads per discipline – academic & service heads

Provincial Specialist to oversee M&E

Both heads to be located in Academic Complex

Relationships with existing structures

No Family Physician in District Office

No comment on interaction with MNCWH coordinator
Orientation

Adopt National framework
Develop provincial implementation plan with HRM

12.4.9. Western Cape

The visit to the Western Cape was agreed upon after invitation from the HOD to the MTT although there was an initial thought that the MTT would not be visiting the Province since the Province had opted out of the DCST programme.

The MTT did not make any presentation as was usual at all other provinces. The meeting was attended by the HOD, 2 DDGs, Lead Clinicians, Chief Directors and Directors including the Director in the new post of Director Rural Districts.

An introduction was given by Prof Househam with special emphasis on the programme of the strengthening of General Specialists in districts with outreach and support, including funds and resources.

A programme on the Lead Clinician (= Coordinating Clinician) was started in 2006 with such a lead clinician in each of the general specialist areas of Anaesthetics, Paediatrics, Obstetrics and Gynaecology, Surgery and Emergency Medicine. The intention was to draw all clinicians within geographic service areas (GSA) with a particular person leading each discipline within a GSA. Examples of GSA’s include Metro East, Metro West. A general specialist is also employed within each GSA, in the Metro at Head of Clinical Department and in the other Districts at Head of Clinical Unit level. General Specialists are also employed at the regional level with competency across all referral levels. At district level only Family Physician Specialists are employed. A rapid appraisal team was also formed to assess the competencies of the previously qualified (prior to 2008) family physicians in 10 output areas. Simultaneously there is a parallel programme to increase the number of general specialists at the Regional Hospitals.

General physicians are also to lead services in the Central Hospitals. Difficulties are experienced with change management as the academic leaders are resisting these changes.

Referrals currently are 90% to the Primary Health Care level, 8% to the Regional Hospital level and 1% to Cape Town from the districts. Less than 300 per month from Eden and 90 from Central Karoo. There is a programme to increase services delivered at district level, e.g. Oncology now at George (Eden).

Outreach and Support has 2 components from a specialist perspective, namely a general specialist with support to the outreach team and a more junior specialist. There is a need for people who understand the system.
The Provincial Clinical Committee (PCC) system is functional within each GSA with a primary responsible person. This is a formal structure which includes the Chief Director for Strategic Health Programmes, Specialist Heads, Programme Heads, amongst others to assess many tasks, including protocol development, outreach and support, service delivery, measure referral rates, quality of referrals, etc. The success is having a single person responsible for driving towards good health outcomes and things are more structured.

An example mentioned is a specialist appointed at Tygerberg Hospital to work and spend some time at Khayelitsha Hospital. If a problem surfaces it is assessed by an experienced Family Physician (as COO) and the problem is referred to the GSA if not resolved.

Community service for specialists is absolutely necessary. Paediatrics is already training in community health. Agreements already exist between Western Cape and Eastern Cape Department of Health.
12.5. Presentation to the National Health Council (4 August and 2 December 2011)
12.5.1. 4th August 2011

Composition and placement of District Specialist Teams
- Proposed team members
  - Family physician
  - Obstetrician and Gynaecologist
  - Paediatrician
  - Anaesthetist
  - Midwife
  - Primary Health Care Nurse
  - Paediatric Nurse
- Flexible approach
  - District office; and/or
  - Regional hospital
- Local context to be considered
  - Catchment area serviced
  - Burden of disease
  - Referral patterns
  - Processes / systems already established

Ideal Model

Consolidated Model
- Merge “geographic areas” / Districts
  - Fewer teams cover bigger areas
- Consolidate areas around “functional” site
- Deploy additional teams
  - To functional site
  - To service bigger area

Contractual Model
- Identify:
  - Functional service / academic centre
  - Unserviced “geographic area” / District
- Link functional centre with unserviced area
- Contract functional centre to service distant area
- Allocate team posts to functional centre
- Service distant area on rotational basis

Job description - medical
- General
  - Promote equitable access to appropriate care
  - Assist with strategic & operational planning
  - Coordinate, monitor, supervise & support discipline related services
  - Maintain competency in discipline
- Facility support
  - Clinical focus – packages, outreach & participation

Job description - medical
- Organisational support
  - Infrastructure, equipment, resources
  - Staffing – recruitment, development & support
- Systems & logistical support
  - Information, referral & surveillance
- Monitoring & evaluation
  - Quality improvement programme & reporting systems
  - Mortality audits
Job description - nursing

- General – provide and promote within the district
  - Primary prevention, promotive and curative health care services
  - Quality maternal and child health
  - Clinical leadership & support in the functional area of expertise/ registration
  - Equitable access to appropriate care
  - Assistance with strategic & operational planning
- Facility support
  - Packages, outreach, teaching and training
  - Policies and protocol

Job description - nursing

- Organisational support
  - Essential drugs, equipment, infrastructure, resources
  - Staffing – recruitment, development, support, evaluation
  - Unit systems and management
- Systems & logistical support
  - Information, referral & surveillance
- Monitoring & evaluation
  - Quality improvement programme and reporting systems

Human Resource Attraction

- Experienced retirees
- Expatriates
- Private practitioners - contracted/ sessional/ incentives for full time
- Rotation schemes – contractual model
- Other:
  - Joint appointments
  - Career pathing
  - Opportunities for development, training
  - Professional recognition

Preparation for Recruitment Process

- Remuneration and OSD aligned
- Allowances, benefits and incentives - current policy & practice as well as additional recommendations
- Contract options explored
- NDOH places block advertisement
  - Contracts
  - Remuneration, etc...
  - Location / Placement
- Understanding of required structural changes in Provinces to enable implementation

Facilitation

- Facilitate and enable direct access to information from
  - Senior Provincial and District management
  - Human Resources
  - Chief Financial Officers’
- Orientation, continuing education and continuous support programmes required
- Any other advice

Comments and approvals required

- Composition, model
- Generic job descriptions
- Block advert
- Attraction proposals, delivery proposals
- Recruitment and selection process/ centralised
- Appointment process and proposed dates
- Assistance from provincial and district perspective – communications; posts; remuneration; incentives and benefits; structural changes; orientation
12.5.1. 2nd December 2011

Ministerial Task Team
“District Specialist Teams”

Report

National Health Council
Port Elizabeth

2 December 2011

Focus of report

• Previous reports to NHC Tech Comm and NHC refer
• Provincial Briefings to date

• Applications received: total and captured to date
• Selection Process and appointment process
  o Short listing, Interviews, appointment
  o Induction and orientation

• Recommendations
• Discussion / Points of clarification

Provincial Consultations Eastern Cape

• Model: Merging / clustering method of districts; Minimum 5 teams
• Considerations for placements:
  o Geographic - Remoteness
  o Existing Resources
  o Population size of districts
  o Teaching platform
  o Burden of disease

Provincial Consultations Eastern Cape

• Priority Districts: Minimum - Chris Hani, Joe Gqabi, OR Tambo & Alfred Nzo, Amathole & Buffalo City, NMM & Cacadu
• DCST should have relationship with:
  o Academic institution
  o HOD of particular discipline (Tertiary institution)
  o Ongoing relations with DM
• Issue of team leader still under discussion
• availability of space from where to work
• provide means of transport
• Car subsidies

• Province to provide office furniture, office equipment, and other working tools
• Appropriate Medical equipment to be available at the facilities
• Equipment lists to be finalised with inputs from Specialists
• DM’s to identify required infrastructure needs for structural changes (COSTED) – to be forwarded to NDoH urgently
Provincial Consultations Eastern Cape

- Accountability and reporting:
  - Contract with the Provincial DoH
  - National Office umbrella oversight
  - DDG Clinical / Provincial Specialist – direct line
  - DDG MCWH – dotted line
  - District Manager

Provincial Consultations Northern Cape

- **Consolidated model** is preferred with 2 teams to serve two areas
- **Alternative models**: 1 full-time local team in Kimberley with focus on 2 priority districts; 1 full-time team & 1 contracted team; 2 contracted teams
- Offices preferably in an independent unit attached to training center
- Clinical reporting to Provincial specialist in Provincial office
- Admin reporting to District Manager

Provincial Consultations Northern Cape

- Joint Appointments
- Rural allowance; Commuted overtime
- Accommodation; School arrangements for children
- Transport
- Communication costs- laptop, internet connection, cellphone
- Resource centre would be ideal

Provincial Consultations KwaZulu Natal

- Model : ideal
- Placements : to be decided taking into account population size, distances to be travelled, etc.
- Accountability / Line Reporting --- dual
- Establishment of Provincial Specialists – direct line of reporting ; monitoring and provincial oversight
- Joint Appointments
- Confirmation of these at a smaller meeting of district managers ...08 December 2011

Provincial Consultations Free State

- Mangaung Metro support Xhariep, placement at Bloemfontein
- UFS to support Xhariep on contractual basis
- Other 4 districts each to have a full team; priority determined by health indicators
- DCST posts already created on the district staff establishments
- Joint appointments

Provincial Consultations Free State

- Clinically reporting to Provincial Specialist, Admin to District manager
- Rural allowance; Commuted overtime
- Accommodation; School arrangements for children
- Transport
- Communication costs- laptop, internet connection, cellphone
- Resource centre would be ideal
Provincial Consultations Free State

- The province look at own budget and re-prioritize funds
- Support from national office - bonus
- The province not be stifled by the process
- National responsible for salaries and some allowances
- Create a small provincial team to research financing of the other incentives
- Recommends to national to establish a ringfenced grant to fund the DCST’s

General Principles

- Impression of Provincial visits:
  o Value: buy-in / ownership by District Managers and Academics, detailed insight into purpose, roles, processes of selection and appointment
  o Slow process, process of decision-making
- Visits to other Provinces;
  o Gauteng 09 December 2011
  o Limpopo early January
  o Awaiting dates from remainder of provinces

Selection and Appointment

- Shortlisting process
  o Clear guidelines to be developed to inform panel
  o Composition of panel at shortlisting:
    ➢ 1 person from each of following:
      NDoH (Chair), appropriate MTT member, National HR, Nursing profession
    ➢ 1 Person representing each province
    ➢ 1 representative from the COMD

Selection and Appointment

- Interview process
  o National process
  o 1 representative of each province to participate in interview panel
  o Panels - 1 specialist of each discipline to chair the panel for that discipline, rest same as for shortlisting panel
  o 4-5 panels proposed

