health
Department:
Health
REPUBLIC OF SOUTH AFRICA

AHP AFRICA HEALTH PLACEMENTS

Rural Health Advocacy Project

GUIDELINES TO FACILITIES AND DISTRICTS FOR USE OF THE NORTH WEST PROVINCE RECRUITMENT PRIORITISATION TOOL

1. Introduction

Following national and provincial North West roundtables on "protecting critical health posts guidelines", the National and North West Province Department of Health have initiated a process to facilitate the recruitment of priority posts to ensure that critical frontline services can still be maintained while the flexible moratoria is in place. This process has been developed through collaboration with Provincial, District and Facility stakeholders and is being supported by two NGO's: Africa Health Placements and the Rural Health Advocacy Project. This is a pilot project which will be reviewed and refined where necessary, while also informing national policy processes.

Recognizing that it is unlikely to fill all vacant posts, managers must ensure that the process of prioritizing posts is:

i. Legal, rational, proportional and evidence-based
ii. Driven by specific local needs at the facility/district level
iii. Consistent and equitable across the provincial level (see Annexure A)
iv. Flexible and adaptable as budgets change or new needs emerge
v. Transparent and fair (and perceived as such)
vi. In line with the Constitution and Government's priorities of NHI and NDP. Both policy imperatives seek to ensure universal access and equity in healthcare
vii. Quick, simple and predictable

The objectives for this process are to:

a. Maintain critical frontline health services during a time of crisis
b. Protect the most vulnerable patients who have no access to alternative health services
c. Protect hard-won progress and prevent the collapse of facilities

d. Balance the need for cost containment with the constitutional obligation to progressively realise the right to have access to health care services.

2. The Recruitment Prioritisation Process:

2.1 Preparation

Prioritization is never an easy process and while the tool attempts to guide managers, it cannot capture local implementation realities. Accordingly, before completing the tool it may be useful to consider your implementation context. Some important considerations include: the health needs of the community you serve, the impact on delivery or access to services for key populations such people living with HIV, women and children as well as vulnerable communities and how your overall staffing mix can best respond to these needs.

The recruitment prioritization process will follow the following steps by completing relevant parts of the tool:

1. Facilities will list their recruitment needs in order of priority, using the prioritization tool template.
2. Districts will review the lists submitted by their facilities using the decision-making matrix. After ensuring continued service delivery, equity and access have been protected in the best possible manner, they will then consolidate the individual lists into a single District List of priority recruitment, based on greatest need.
3. Province and district representatives will meet to review the District Lists and, using the decision-making matrix, consolidate these into a single Provincial List of priority recruitment, based on greatest need.
4. This provincial list together with the completed decision-making matrix will be submitted to Provincial Treasury who will approve as many of the posts as they are able, in order of the priority specified, depending on the available budget.
5. The Province will feed back to the Districts and Facilities the outcome of the process.
6. Facilities will be able to start to advertise and recruit based on this pre-approved recruitment list.
7. The exercise will be repeated on a regular basis as recruitment priorities evolve.

2.2 How to complete the Recruitment Prioritisation Tool

For facilities: the tool is in the form of an excel spreadsheet with the following fields. Please refer to Annexure A for more guidance on equity principles.

Prepared by	The name and position of the member of staff who prepared the list.
Date	The date when the list was prepared.
Facility	The name of the facility
Distance to referral centre	State the kilometers to the nearest referral centre (community health centre; district hospital or regional hospital) as an indication of rurality and the potential of catastrophic health expenditure if the patient cannot access the service at the appropriate level of care.
Name of District	The name of the district
Post	There are three elements to be completed for this component in the tool when identifying priority posts: **1.Priority #:** Posts should be listed in order of priority. So, the most important post should be listed and first, and so on down the list. If you are requesting more than one set of recruitment for a cadre of staff (e.g. two Grade 1 Medical Officers) then each should be listed separately, in its own row. **2. Position:** list type and grade of each post you are requesting. These should be listed in order of priority (see point 1 above) **3. Existing #:** provide number of staff you already have of the same type as the post you are requesting. Example, if you already have three Medical Officer Posts, you should write three, with their level, in this column
Funding	There are two elements to be completed for this component that must be completed when identifying the funding requirements for a requested post **1. Cost:** in the cost column fill in the total annual budgetary cost for the post based on the total cost to company per the DPSA salary scales **2. Source of funding:** in this column list where the money for this post is likely to come from. This could be general budget or conditional grant (for conditional grant provide the name of the grant e.g. HIV and AIDS conditional grant)
Justification	There are four elements that must be completed for this component in the tool when justifying why the post is important. **1. Affected service:** which service will be affected by not having this post filled according to the package of services for your facility e.g. District Hospital package of services, PHC package of services. For instance: Obstetrics will be affected by not having this midwife in place.

	2. Current indicator: list the indicator that best illustrates why this post is important to improving care e.g. if the post will affect obstetric services provide the 'in facility maternal mortality rate' **3. Extent and nature of impact on affected service:** In what way is the service affected and does it affect equity? Be specific if it concerns a reduced access to service and/or whether it will require patients to seek care at another institution. For instance: women in labour will have to be transferred to the referral centre by EMS; Outreach service stops completely and child with CP will not be able to access care; clinic will likely close on certain days as too few remaining nurses need to take leave or are off-sick. **4. Impact on other services:** What other services are being impacted (it might be indirectly) by not having this staff member in place. Linked to the National Core Standards and accepted package of services for your facility e.g. District Hospital Package of services, PHC package of services. For instance, all services are affected if there is no procurement officer in the hospital; or cleaner in the clinic.