Selection and Appointment

- Shortlisting and interview process:
  o Screening, short listing - invited to interviews;
  o Clearly defined selection criteria and methodology;
  o Prioritisation and location of interviews: prioritisation of districts in interview process ;
  o Reference and background checks of candidates; and
  o Preparation of submissions to obtain approval for appointments

Selection and Appointment

- Screening and shortlisting – 1 December – 31 January 2012
- Interviews and reference and background checks – February 2012
- Approval of recommended appointments - national and provincial – March 2012
- Assumption of duty - 1 April 2012
- Induction and orientation – April 2012
Financial implications

- Spreadsheet

<table>
<thead>
<tr>
<th>Province</th>
<th>Nursing Professionals</th>
<th>Medical Specialists</th>
<th>Medical Officers</th>
<th>Total</th>
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<tr>
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<td>Free State</td>
<td>205</td>
<td>11</td>
<td>8</td>
<td>224</td>
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<td>Gauteng</td>
<td>504</td>
<td>86</td>
<td>92</td>
<td>682</td>
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<td>KwaZulu-Natal</td>
<td>240</td>
<td>77</td>
<td>161</td>
<td>353</td>
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<td>Limpopo</td>
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<td>Mpumalanga</td>
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<td>North west</td>
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<td>100</td>
<td>50</td>
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<td>177</td>
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</table>

Number of Specialists’ Applicants

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<thead>
<tr>
<th>Applicants</th>
<th>Anesthesiologists</th>
<th>O&amp;G</th>
<th>Pediatrics</th>
<th>Family Medicine</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>20</td>
<td>21</td>
<td>29</td>
<td>74</td>
<td>144</td>
</tr>
</tbody>
</table>

Terms of reference

- Develop MTT Work-plan ✔
- Agree composition and TOR’s ✔
- Develop job descriptions ✔
- Place national adverts ✔
- Clarify roles and responsibilities ✔
- Clarify the reporting lines and lines of accountability ✔
- Suggest the contents of the orientation programme ✗
- Consider the contract options and the salary and incentive packages ▼

Terms of reference

- Inclusion SA HR Strategy ✔
- Clarify the financial resource implications ✔
- Clarify the communications necessary for establishing the teams ✔
- Work closely with other NDOH PHC work streams ✔
- Perform outcome audits of districts ✔
- Monitoring and evaluation ✔
- Communication Strategy for DCST’s ✔
- Oversee the recruitment process ✔
- Prepare a detailed report for the Minister ✔

Recommendations and decisions

- Either continuation of the MTT for 6 months or establish a team within NDoH to complete tasks:
  - remainder of provincial visits
  - assist with selection and appointment process
  - completion of induction and Orientation programmes and processes
  - guidelines for quality audits, assurance, reporting, implementation of national guidelines and protocols
  - discussions with other PHC re-engineering streams
  - Planning national guidelines for resource centres
- National oversight for implementation and monitoring and evaluation
- Temporary team to assist with selection process
### 12.6. District Clinical Specialist Team costing model

<table>
<thead>
<tr>
<th>Position (DCST)</th>
<th>Position Type</th>
<th>Salary</th>
<th>Rural Allowance</th>
<th>Total</th>
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<tbody>
<tr>
<td>FAMILY PHYSICIAN (DCST)</td>
<td>Head: Clinical Unit Grade 1</td>
<td>1 087 297</td>
<td>239 205</td>
<td><strong>1 326 502</strong></td>
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<tr>
<td>PAEDIATRICIAN (DCST)</td>
<td>Head: Clinical Unit Grade 1</td>
<td>1 087 297</td>
<td>239 205</td>
<td><strong>1 326 502</strong></td>
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<tr>
<td>OBSTETRICATION AND GYNAECOLOGIST (DCST)</td>
<td>Head: Clinical Unit Grade 1</td>
<td>1 087 297</td>
<td>239 205</td>
<td><strong>1 326 502</strong></td>
</tr>
<tr>
<td>ANAESTHETIST (DCST)</td>
<td>Head: Clinical Unit Grade 1</td>
<td>1 087 297</td>
<td>239 205</td>
<td><strong>1 326 502</strong></td>
</tr>
<tr>
<td>ADVANCED PAEDIATRIC NURSING PROFESSIONAL</td>
<td>Manager Nursing</td>
<td>633 255</td>
<td>139 316</td>
<td><strong>772 571</strong></td>
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<tr>
<td>ADVANCED MIDWIFERY NURSING PROFESSIONAL</td>
<td>Manager Nursing</td>
<td>633 255</td>
<td>139 316</td>
<td><strong>772 571</strong></td>
</tr>
<tr>
<td>ADVANCED PRIMARY HEALTH CARE NURSING PROFESSIONAL</td>
<td>Manager Nursing</td>
<td>633 255</td>
<td>139 316</td>
<td><strong>772 571</strong></td>
</tr>
<tr>
<td><strong>TOTAL FOR DCST</strong></td>
<td></td>
<td><strong>6 248 953</strong></td>
<td><strong>1 374 770</strong></td>
<td><strong>7 623 723</strong></td>
</tr>
</tbody>
</table>
NOTES:
1. Rural allowance calculated at 22% of basic portion of package (70%) - current negotiated agreement will determining which sites qualify for rural allowance, applies.
2. Commuted overtime calculated using notch times 16 hours/ 30

Other staff related items to be budgeted: (MTT deliberated on existing best practice and guidance is needed from NDOH/ DPSA in order to recommend/ develop appropriate guidelines)
1. Accommodation (single/family)
2. Transport
3. Cell phones, lap tops, GPS equipment, "tools of the trade"
12.7. Attraction and retention discussion paper

Introduction

The introduction of multidisciplinary specialist teams in districts to address the high levels of child and maternal mortality represents an extraordinary effort improve health outcomes in South Africa.

The purpose of this section is to present an overview of the anticipated working environment (including challenges and demands) of DCS teams which will have an impact on the attraction and retention of team members as well as proposed strategies to improve attraction and retention of employees for the teams.

Anticipated challenges and demands

To gain understanding of the attraction and retention issues that would be pertinent for DCS teams, the anticipated challenges of working and functioning in these multi-disciplinary teams need to be considered.

The challenges and demands are categorised into three broad themes:

Health system challenges

DCS team members will be faced with various challenges, which will often differ across districts and be specific to the geographic area where teams are deployed, such as:

- Inequity of access to healthcare;
- Fragmentation of the healthcare system;
- Burden of disease;
- Lack of planning and co-ordination on various levels and contexts;
- Poor or no management and administrative support;
- Resourcing of health facilities;
- Geographic and infrastructure issues; and
- Unrealistic stakeholder expectations.

Working environment challenges

Challenges and demands in this category include the following:

- Different expectations regarding performance and quality standards across different districts/provinces;
- Negative perceptions and mistrust about the work that DCS teams will perform;
- High need for urgent training and reskilling of health workforce and the expectations on DCS teams to achieve possibly unrealistic targets in this regard;
- Safety concerns (health facilities; travel; etc.); and
- Lack of management competence in health facilities; resulting in frustration by employees and ineffective service delivery.
Challenges associated with working in multi-disciplinary teams

Anticipated challenges and demands in this category include the following:

- Handling dual reporting lines; i.e. to the Provincial Specialist from a clinical perspective and the District Manager with regard to administrative and operational matters;
- Gaining role clarity within the team to ensure performance in terms of individual job descriptions and within the district health system to ensure effective contribution from a team perspective;
- Working in a multi-disciplinary team/group of teams versus practicing as an individual specialist;
- Working in “incomplete” teams where not all team members as envisaged in the ideal model are in place or located in the same geographical area;
- Dealing with stages of group formation and becoming effective teams as soon as possible;
- Dealing with the dynamics associated with rotational team leadership.

It is argued that the manner in which the above challenges are handled or mitigated will have an impact on attraction and retention of DCS team members. The attraction and retention factors can be classified as “pull” factors which are typically those that attract an individual to a new destination such as career prospects, higher income, improved living conditions or a more stimulating and rewarding working environment whilst the “push” factors are deemed to repel an individual away from a location such as poor remuneration, living conditions or lack of support and role confusion in the workplace. (Lehmann, U; Dieleman, M and Martineau, T, 2008)

Attraction and retention factors

For the purposes of this document, Lehmann’s model (Lehmann, U; Dieleman, M and Martineau, T, 2008) is used to discuss a few key push and pull factors that are deemed relevant for DCS teams. These are categorised as follows:

- National (policy);
- Local (home and social);
- Work environment; and
- Individual/personal.

National

The policy paper on National Health Insurance introduces the creation of DCS teams to promote innovative ways to bridge gaps in the existing primary healthcare environment. This solution is deemed to become an integral and permanent feature of health care delivery in South Africa.

Attraction and retention of DCS team members could be promoted by allowing team members to participate in healthcare policy and strategy planning in an advisory and expert capacity at international, national, provincial and district level.

DCS team members could also play a leading role in sharing experiences and learning at international, national and regional congresses, workshops, meetings, CPD events and other educational/developmental...
interventions. This will enhance their visibility, credibility and professional profile in the overall healthcare arena and serve as an important retention strategy.

**Local environment**

The lack of housing and schools, limited access to health care and poor infrastructure are significant reasons why employees either do not join or leave health services employment, particularly in remote areas (Lehmann, U; Dieleman, M and Martineau, T, 2008).

To compensate for unattractive living environments, it may be appropriate to consider the introduction of “hardship” or “deep rural” allowances for DCS teams. Such allowances would be determined by consideration of factors such as health status in the district, demographic indicators (age distribution, number of women and children), mortality rates, quality of life, and access to training, etc. and could be used to improve or enhance the current unsatisfactory policy on “rural allowances”.

**Work environment**

Although various studies have showed that financial incentives, particularly rural allowances, have positively influenced attraction and retention of health care workers in South Africa (Reid, 2004), challenges have been experienced with inconsistent (and sometimes incomprehensible) application of such policies. It is recommended at this stage that the package of benefits to be offered to all DCS teams includes payment of rural allowance and commuted overtime, where applicable and within the relevant policy frameworks.

A study by Kotzee & Couper (2006) which investigated retention strategies for rural doctors in Limpopo (Kotzee, 2006), found that the high workload of doctors in primary care resulted in them not utilising their annual leave which in turn led to burnout. The study recommended that in order to promote attraction and retention of doctors in rural environments, they should be afforded an opportunity to take extended periods of unpaid leave and/ or sabbatical leave to further their studies or to enhance clinical competence in another environment. This proposal should be considered for inclusion in the package of benefits to be offered to DCS team members.

The lack of supportive and competent management and systems in district health care is well documented (Couper & de Villiers, 2005). The recruitment of competent managers and their on-going training and development by provincial/ district health management will be critical to provide the necessary platform for an attractive working environment for DCS team members. Such working environment should reflect the following in order to retain high calibre professionals:

- Supportive organisational culture, values and organisational arrangements including workload management and effective handling of bureaucracy (Kotzee, 2006) (Lehmann, U; Dieleman, M and Martineau, T, 2008);
- Clarity in terms of roles and accountability;
- Availability of and access to resources;
- Appreciation and respect for DCS team members in their professional capacity;
- Availability of hospital infrastructure, equipment and “tools of the trade”, including timeous maintenance thereof;
• Risk management (health and safety, employee wellness, labour relations, etc.)
• Inclusive/consultative decision making; and
• Clear and accessible communication channels.

Individual factors

It is recorded that the personal attributes of professional healthcare workers such as where they originate from (e.g. rural area) and their value system are strong determinants of whether they will consider taking up a job in a geographic area/health facility outside metropolitan areas/in primary health care (Couper I. H., 2007).

Couper et al. (2007) (Couper I. H., 2007) identified five key factors namely “personal, facilitating, contextual, staying and reinforcing” aspects that influence the decision of a health professional to work in a rural environment (i.e. primary health care) Each factor is discussed in terms of key themes and sub themes that explain what is meant by the theme statement.
<table>
<thead>
<tr>
<th>Influencing factor</th>
<th>Theme</th>
<th>Sub theme</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal</strong></td>
<td>Rural origin and community connection</td>
<td>Familiarity with and ability to relate with rural people and environment.</td>
</tr>
<tr>
<td></td>
<td>Values</td>
<td>Political, religious and need for “wanting to serve”.</td>
</tr>
<tr>
<td><strong>Facilitating</strong></td>
<td>Role models</td>
<td>Current rural health professionals who are working in rural areas and serve as an inspiration.</td>
</tr>
<tr>
<td></td>
<td>Exposure to rural practice</td>
<td>Training opportunities such as rural electives or holiday work in rural environment.</td>
</tr>
<tr>
<td></td>
<td>Rural people’s needs</td>
<td>Awareness of the absence of rural physicians and the poor treatment of rural people.</td>
</tr>
<tr>
<td></td>
<td>Dislike to urban work</td>
<td>Cities are regarded as unsafe, dehumanising, and associated with a pressurised lifestyle and require a specialised approach to working.</td>
</tr>
<tr>
<td><strong>Context</strong></td>
<td>Physical environment</td>
<td>Appreciation of the natural physical surroundings in rural environments.</td>
</tr>
<tr>
<td></td>
<td>Job</td>
<td>Rural practice is associated with more diversity of tasks and patients as well as the opportunity to become involved in the community.</td>
</tr>
<tr>
<td></td>
<td>People</td>
<td>Rural patients are deemed to be friendly and less demanding compared to urban patients who insist on specialist treatment and specific medication.</td>
</tr>
<tr>
<td></td>
<td>Financial</td>
<td>Health care professionals (especially public servants) working in rural environments earn more than urban counterparts because they qualify for rural allowances and housing benefits.</td>
</tr>
<tr>
<td><strong>Staying</strong></td>
<td>Family</td>
<td>The ability to spend more quality time with family and friends</td>
</tr>
<tr>
<td></td>
<td>Supportive team</td>
<td>Medical and management team in the hospital/ clinic is vital to ensure that the healthcare professional stay in a rural area.</td>
</tr>
<tr>
<td></td>
<td>Training</td>
<td>The opportunity to train further, especially post graduate training, is an important contributor to staying in a rural area.</td>
</tr>
<tr>
<td><strong>Reinforcing</strong></td>
<td>Being a role model</td>
<td>The potential to uplift the community and improve rural health care by being a role model and an advocate for the broader community.</td>
</tr>
<tr>
<td></td>
<td>Relationships</td>
<td>A close relationship with the community and feeling appreciated and recognised.</td>
</tr>
</tbody>
</table>

Source: Couper et al. (2007:1083)
The above model proposes that the decision to choose a career in primary health care outside of metropolitan areas is facilitated by previous exposure to rural practice during training time as well as an understanding of rural community needs and exposure to role models who practice in rural communities. Contextual factors such as the nature of the work, the environment and patients influence the decision to remain.

The length of stay in a rural environment will be determined by the adjustment of families and ability to establish a network of friends, the opportunity for on-going training and development, as well as the experience of the health service management system within which they have to function on a daily basis.

Personal motivation to remain in rural practice is reinforced by a positive relationship with the community, and by the ability to influence and improve healthcare in the rural environment.

This study is relevant to give context to personal factors that would influence attraction and retention of DCS team members, particularly with regard to rural areas.

**Conclusion**

This section is not exhaustive, but introduces some key and fundamental issues to be considered for the attraction and retention of DCS team members specifically, however keeping in mind alignment with overall strategies for attraction and retention of health workers within the Health Human Resources policy context.
12.8. DCST job descriptions – generic and specific roles

DISTRICT CLINICAL SPECIALIST TEAM (DCST)
JOB DESCRIPTION:
ADVANCED MIDWIFERY NURSING PROFESSIONAL

JOB INFORMATION SUMMARY
Name of job holder:
Job title: Advanced Midwifery Nursing Professional
CORE code:
Post level and salary code: OSD (Nursing Manager)
Occupational class code:
Name of component:
Location:
Post reports to:
Date of appointment:

JOB PURPOSE
To strengthen district and community level health services by means of supportive supervision and clinical governance in order to promote the wellbeing of the population within the geographical catchment area of a regional hospital.

KEY PERFORMANCE AREAS
A: GENERAL
- Represent midwifery as a member of a DCST responsible for the delivery of quality health care for mothers, babies and children at all levels within a health district.
- Promote equitable distribution of resources and access to an appropriate level of care for all mothers, babies and children throughout the district.
- Maintain personal competency in maternal and neonatal health care.

B: SUPPORT SERVICE DELIVERY
- Primarily support district hospitals with all aspects of service delivery related to maternal and neonatal health care.
- Secondarily support clinics and community health centres with service delivery related to maternal and neonatal health care.
- Promote clinical effectiveness in all facilities through supporting outreach programmes and development, dissemination and implementation of clinical and nursing protocols and standard treatment guidelines aligned with national norms and standards.

C: PROVIDE EDUCATION AND TRAINING
- Facilitate and participate in the development, training and mentorship of health professionals in all facilities within the district.
- Support the training, development and mentorship of nursing and allied health professionals and community workers.

D: SUPPORT HEALTH SYSTEMS AND LOGISTICS
- Work with the District Management Team to establish and maintain systems including surveillance, health information, communication and referral guidelines and processes to support the delivery of services.
- Provide support to ensure appropriate infrastructure, equipment, resources and sundries for the provision of quality nursing care.
E: MONITOR AND EVALUATE SERVICES
- Assist, support and participate in risk management activities for patients (e.g. critical event analysis, morbidity and mortality meetings), practitioners (e.g. infection control) and the organization (e.g. performance reviews).
- Assist, support and participate in clinical audit and quality improvement cycles in health facilities within the district.
- Implement effective monitoring and evaluation processes, effective use of data and appropriate reporting on outputs and health outcomes.
- Assist, support and participate in relevant research.

F: COLLABORATE, COMMUNICATE AND REPORT EFFECTIVELY
- Foster effective teamwork and collaboration within the DCST and with other professionals in the district involved in the delivery of maternity services.
- Enable engagement with the local community and relevant non-government organisations and private providers, promoting adherence to district clinical public health guidance as appropriate.
- Facilitate and ensure effective communication with all management structures within the district, the regional and tertiary hospitals as relevant as well as the provincial Department of Health.
- Present regular reports on activities, health services and programmes.

G: SUPPORT ORGANISATIONAL ACTIVITIES
- Assist with strategic and operational planning of services in the district and/or catchment area of the regional hospital.
- Coordinate and supervise discipline related services within the district.
- Assist with the recruitment and management of relevant human resources.

ORGANISATIONAL STRUCTURE

Notes:
DCST members have a dual reporting line to discipline specific provincial specialists as well as district managers.

Provincial specialists are responsible to address issues around equity within the province; provide mentorship, support and on-going development of district specialists and provide capacity solutions for incomplete DCSTs.

District managers are responsible to direct the functions, budget and operations of DCSTs in accordance with agreed strategic and operational plans.

APPOINTMENT REQUIREMENTS OF THE JOB
A basic qualification (i.e. diploma/degree in nursing) or equivalent qualification that allows registration with the South African Nursing Council (SANC) as a Professional Nurse; plus a post basic nursing qualification (Advanced Midwifery Nursing Science) with a duration of at least 1 year accredited with the SANC; plus a minimum of 10 years appropriate/recognisable experience in nursing after registration as Professional Nurse with the SANC in General Nursing. At least 6 years of the period referred to above must be appropriate/ recognisable experience in the
specific specialty after obtaining the 1-year post-basic qualification. At least 4 years of the period referred to above must be appropriate/recognisable experience at management level. (Please note: Appropriate/recognisable experience in the context of these requirements also includes experience gained after registration in the particular discipline in a foreign country, and which registration is recognised by the SANC for registration in the particular discipline).

COMPETENCIES REQUIRED
Sound knowledge of the following:
- Ethical nursing practices
- Programme planning, implementation and evaluation
- Clinical governance
- Information management programmes
- Human resources and financial management
- Health and Public Service legislation, regulations and policy

Demonstrated skills in the following areas:
- Leadership
- Communication
- Problem solving
- Functioning in a multi-disciplinary team
- Teaching, mentorship and coaching
- Diversity management
- Basic computer literacy

Behavioural attributes reflecting the following:
- Stress tolerance
- Self confidence
- Objectivity
- Ethical
- Empathic
- Quality oriented

CAREER PATHING

AMENDMENTS TO JOB DESCRIPTION
The Head of Department of his/her nominee reserves the right to make changes and alterations to this job description, as he/she may deem reasonable, after due consultation with the post holder.

JOB DESCRIPTION AGREEMENT

A separate job description will need to be signed off by each job holder to whom the job description applies.

Signature of post holder:___________________________ Date: __________________
Signature of direct manager:_________________________ Date: __________________
Signature of head of department/division:_____________ Date: __________________
DISTRICT CLINICAL SPECIALIST TEAM (DCST)

JOB DESCRIPTION:

ADVANCED PAEDIATRIC NURSING PROFESSIONAL

JOB INFORMATION SUMMARY

Name of job holder: 
Job title: Advanced Paediatric Nursing Professional
CORE code: 
Post level and salary code: OSD (Nursing Manager)
Occupational class code: 
Name of component: 
Location: 
Post reports to: 
Date of appointment: 

JOB PURPOSE

To strengthen district and community level health services by means of supportive supervision and clinical governance in order to promote the wellbeing of the population within the geographical catchment area of a regional hospital.

KEY PERFORMANCE AREAS

A: GENERAL
• Represent paediatric and neonatal nursing as a member of a DCST responsible for the delivery of quality health care for mothers, babies and children at all levels within a health district.
• Promote equitable distribution of resources and access to an appropriate level of care for all mothers, babies and children throughout the district.
• Maintain personal competency in paediatric and neonatal health care.

B: SUPPORT SERVICE DELIVERY
• Primarily support district hospitals with all aspects of service delivery related to paediatric and neonatal health care.
• Secondarily support clinics and community health centres with service delivery related to paediatric and neonatal health care.
• Promote clinical effectiveness in all facilities through supporting outreach programmes and development, dissemination and implementation of clinical and nursing protocols and standard treatment guidelines aligned with national norms and standards.

C: PROVIDE EDUCATION AND TRAINING
• Facilitate and participate in the development, training and mentorship of health professionals in all facilities within the district.
• Support the training, development and mentorship of nursing and allied health professionals and community workers.

D: SUPPORT HEALTH SYSTEMS AND LOGISTICS
• Work with the District Management Team to establish and maintain systems including surveillance, health information, communication and referral guidelines and processes to support the delivery of services.
• Provide support to ensure appropriate infrastructure, equipment, resources and sundries for the provision of quality nursing care.
E: MONITOR AND EVALUATE SERVICES

- Assist, support and participate in risk management activities for patients (e.g. critical event analysis, morbidity and mortality meetings), practitioners (e.g. infection control) and the organization (e.g. performance reviews).
- Assist, support and participate in clinical audit and quality improvement cycles in health facilities in the district.
- Implement effective monitoring and evaluation processes, effective use of data and appropriate reporting on outputs and health outcomes.
- Assist, support and participate in relevant research.

F: COLLABORATE, COMMUNICATE AND REPORT EFFECTIVELY

- Foster effective teamwork and collaboration within the DCST and with other professionals in the district involved in the delivery of paediatric and neonatal care.
- Enable engagement with the local community and relevant non-government organisations and private providers, promoting adherence to district clinical public health guidance as appropriate.
- Facilitate and ensure effective communication with all management structures within the district, the regional and tertiary hospitals as relevant as well as the provincial Department of Health.
- Present regular reports on activities, health services and programmes.

G: SUPPORT ORGANISATIONAL ACTIVITIES

- Assist with strategic and operational planning of services in the district and/or catchment area of the regional hospital.
- Coordinate and supervise discipline related services within the district.
- Assist with the recruitment and management of relevant human resources.

ORGANISATIONAL STRUCTURE

- Provincial Specialist (Paediatrics)
- District Manager
- Paediatrician (DCST)
- Advanced Paediatric Nursing Professional in DCST
- Other specialists in DCST

Notes:
DCST members have a dual reporting line to discipline specific provincial specialists as well as district managers.

Provincial specialists are responsible to address issues around equity within the province; provide mentorship, support and on-going development of district specialists and provide capacity solutions for incomplete DCSTs.

District managers are responsible to direct the functions, budget and operations of DCSTs in accordance with agreed strategic and operational plans.

APPOINTMENT REQUIREMENTS OF THE JOB

A basic qualification (i.e. diploma/degree in nursing) or equivalent qualification that allows registration with the South African Nursing Council (SANC) as a Professional Nurse; plus a post basic nursing qualification (Advanced Paediatric or Neonatal Nursing Science) with a duration of at least 1 year accredited with the SANC; plus a minimum of 10 years appropriate/recognisable experience in nursing after registration as Professional Nurse with
the SANC in General Nursing. At least 6 years of the period referred to above must be appropriate/recognisable experience in the specific specialty after obtaining the 1-year post-basic qualification. At least 4 years of the period referred to above must be appropriate/recognisable experience at management level.

(Please note: Appropriate/recognisable experience in the context of these requirements also includes experience gained after registration in the particular discipline in a foreign country, and which registration is recognised by the SANC for registration in the particular discipline).

**COMPETENCIES REQUIRED**

Sound knowledge of the following:
- Ethical nursing practices
- Programme planning, implementation and evaluation
- Clinical governance
- Information management programmes
- Human resources and financial management
- Health and Public Service legislation, regulations and policy

Demonstrated skills in the following areas:
- Leadership
- Communication
- Problem solving
- Functioning in a multi-disciplinary team
- Teaching, mentorship and coaching
- Diversity management
- Basic computer literacy

Behavioural attributes reflecting the following:
- Stress tolerance
- Self confidence
- Objectivity
- Ethical
- Empathic
- Quality oriented

**CAREER PATHING**

**AMENDMENTS TO JOB DESCRIPTION**
The Head of Department of his/her nominee reserves the right to make changes and alterations to this job description, as he/she may deem reasonable, after due consultation with the post holder.

**JOB DESCRIPTION AGREEMENT**
A separate job description will need to be signed off by each job holder to whom the job description applies.

Signature of post holder: ____________________________ Date: __________________

Signature of direct manager: ____________________________ Date: __________________

Signature of head of department/division: ____________________________ Date: __________________
DISTRICT CLINICAL SPECIALIST TEAMS
JOB DESCRIPTION:
ANAESTHETIST (DCST)

JOB INFORMATION SUMMARY
Name of job holder:
Job title: Anaesthetist (DCST)
CORE code: OSD (Head Clinical Unit)
Post level and salary code: OSD (Head Clinical Unit)

JOB PURPOSE
To strengthen district health services in anaesthetic and emergency care services by means of supportive supervision and clinical governance in order to promote the wellbeing of the population within the geographical catchment area of a regional hospital.

KEY PERFORMANCE AREAS
A: GENERAL
• Represent specialist discipline of anaesthetics as a member of a District Clinical Specialist Team (DCST) responsible for the delivery of quality health care for mothers, babies and children at all levels within a health district.
• Promote equitable distribution of resources and access to an appropriate level of care for all mothers, babies and children throughout the district.
• Maintain personal competency as an anaesthetist by spending 10 to 20% of time on continuing professional education and clinical care at the regional or tertiary hospital.
• Spend at least 80% of time on supporting the improvement of operative and emergency services within the district.

B: SUPPORT SERVICE DELIVERY
• Support anaesthetics and emergency care service delivery in the district.
• Primarily support district hospitals with all aspects of service delivery related to anaesthetics and emergency care.
• Secondarily support clinics, community health centres and primary health care outreach teams, including engaging private providers of anaesthesia and emergency care.
• Promote clinical effectiveness in all facilities through supporting outreach programmes and development, dissemination or implementation of clinical protocols and standard treatment guidelines aligned with national norms and standards.

C: PROVIDE EDUCATION AND TRAINING
• Facilitate and participate in the development, training and mentorship of health professionals in all facilities within the district.
• Facilitate and participate in the training, development and mentorship of under- and post graduate medical, nursing and allied health professionals. This may require involvement with local academic training institutions.
• Support on-going professional development of all health professionals involved in the perioperative and emergency care process.
D: SUPPORT HEALTH SYSTEMS AND LOGISTICS
• Work with the District Management Team to establish and maintain systems including surveillance, health information, communication and referral guidelines and processes to support the delivery of anaesthetics and emergency care services.
• Provide support to ensure appropriate infrastructure, equipment, resources and sundries for the provision of quality clinical care.

E: MONITOR AND EVALUATE SERVICES
• Initiate, support and participate in risk management activities for patients (e.g. critical event analysis, morbidity and mortality meetings), practitioners (e.g. infection control) and the organization (e.g. performance reviews).
• Initiate, support and participate in clinical audit and quality improvement cycles with specific focus on anaesthetics and emergency care.
• Implement effective monitoring and evaluation processes, effective use of data and appropriate reporting on outputs and health outcomes.
• Initiate, support or participate in relevant research. This may require involvement with local academic training institutions.

F: COLLABORATE, COMMUNICATE AND REPORT EFFECTIVELY
• Foster effective teamwork and collaboration within the DCST.
• Enable engagement with the local community, relevant non-government organisations and private providers.
• Facilitate and ensure effective communication with all management structures within the district, the regional and tertiary hospitals as relevant as well as the provincial Department of Health.
• Participate in provincial and national activities and initiatives to save mothers, babies and children.
• Present regular reports on activities, health services and programmes.

G: SUPPORT ORGANISATIONAL ACTIVITIES
• Assist with strategic and operational planning of services in the district and/or catchment area of the regional hospital.
• Assist with the coordination and supervision of anaesthetics and emergency care services within the district.
• Assist with the recruitment and management of relevant human resources.

ORGANISATIONAL STRUCTURE

Provincial Specialist (Anaesthetics and Emergency Care)  District Manager

Anaesthetist (DCST)  Other specialists in DCST
Notes:
DCST members have a dual reporting line to discipline specific provincial specialists as well as district managers. Provincial specialists are responsible to address issues around equity within the province; provide mentorship, support and on-going development of district specialists and provide capacity solutions for incomplete DCST. District managers are responsible to direct the functions, budget and operations of DCST in accordance with agreed strategic and operational plans.

APPOINTMENT REQUIREMENTS OF THE JOB
Appropriate specialist qualification that allows registration with the Health Professions Council of South Africa (HPCSA) as an Anaesthetist plus at least 5 years experience after obtaining qualification.

COMPETENCIES REQUIRED
Sound knowledge of the following:
- Own clinical discipline
- Medical ethics
- Programme planning, implementation and evaluation
- Information management programmes
- Epidemiology and statistics
- Quality assurance and improvement programmes
- Human resources and financial management
- Health and Public Service legislation, regulations and policy

Demonstrated skills in the following areas:
- Leadership
- Communication
- Teaching, mentorship and coaching
- Problem solving
- Functioning in a multi-disciplinary team
- Computer literacy

Behavioural attributes reflecting the following:
- Stress tolerance
- Self confidence
- Objectivity
- Ethical
- Empathic

CAREER PATHING

AMENDMENTS TO JOB DESCRIPTION
The Head of Department of his/ her nominee reserves the right to make changes and alterations to this job description, as he/ she may deem reasonable, after due consultation with the post holder.

JOB DESCRIPTION AGREEMENT
A separate job description will need to be signed off by each job holder to whom the job description applies.

Signature of post holder: _______________________________ Date: ________________
Signature of direct manager: __________________________ Date: ________________
Signature of head of department/ division: ______________ Date: ________________
DISTRICT CLINICAL SPECIALIST TEAMS

JOB DESCRIPTION:

FAMILY PHYSICIAN (DCST)

JOB INFORMATION SUMMARY

Name of job holder: 
Job title: Family Physician (DCST)
CORE code: 
Post level and salary code: OSD (Head Clinical Unit)
Occupational class code: 
Name of component: 
Location: 
Post reports to: 
Date of appointment: 

JOB PURPOSE

To strengthen district and community level health services by means of supportive supervision and clinical governance in order to promote the wellbeing of the population within the geographical catchment area of a regional hospital.

KEY PERFORMANCE AREAS

A: GENERAL

• Represent family medicine as a member of the District Clinical Specialist Team (DCST) responsible for the delivery of quality health care for mothers, babies and children at all levels within a health district.
• Promote equitable distribution of resources and access to an appropriate level of care for all mothers, babies and children throughout the district.
• Maintain personal competency as a family physician by spending 10 to 20% of time on continuing professional education and clinical care at a relevant facility be it a district, regional or tertiary hospital.
• Spend at least 80% of time on supporting the improvement of health services within the district.

B: SUPPORT SERVICE DELIVERY

• Support community orientated clinical services in the district by responding to family and community health needs, spanning the range of risk and environmental hazards within families and communities.
• Primarily support clinics, community health centres and primary health care outreach teams, including engaging private sector practitioners regarding service delivery related matters.
• Secondarily support district hospitals with all aspects of service delivery related to family practice.
• Promote clinical effectiveness in all facilities through supporting outreach programmes to primary care teams in their community, dissemination or implementation of clinical protocols and standard treatment guidelines aligned with national norms and standards.

C: PROVIDE EDUCATION AND TRAINING

• Facilitate and participate in the development, training and mentorship of health professionals in all facilities within the district.
• Facilitate and participate in the training, development and mentorship of under- and post graduate medical, nursing and allied health professionals. This may require involvement with local academic training institutions.

D: SUPPORT HEALTH SYSTEMS AND LOGISTICS

• Work with the District Management Team to establish and maintain systems including surveillance, health information, communication and referral guidelines and processes to support the delivery of medical services, including epidemiological research, disease profiles and establishment of community needs.
• Provide support to ensure appropriate infrastructure, equipment, resources and sundries for the provision
of quality clinical care.

E: MONITOR AND EVALUATE SERVICES
- Initiate, support and participate in risk management activities for patients (e.g. critical event analysis, morbidity and mortality meetings), practitioners (e.g. infection control) and the organization (e.g. performance reviews).
- Initiate, support and participate in clinical audit and quality improvement cycles.
- Implement effective monitoring and evaluation processes, effective use of data and appropriate reporting on outputs and health outcomes.
- Initiate, support or participate in relevant research. This may require involvement with local academic training institutions.

F: COLLABORATE, COMMUNICATE AND REPORT EFFECTIVELY
- Foster effective teamwork and collaboration within the DCST.
- Enable engagement with the local community, relevant non-government organisations and private providers.
- Facilitate and ensure effective communication with all management structures within the district, the regional and tertiary hospitals as relevant, as well as the provincial Department of Health.
- Present regular reports on activities, health services and programmes.
- Participate in provincial and national activities and initiatives to save mothers, babies and children.

G: SUPPORT ORGANISATIONAL ACTIVITIES
- Assist with strategic and operational planning of services in the district and/or catchment area of the regional hospital.
- Assist with the coordination and supervision of medical services within the district.
- Assist with the recruitment and management of relevant human resources.

ORGANISATIONAL STRUCTURE

Notes:
DCST members have a dual reporting line to discipline specific provincial specialists as well as district managers. Provincial specialists are responsible to address issues around equity within the province; provide mentorship, support and on-going development of district specialists and provide capacity solutions for incomplete DCST.

District managers are responsible to direct the functions, budget and operations of DCST in accordance with agreed strategic and operational plans.

APPOINTMENT REQUIREMENTS OF THE JOB
Appropriate specialist qualification that allows registration with the Health Professions Council of South Africa (HPCSA) as a Family Physician Plus at least 5 years experience after obtaining qualification.
COMPETENCIES REQUIRED

Sound knowledge of the following:

- Own clinical discipline
- Medical ethics
- Programme planning, implementation and evaluation
- Information management programmes
- Epidemiology and statistics
- Quality assurance and improvement programmes
- Human resources and financial management
- Health and Public Service legislation, regulations and policy

Demonstrated skills in the following areas:

- Leadership
- Communication
- Teaching and training
- Problem solving
- Functioning in a multi-disciplinary team
- Computer literacy

Behavioural attributes reflecting the following:

- Stress tolerance
- Self confidence
- Objectivity
- Ethical
- Empathic

CAREER PATHING

AMENDMENTS TO JOB DESCRIPTION
The Head of Department of his/ her nominee reserves the right to make changes and alterations to this job description, as he/ she may deem reasonable, after due consultation with the post holder.

JOB DESCRIPTION AGREEMENT

A separate job description will need to be signed off by each job holder to whom the job description applies.

Signature of post holder:__________________________ ___ Date: __________________

Signature of direct manager:__________________________ ___ Date: __________________

Signature of head of department/ division:__________________________ ___ Date: __________________
DISTRICT CLINICAL SPECIALIST TEAMS
JOB DESCRIPTION:
OBSTETRICIAN AND GYNAECOLOGIST (DCST)

JOB INFORMATION SUMMARY
Name of job holder: Obstetrician and Gynaecologist (DCST)
Job title: Obstetrician and Gynaecologist (DCST)
CORE code: OSD (Head Clinical Unit)
Post level and salary code: OSD (Head Clinical Unit)
Occupational class code: Name of component:
Location: Post reports to:
Date of appointment:

JOB PURPOSE
To strengthen obstetric and gynaecological health services at district and community levels through supportive supervision and clinical governance in order to promote the wellbeing of the population within the geographical catchment area of a regional hospital.

KEY PERFORMANCE AREAS
A: GENERAL
- Represent obstetrics and gynaecology as a member of a District Clinical Specialist Team responsible for the delivery of quality health care for mothers, babies and children at all levels within a health district.
- Promote equitable distribution of resources and access to an appropriate level of care for all mothers, babies and children throughout the district.
- Maintain personal competency as an obstetrician and gynaecologist by spending 10 to 20% of time on continuing professional education and clinical care at the regional or tertiary hospital.
- Spend at least 80% of time on supporting the improvement of obstetrics and gynaecological services within the district.

B: SUPPORT SERVICE DELIVERY
- Support obstetric, neonatal and sexual and reproductive health care service delivery in the district.
- Primarily support district hospitals with all aspects of service delivery related to obstetrics and gynaecology.
- Secondarily support clinics, community health centres and primary health care outreach teams, including engaging private sector obstetricians and gynaecologists with service delivery related matters.
- Promote clinical effectiveness in all facilities through supporting outreach programmes and development, dissemination or implementation of clinical protocols and standard treatment guidelines aligned with national norms and standards:

C: PROVIDE EDUCATION AND TRAINING
- Facilitate and participate in the development, training and mentorship of health professionals in all facilities within the district.
- Facilitate and participate in the training, development and mentorship of under- and post graduate medical, nursing and allied health professionals. This may require involvement with local academic training institutions.

D: SUPPORT HEALTH SYSTEMS AND LOGISTICS
- Work with the District Management Team to establish and maintain systems including surveillance, health information, communication and referral guidelines and processes to support the delivery of obstetrics and gynaecological services.
- Provide support to ensure appropriate infrastructure, equipment, resources and sundries for the provision of quality clinical care.
E: MONITOR AND EVALUATE SERVICES
- Initiate, support and participate in risk management activities for patients (e.g. critical event analysis, morbidity and mortality meetings), practitioners (e.g. infection control) and the organization (e.g. performance reviews).
- Initiate, support and participate in clinical audit and quality improvement cycles with specific focus on obstetrics and gynaecological assessments.
- Implement effective monitoring and evaluation processes, effective use of data and appropriate reporting on outputs and health outcomes.
- Initiate, support or participate in relevant research. This may require involvement with local academic training institutions.

F: COLLABORATE, COMMUNICATE AND REPORT EFFECTIVELY
- Foster effective teamwork and collaboration within the DCST.
- Enable engagement with the local community, relevant non-government organisations and private providers.
- Facilitate and ensure effective communication with all management structures within the district, the regional and tertiary hospitals as relevant as well as the provincial Department of Health.
- Present regular reports on activities, health services and programmes.
- Participate in provincial and national activities and initiatives to save mothers, babies and children.

G: SUPPORT ORGANISATIONAL ACTIVITIES
- Assist with strategic and operational planning of services in the district and/or catchment area of the regional hospital.
- Assist with the coordination and supervision of obstetrics and gynaecological services within the district.
- Assist with the recruitment and management of relevant human resources.

**ORGANISATIONAL STRUCTURE**

**Notes:**
DCST members have a dual reporting line to discipline specific provincial specialists as well as district managers. Provincial specialists are responsible to address issues around equity within the province; provide mentorship, support and on-going development of district specialists and provide capacity solutions for incomplete DCS teams. District managers are responsible to direct the functions, budget and operations of DCSTs in accordance with agreed strategic and operational plans.

**APPOINTMENT REQUIREMENTS OF THE JOB**
Appropriate specialist qualification that allows registration with the Health Professions Council of South Africa (HPCSA) as an Obstetrician and Gynaecologist Plus at least 5 years experience after obtaining qualification.
COMPETENCIES REQUIRED
Sound knowledge of the following:
- Own clinical discipline
- Medical ethics
- Programme planning, implementation and evaluation
- Information management programmes
- Epidemiology and statistics
- Quality assurance and improvement programmes
- Human resources and financial management
- Health and Public Service legislation, regulations and policy

Demonstrated skills in the following areas:
- Leadership
- Communication
- Teaching, mentorship and coaching
- Problem solving
- Functioning in a multi-disciplinary team
- Computer literacy

Behavioural attributes reflecting the following:
- Stress tolerance
- Self confidence
- Objectivity
- Ethical
- Empathic

CAREER PATHING

AMENDMENTS TO JOB DESCRIPTION
The Head of Department of his/ her nominee reserves the right to make changes and alterations to this job description, as he/ she may deem reasonable, after due consultation with the post holder.

JOB DESCRIPTION AGREEMENT
A separate job description will need to be signed off by each job holder to whom the job description applies.

Signature of post holder: ___________________________ Date: _________________
Signature of direct manager: _________________________ Date: _________________
Signature of head of department/ division: ______________ Date: _________________
DISTRICT CLINICAL SPECIALIST TEAMS

JOB DESCRIPTION:

**PAEDIATRICIAN (DCST)**

**JOB INFORMATION SUMMARY**

Name of job holder: Paediatrician (DCST)

CORE code: OSD (Head Clinical Unit)

Post level and salary code: OSD (Head Clinical Unit)

Occupational class code: Post reports to:

Location:

Date of appointment:

**JOB PURPOSE**

To strengthen paediatric and health services at district and community levels through supportive supervision and clinical governance in order to promote the wellbeing of the population within the geographical catchment area of a regional hospital.

**KEY PERFORMANCE AREAS**

A: GENERAL

- Represent paediatric specialist discipline as a member of a District Clinical Specialist Team responsible for the delivery of quality health care for mothers, babies and children at all levels within a health district.
- Promote equitable distribution of resources and access to an appropriate level of care for all mothers, babies and children throughout the district.
- Maintain personal competency as a paediatrician by spending 10 to 20% of time on continuing professional education and clinical care at the regional or tertiary hospital.
- Spend at least 80% of time on supporting the improvement of paediatric services within the district.

B: SUPPORT SERVICE DELIVERY

- Support neonatal, child and youth health service delivery in the district.
- Primarily support district hospitals with all aspects of service delivery related to paediatrics and child health.
- Secondarily support clinics, community health centres and primary health care outreach teams, including engaging private sector paediatricians with service delivery related to paediatrics and child health.
- Promote clinical effectiveness in all facilities through supporting outreach programmes and development, dissemination or implementation of clinical protocols and standard treatment guidelines aligned with national norms and standards:

C: PROVIDE EDUCATION AND TRAINING

- Facilitate and participate in the development, training and mentorship of health professionals in all facilities within the district.
- Facilitate and participate in the training, development and mentorship of undergraduate and postgraduate medical, nursing and allied health professionals. This may require involvement with local academic training institutions.

D: SUPPORT HEALTH SYSTEMS AND LOGISTICS

- Work with the District Management Team to establish and maintain systems including surveillance, health information, communication and referral guidelines and processes to support the delivery of paediatric and child health services.
- Provide support to ensure appropriate infrastructure, equipment, resources and sundries for the provision of quality clinical care in paediatrics and child health.
E: MONITOR AND EVALUATE SERVICES

- Initiate, support and participate in risk management activities for patients (e.g. critical event analysis, morbidity and mortality meetings), practitioners (e.g. infection control) and the organization (e.g. performance reviews).
- Initiate, support and participate in clinical audit and quality improvement cycles with specific focus on paediatric and child health assessments.
- Implement effective monitoring and evaluation processes, effective use of data and appropriate reporting on outputs and health outcomes.
- Initiate, support or participate in relevant research. This may require involvement with local academic training institutions.

F: COLLABORATE, COMMUNICATE AND REPORT EFFECTIVELY

- Foster effective teamwork and collaboration within the DCST.
- Enable engagement with the local community, relevant non-government organisations and private providers.
- Facilitate and ensure effective communication with all management structures within the district, the regional and tertiary hospitals as relevant as well as the provincial Department of Health.
- Present regular reports on activities, health services and programmes.
- Participate in provincial and national activities and initiatives to save mothers, babies and children.

G: SUPPORT ORGANISATIONAL ACTIVITIES

- Assist with strategic and operational planning of services in the district and/or catchment area of the regional hospital.
- Assist with the coordination and supervision of paediatric and child health services within the district.
- Assist with the recruitment and management of relevant human resources.

**ORGANISATIONAL STRUCTURE**

- Provincial Specialist (Paediatrics)
- District Manager
- Paediatrician (DCST)
- Advanced Paediatric Nursing Professional in DCST
- Other specialists in DCST

**Notes:**

DCST members have a dual reporting line to discipline specific provincial specialists as well as district managers.

Provincial specialists are responsible to address issues around equity within the province; provide mentorship, support and on-going development of district specialists and provide capacity solutions for incomplete DCSTs.

District managers are responsible to direct the functions, budget and operations of DCSTs in accordance with agreed strategic and operational plans.

**APPOINTMENT REQUIREMENTS OF THE JOB**

Appropriate specialist qualification that allows registration with the Health Professions Council of South Africa (HPCSA) as a Paediatrician plus at least 5 years experience after obtaining qualification.
COMPETENCIES REQUIRED
Sound knowledge of the following:
- Own clinical discipline
- Medical ethics
- Programme planning, implementation and evaluation
- Information management programmes
- Epidemiology and statistics
- Quality assurance and improvement programmes
- Human resources and financial management
- Health and Public Service legislation, regulations and policy

Demonstrated skills in the following areas:
- Leadership
- Communication
- Teaching, mentorship and coaching
- Problem solving
- Functioning in a multi-disciplinary team
- Computer literacy

Behavioural attributes reflecting the following:
- Stress tolerance
- Self confidence
- Objectivity
- Ethical
- Empathic

CAREER PATHING

AMENDMENTS TO JOB DESCRIPTION
The Head of Department of his/ her nominee reserves the right to make changes and alterations to this job description, as he/ she may deem reasonable, after due consultation with the post holder.

JOB DESCRIPTION AGREEMENT
A separate job description will need to be signed off by each job holder to whom the job description applies.

Signature of post holder: ______________________________ Date: ________________
Signature of direct manager: _________________________ Date: ________________
Signature of head of department/ division: ______________ Date: ________________
DISTRICT CLINICAL SPECIALIST TEAM (DCST)  
JOB DESCRIPTION:  
ADVANCED PRIMARY HEALTHCARE NURSING PROFESSIONAL  

JOB INFORMATION SUMMARY  
Name of job holder:  
Job title: Advanced Primary Healthcare Nursing Professional  
CORE code:  
Post level and salary code: OSD (Nursing Manager)  
Occupational class code:  
Name of component:  
Location:  
Post reports to:  
Date of appointment:  

JOB PURPOSE  
To strengthen district and community level health services by means of supportive supervision and clinical governance in order to promote the wellbeing of the population within the geographical catchment area of a regional hospital.  

KEY PERFORMANCE AREAS  
A: GENERAL  
• Represent primary health care nursing as a member of a District Clinical Specialist Team (DCST) responsible for the delivery of quality health care for mothers, babies and children at all levels within a health district.  
• Promote equitable distribution of resources and access to an appropriate level of care for all mothers, babies and children throughout the district.  
• Maintain personal competency in primary health care nursing.  

B: SUPPORT SERVICE DELIVERY  
• Primarily support clinics and community health centres with all aspects of service delivery related to primary health care nursing.  
• Secondarily support district hospitals with primary health care service delivery.  
• Promote clinical effectiveness in all facilities through supporting outreach programmes and development, dissemination and implementation of clinical and nursing protocols and standard treatment guidelines aligned with national norms and standards.  

C: PROVIDE EDUCATION AND TRAINING  
• Facilitate and participate in the development, training and mentorship of health professionals in all facilities within the district.  
• Facilitate and participate in the training, development and mentorship of nursing and allied health professionals and community health workers.  

D: SUPPORT HEALTH SYSTEMS AND LOGISTICS  
• Work with the District Management Team to establish and maintain systems including surveillance, health information, communication and referral guidelines and processes to support the delivery of services.  
• Provide support to ensure appropriate infrastructure, equipment, resources and sundries for the provision of quality nursing care.  

E: MONITOR AND EVALUATE SERVICES  
• Assist, support and participate in risk management activities for patients (e.g. critical event analysis, morbidity and mortality meetings), practitioners (e.g. infection control) and the organization (e.g. performance reviews).
• Assist, support and participate in clinical audit and quality improvement cycles in health facilities and, where appropriate, in community settings such as schools and ward based primary health care teams.
• Implement effective monitoring and evaluation processes, effective use of data and appropriate reporting on outputs and health outcomes.
• Assist, support and participate in relevant research.

F: COLLABORATE, COMMUNICATE AND REPORT EFFECTIVELY
• Foster effective teamwork and collaboration within the DCST and with other professionals in the district involved in the delivery of primary health care.
• Enable engagement with the local community and relevant non-government organisations and private providers, promoting adherence to district clinical public health guidance as appropriate.
• Facilitate and ensure effective communication with all management structures within the district, the regional and tertiary hospitals as relevant as well as the provincial Department of Health.
• Present regular reports on activities, health services and programmes.

G: SUPPORT ORGANISATIONAL ACTIVITIES
• Assist with strategic and operational planning of services in the district and/or catchment area of the regional hospital.
• Coordinate and supervise discipline related services within the district.
• Assist with the recruitment and management of relevant human resources.

ORGANISATIONAL STRUCTURE

Notes:
DCST members have a dual reporting line to discipline specific provincial specialists as well as district managers. Provincial specialists are responsible to address issues around equity within the province; provide mentorship, support and on-going development of district specialists and provide capacity solutions for incomplete DCSTs. District managers are responsible to direct the functions, budget and operations of DCSTs in accordance with agreed strategic and operational plans.

APPOINTMENT REQUIREMENTS OF THE JOB
A basic qualification (i.e. diploma/degree in nursing) or equivalent qualification that allows registration with the South African Nursing Council (SANC) as a Professional Nurse; plus a post basic nursing qualification with a duration of at least 1 year accredited with the SANC in Clinical Assessment, Treatment and Care (CATC); plus a minimum of 10 years appropriate/recognisable experience in nursing after registration as Professional Nurse with the SANC in General Nursing. At least 6 years of the period referred to above must be appropriate/recognisable experience in the specific specialty after obtaining the 1-year post-basic qualification. At least 4 years of the period referred to above must be appropriate/recognisable experience at management level.
(Please note: Appropriate/recognisable experience in the context of these requirements also includes experience gained after registration in the particular discipline in a foreign country, and which registration is recognised by the SANC for registration in the particular discipline).
COMPETENCIES REQUIRED

Sound knowledge of the following:

- Ethical nursing practices
- Programme planning, implementation and evaluation
- Clinical governance
- Information management programmes
- Human resources and financial management
- Health and Public Service legislation, regulations and policy

Demonstrated skills in the following areas:

- Leadership
- Communication
- Problem solving
- Functioning in a multi-disciplinary team
- Teaching, mentorship and coaching
- Diversity management
- Basic computer literacy

Behavioural attributes reflecting the following:

- Stress tolerance
- Self confidence
- Objectivity
- Ethical
- Empathic
- Quality oriented

CAREER PATHING

AMENDMENTS TO JOB DESCRIPTION

The Head of Department of his/ her nominee reserves the right to make changes and alterations to this job description, as he/ she may deem reasonable, after due consultation with the post holder.

JOB DESCRIPTION AGREEMENT

A separate job description will need to be signed off by each job holder to whom the job description applies.

Signature of post holder: ____________________________ Date: __________________

Signature of direct manager: ____________________________ Date: __________________

Signature of head of department/ division: ____________________________ Date: __________________
12.9. DCST Selection Process Guidelines

The following are the guidelines for the completion of the process of the screening, short listing, verification and interview processes for appointment of the qualifying applicants to the DCSTs.

**PROJECT PLAN FOR SHORT-LISTING AND INTERVIEW OF NURSES APPLICATIONS**

<table>
<thead>
<tr>
<th>Task</th>
<th>Process</th>
<th>Responsible Person</th>
<th>Process Period</th>
<th>Sign-off date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Draw up a check-list form for short-listing</td>
<td>The check-list will assist in identifying eligible candidates who meet the requirements</td>
<td>V Khanyile</td>
<td>13 Dec 2011</td>
<td></td>
</tr>
<tr>
<td>Approve check-list form for short-listing</td>
<td>The check-list must be approved by the DDG: Dr Y Pillay and the delegated member of the MTT (Dr K Jacobs)</td>
<td>Dr Y Pillay</td>
<td>15 Dec 2011</td>
<td></td>
</tr>
<tr>
<td>Request provinces for Assistance on the Short-list process</td>
<td>Write a request to the provinces asking for employees to assist with the first short list process (i.e. employees to assist for the period 9/01/2012-13/01/2012)Provinces to provide names not later than 14/ December 2011</td>
<td>H Groenewald</td>
<td>15 Dec 2011</td>
<td></td>
</tr>
<tr>
<td>Logistics for Assisting personnel</td>
<td>Flight arrangements, accommodation and S&amp;T for assisting employees will be sorted by the NDoH where Provinces cannot cover the expenditure</td>
<td>H Groenewald</td>
<td>5 Jan 2012</td>
<td></td>
</tr>
<tr>
<td>First Short-List process</td>
<td>Completing the check-list form and identifying applicants meeting the requirements</td>
<td>Assisting Personnel from Provinces</td>
<td>9-13 Jan 2012</td>
<td></td>
</tr>
<tr>
<td>Coordinate the finalized documents</td>
<td>The identified applicants placed in a list per province and district as applied for.</td>
<td>H Groenewald</td>
<td>16-18 Jan 2012</td>
<td></td>
</tr>
<tr>
<td>Approval of the final list of candidates for interviews</td>
<td>The team appointed by the DG in terms of the letter dated 24/11/2011 approves and signs-off the completed list</td>
<td>Team identified by DG</td>
<td>19 -20 Jan 2012</td>
<td></td>
</tr>
<tr>
<td>Preparation for interviews</td>
<td>The documents are referred to the relevant HOD</td>
<td>Dr Y Pillay</td>
<td>24 Jan 2012</td>
<td></td>
</tr>
<tr>
<td>Constitution of the interviewing panel</td>
<td>The province constitutes a panel for interviews</td>
<td>HOD</td>
<td>26 Jan 2012</td>
<td></td>
</tr>
<tr>
<td>Invitation for interviews</td>
<td>The province invites the applicants for interviews</td>
<td>HOD</td>
<td>30 Jan 2012</td>
<td></td>
</tr>
<tr>
<td>Interviews</td>
<td>Interviews are held</td>
<td>HOD</td>
<td>6-17 Feb 2012</td>
<td></td>
</tr>
<tr>
<td>Task</td>
<td>Process</td>
<td>Responsible Person</td>
<td>Process Period</td>
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<tr>
<td>Submission to approve preferred candidates</td>
<td>The Provincial HR Division compiles the submission for appointments and letters</td>
<td>HOD</td>
<td>22 Feb 2012</td>
<td></td>
</tr>
<tr>
<td>Issue letter of appointments</td>
<td>The province issues the letter of appointment to a preferred candidate by the Provincial HR Division</td>
<td>HOD</td>
<td>27 Feb 2012</td>
<td></td>
</tr>
<tr>
<td>Serving of notice</td>
<td>Preferred candidate serves notice for the March 2012 month</td>
<td>Preferred Candidates</td>
<td>March 2012</td>
<td></td>
</tr>
<tr>
<td>Commencement of appointment</td>
<td>Candidates assumes duty at the respective district on 1 April 2012</td>
<td>Preferred Candidates</td>
<td>1 April 2012</td>
<td></td>
</tr>
<tr>
<td>Task</td>
<td>Process</td>
<td>Responsible Person</td>
<td>Process Period</td>
<td>Sign-off date</td>
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<tr>
<td>Draw up a check-list form for short-listing</td>
<td>The check-list will assist in identifying eligible candidates who meet the requirements</td>
<td>Dr Kenny Jacobs</td>
<td>13 Dec 2011</td>
<td></td>
</tr>
<tr>
<td>Approve check-list form for short-listing</td>
<td>The check-list must be approved by the DDG: Dr Y Pillay and the delegated member of the MTT (Dr K Jacobs)</td>
<td>Dr Y Pillay and Dr Kenny Jacobs</td>
<td>15 Dec 2011</td>
<td></td>
</tr>
<tr>
<td>First Short-List process</td>
<td>Completing the check-list form and identifying applicants meeting the requirements</td>
<td>NdoH – Prof E Mhlanga, Dr L Bamford, Dr N ......, Prof J Moodley, Dr K Jacobs</td>
<td>21-22 Dec 2011</td>
<td></td>
</tr>
<tr>
<td>Coordinate the finalized documents</td>
<td>The identified applicants placed in a list per province and district as applied for.</td>
<td>H Groenewald, V Khanyile and Dr K Jacobs</td>
<td>10-12 Jan 2012</td>
<td></td>
</tr>
<tr>
<td>Approval of the final list of candidates for interviews</td>
<td>The team appointed by the DG in terms of the letter dated 24/11/2011 approves and signs-off the completed list</td>
<td>Team identified by DG</td>
<td>19-20 Jan 2012</td>
<td></td>
</tr>
<tr>
<td>Preparation for interviews</td>
<td>The documents are referred to the DG</td>
<td>Dr Y Pillay</td>
<td>24 Jan 2012</td>
<td></td>
</tr>
<tr>
<td>Constitution of the interviewing panel</td>
<td>National and the MTT constitutes a panel for interviews</td>
<td>DG</td>
<td>26 Jan 2012</td>
<td></td>
</tr>
<tr>
<td>Invitation for interviews</td>
<td>The applicants are invited for interviews</td>
<td>NDoH</td>
<td>30 Jan 2012</td>
<td></td>
</tr>
<tr>
<td>Interviews</td>
<td>Interviews are held</td>
<td>Panel</td>
<td>6-17 Feb 2012</td>
<td></td>
</tr>
<tr>
<td>Submission to approve preferred candidates</td>
<td>The National HR Division compiles the submission for appointments and letters</td>
<td>Head of HR</td>
<td>22 Feb 2012</td>
<td></td>
</tr>
<tr>
<td>Issue letter of appointments</td>
<td>The province issues the letter of appointment to a preferred candidate by the Provincial HR Division</td>
<td>HOD</td>
<td>27 Feb 2012</td>
<td></td>
</tr>
<tr>
<td>Serving of notice</td>
<td>Preferred candidate serves notice for the March 2012 month</td>
<td>Preferred Candidates</td>
<td>March 2012</td>
<td></td>
</tr>
<tr>
<td>Commencement of appointment</td>
<td>Candidates assumes duty at the respective district on 1 April 2012</td>
<td>Preferred Candidates</td>
<td>1 April 2012</td>
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12.10. DCS Induction and Orientation Guidelines

Identification and circumstances of the participants

Induction refers to the initial introduction of the members of the DCSTs to their new roles and orientation to the longer term training and retraining on aspects of the key performance areas.

GANTT Chart of activities in the induction and orientation programme

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<td>District-based work by DCSTs</td>
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<td>Clinical orientation workshops</td>
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<td>Leadership, Mx and OD workshops</td>
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<td>On-site support visits</td>
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</tbody>
</table>

Method of delivery

- Face-to-face workshop-based
- Electronic on-line learning
- On-site mentoring and coaching

Structure of a typical workshop day

A typical workshop day will comprise three-2-hour sessions, as illustrated below. It would be best if participants arrived at the workshop venue the day before, enabling an early start on the first day. Departure time on the last day of the workshop could be at 15h00, enabling sufficient daylight time to travel home.

08h00 Arrival
08h30-10h30 Session 1
10h30-11h00 Tea
11h00-13h00 Session 2
13h00-14h00 Lunch
14h00-16h00 Session 3
16h00-17h00 Reflection and Closure

Teaching and learning approaches to be used in the Induction and Orientation Programme

- Lecture-based, to introduce a topic
- Problem-based, including structured exercises and actual problems arising from the sites
- Experiential, in on on-site experiences
- Self-directed, individual and group learning
- Self and team reflection (action learning)
## Proposed curriculum

See following pages

### Key

<p>| | |</p>
<table>
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<td><strong>Rationale for District Clinical Specialist Teams</strong></td>
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|       | District Context | ▪ Department of Health Organogram  
▪ General background information on district  
  o Demographic profile  
  o Socio-economic profile  
  o Health and disease profile  
  o Health services available  
▪ District Health Management Team (names and contact details)  
▪ Hospital Management structures (names and contact details) | Handout with links to various websites  
Manual for situation analysis | Hands on, computer based session to develop a District Portfolio – with access to internet and intranet.  
DCSTs to be provided with a series of links they can follow to obtain specific information about their district. |
|       | Service priorities | ▪ Programme specific strategic priorities  
▪ Programme specific packages of care  
▪ Norms and standards | DOH planning documents  
Packages of care | Team exercise to review priorities and identify how they would check that priorities are being addressed in their district. |
| Day 3 | Situation analysis | ▪ Introduction to evaluation research  
▪ Conceptual framework for situation analysis  
▪ Indicators to be measured in Situation Analysis | Hand-outs on indicators, uses and definitions  
  ○ Health indicators: Outcomes; Quality of care; Facility functioning; Service availability and accessibility.  
  ○ Indicators of organisational functioning: Management efficiency; System effectiveness; leadership effectiveness  
  ○ Health worker satisfaction  
  ○ Patient satisfaction | Exercise to develop indicators.  
Critical analysis of indicators that have been developed.  
Comparison of indicators developed with those recorded in the manual for the situation analysis. |
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<th>Resource material</th>
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| **Day 3** | Information systems | ▪ Sources of data  
  o Surveillance systems  
  o Electronic (e.g. DHIS, PPIP, ChPIP); paper-based (e.g. facility registers); patient held (patient records)  
  o Community data (e.g. CoMMiC)  
 ▪ Information management at district level (data collection, capture, flow, feedback)  
 ▪ Analysing the quality of available data | Representatives from Provincial Epi Unit and Information Technology Unit  
 District Information Officers  
 Samples of registers and patient held records | ▪ Presentation on information systems and information management in the Districts and the Province  
 ▪ Hands on computer session to explore the electronic information systems |
| Preparing for the Situation Analysis | | ▪ Organising/coordinating the Situation Analysis  
 ▪ Collecting data during the Situation Analysis  
 ▪ Capturing the data  
 ▪ Collating the data  
 ▪ Checking data quality | Manual for conducting the situation analysis | ▪ Team planning exercise to implement the situation analysis |
| **Day 4** | DCST Vision and values | ▪ Establishing vision and values by the DCST for their own team | Still to be determined | Team exercise with Discussion |
| | Understanding self within the team | ▪ Individual strengths/weaknesses  
 ▪ Resources available within the team | Still to be determined | Team exercise with discussion |
| | Revisit team roles and responsibilities | ▪ Preferred team roles  
 ▪ Distributed leadership responsibilities  
 ▪ Identifying a team coordinator | Still to be determined | Team exercise with discussion |
| **Day 5** | Strategies for entry into District | Still to be determined | Still to be determined | Still to be determined |
| | Overview of induction and orientation | ▪ Purpose and overall structure and organisation of Induction and Orientation Programme  
 ▪ Time schedule/deadlines  
 ▪ Tasks to be completed before next workshop | Still to be developed | Still to be determined |
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| Week 2-7 | Situation analysis                   | ▪ Each DCST to conduct a situation analysis of all Level 1 Hospitals, Community Health Centres and clinic-based services in their district.  
▪ Collect and capture data  
▪ Check the quality of the data                                                             | Manual developed for the purpose of capturing information required for the baseline assessment. | Team pairs to work together |
| Week 8 Day 1 | Data analysis                      | ▪ Analysing data collected during the Situation Analysis  
▪ Interpretation of data                                                                                                                               | Hand-outs on data analysis                                                                  | Computer-based session |
|         | Report writing                       | ▪ Determining purpose, scope, audience of reports  
▪ Structuring a report (individual reports and integrated reports)  
▪ Identifying key messages  
▪ Selecting appropriate reporting outputs  
▪ Selecting appropriate literary styles and graphic outputs                                      | Hand-outs on report writing                                                                  | Computer-based session |
| Day 2   | Planning (based on information arising from Situation Analysis) | ▪ Population-based planning  
▪ Strategic management  
▪ Programme and project planning                                                                                                                 | Hand-outs on:  
▪ Different approaches to health planning  
▪ Strategic management  
▪ Operational management  
▪ Programme planning  
▪ Project planning                                                                                                                              | Team planning exercise |
|         | Monitoring and evaluation            | ▪ Routine vs. periodic monitoring and evaluation  
▪ Basic research methodology                                                                                                                      | Hand-outs on Introduction to evaluation research design, methods and instruments          | Team exercise planning  
individual, pair and team reporting framework |
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|       |                              | ▪ Reporting framework  
▪ Reporting and accountability                                                                                                                                 |                            |                                                                                                   |
| Day 3 | Communicating strategy      | ▪ Stakeholder management  
▪ Commitment Building  
▪ Managing change  
▪ Advocacy                                                                                                                                 | Still to be determined     | Still to be determined                                                                         |
|       | Action learning              | ▪ Action learning cycle  
▪ Tasks to be completed before next workshop                                                                                                                                 | Literature on action learning teams | Discussion of on-site support visits and role action learning cycle |
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<td>Week 9-11</td>
<td>District based work</td>
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| Week 12 2 days -with joint time and discipline specific time | Clinical orientation workshop | ▪ ANC and EPOC  
▪ PMTCT  
▪ Neonatal Care and neonatal resuscitation  
▪ KMC | Packages of care  
Protocols of management  
Norms and standards  
Organisation of services | Still to be determined |
| Week 13-15                 | District based work                        |                                                                         |                                                                 |                                   |
| Week 16 Day 1             | Report-back and reflection                 | ▪ Identification of priority issues that have arisen and require resolution | Provincial and District representatives         | Still to be determined |
|                            | Clinical Governance                        | ▪ Managing clinical effectiveness  
▪ Risk management  
▪ Managing adverse events  
▪ Clinical audit processes, techniques and tools | Still to be determined | Still to be determined |
|                            | Approaches to quality management           | ▪ Process approach to quality management  
▪ Systems approach to quality management | Still to be determined | Still to be determined |
|                            | Day 2                                      | ▪ Characteristics of a learning organisation  
▪ Knowledge management | Still to be determined | Still to be determined |
|                            | Developing a learning organisation         | ▪ How adults learn  
▪ Effective facilitation of adult learning  
▪ Small group facilitation | Still to be determined | Still to be determined |
|                            | Teaching and facilitating learning amongst adult learners | ▪ Purpose of supervision  
▪ Levels of supervision  
▪ Supervision styles  
▪ Supervision methods and tools | Human resource development policies of the DOH | Still to be determined |
<p>|                            | Supportive supervision and human resource development |                                                                         |                                                                 |                                   |</p>
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<td>District based work</td>
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<td>Week 20</td>
<td>Report-back and reflection</td>
<td>- Identification of priority issues that have arisen and require resolution</td>
<td>Provincial and District representatives</td>
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<td>Leadership – ensuring efficiency</td>
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<td>Resource management</td>
<td>- Human Resource Planning and Management</td>
<td>DOH policy and regulations on human resources and financial resources</td>
<td>Still to be determined</td>
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<td>- Financial Management (including budgeting)</td>
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<td>- Drug management</td>
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<td>Supply chain management</td>
<td>- Ordering procedures</td>
<td>Still to be determined</td>
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<td>- Checking stock control procedures</td>
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<td>Basic Intrapartum Care</td>
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<td>Infant feeding/child nutrition</td>
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<td>Week 28</td>
<td>Report-back and reflection</td>
<td>- Identification of priority issues that have arisen and require resolution</td>
<td>Provincial and District representatives</td>
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<td>Theme: Community based health programmes</td>
<td>Still to be determined</td>
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<td>Week 33-35</td>
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<td>Week 36</td>
<td>Clinical orientation workshop</td>
<td>ESMOE PALS Child Abuse/Sexual assault A&amp;E GBV</td>
<td>Still to be determined</td>
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<td>District based work</td>
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<td>Week 40</td>
<td>Theme: Planning an operational research project</td>
<td>Still to be determined</td>
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<td>Week 41-43</td>
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<td>Week 44</td>
<td>Protocol presentations</td>
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12.11. DCS Team Advertisements

Placed in The Lancet and British Medical Journal, 15 October 2011

The Minister of Health, Dr. Aaron Motsoaledi, recently announced several new measures aimed at improving health services in South Africa. Among these is the introduction of Teams of District (Clinical) Specialists which will consist of various categories of medical specialists and/or experienced medical officers and advanced nurses. The teams will be responsible for strengthening district and community level health services and ensuring equitable access to appropriate and improved quality of care for mothers, newborn babies and children. The teams will be based in all health districts; some teams will have an attachment to a Regional Hospital and an Academic Centre.

**DISTRICT CLINICAL SPECIALIST (Head: Clinical Unit)**

REF. NO.: NDOH 149/2011

RENUMERATION: An all-inclusive annual package of R1,024,000.00 is offered (subject to applicable conditions/rules)
Full time, part time and sessional positions are available for the following categories of medical specialists: +Family Physicians +Obstetrician and Gynaecologists +Paediatricians +Anaesthetists.

**DISTRICT CLINICAL SPECIALIST (Head: Clinical Unit)**

REF. NO.: NDOH 150/2011

RENUMERATION: An all-inclusive annual package of R1,024,000.00 is offered (subject to applicable conditions/rules)
Annual renewable contract positions are available for the following categories of retired medical specialists/professors and academics: +Family Physicians +Obstetrician and Gynaecologists +Paediatricians +Anaesthetists.

**DISTRICT CLINICAL MEDICAL OFFICER (Clinical Manager: Medical Services)**

REF. NO.: NDOH 148/2011

RENUMERATION: An all-inclusive annual package of R695,618.00 is offered (subject to applicable conditions/rules)
Full time, part time and sessional positions are available for highly competent and experienced medical officers to be employed at the level of Clinical Manager: Medical Services as members of the District Clinical Specialist Teams.

**ADVANCED DISTRICT NURSING PROFESSIONAL**

REF. NO.: NDOH 147/2011

RENUMERATION: An all-inclusive annual package of R526,812.00 is offered (subject to applicable conditions/rules)
Full time, part time and sessional positions are available for the following categories of professional nurses who have an advanced level of expertise and qualification: +Midwife +Primary Health Care Nurse +Paediatric Nurse.

ENQUIRIES (ALL POSTS): Mr Victor Khanyile, tel. +27 12 395 8685 / 8686 / 8704.

CLOSING DATE: 14 November 2011 (Applications received after the closing date will not be considered)

For full details of the above positions (appointment requirements, competencies required, other benefits offered and key performance areas) as well as the application procedure, kindly log on to: www.ursonline.co.za