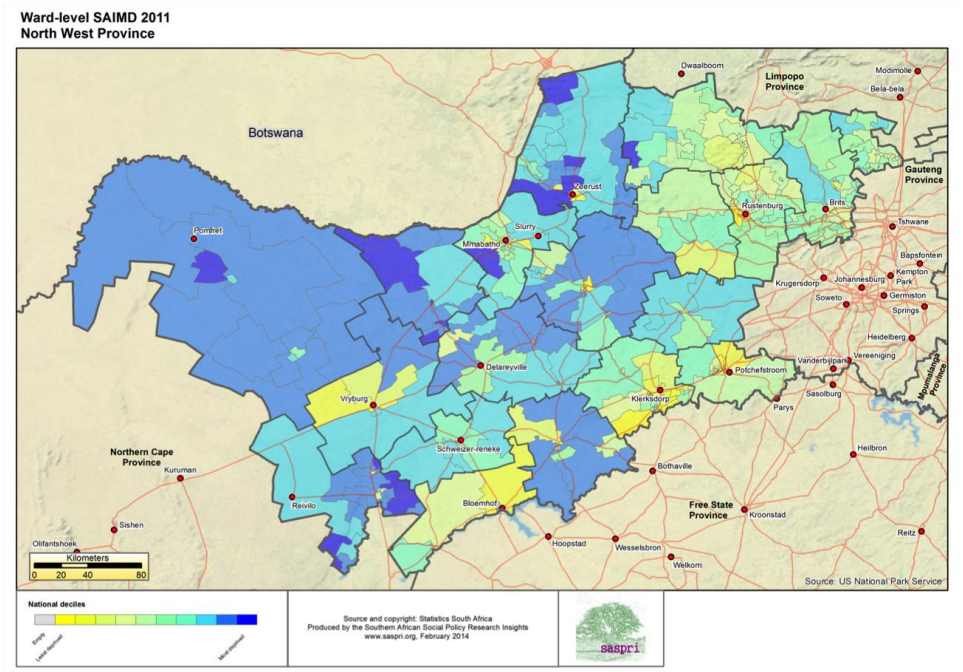
For districts and provinces only: a decision-making matrix has been included in the excel spreadsheet. Please refer to Annexure A for guidance on protecting equity in priority-setting processes.

Decision-making Matrix	For each post under consideration there are three questions that should be answered. Each question should be answered by indicating the post's relative importance in sustaining or improving services by indicating if it is Very High, High, Medium, Low, or Very Low **1.Clinical Consequences (mortality/morbidity)**: indicate the relative importance of this post in preventing mortality/morbidity such as TB-defaulting or preventable disability. **2.Rural Location / no alternative services:** indicate the relative importance of the post in terms of the lack of alternatives for patients. For example, if there are no alternatives nearby then its importance should be given as very high, if there are some alternatives at other facilities near by then indicate medium and if services are unlikely to be compromised then indicate low **3.Vulnerable patient group/ Poor or marginalized:** indicate if the relative importance of the post in terms of the community it is likely to benefit. If, for example, it is a deprived rural community with no alternatives then indicate very high but if it is a relatively wealth urban community with alternatives then indicate low priority
Feedback on Prioritization Decision	For this element consider each post in terms of the questions asked in the decision-making matrix and explain the most important considerations used when indicating the relative importance of

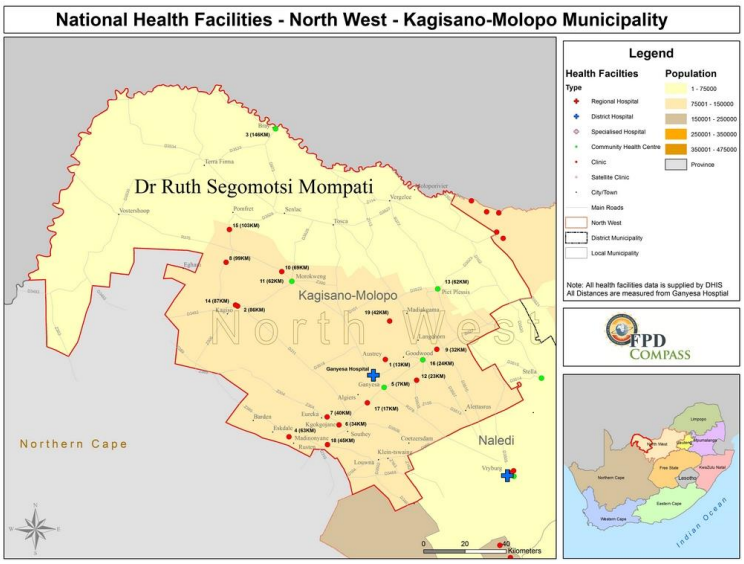
	that post. E.g. the post is very important because it will have a high impact on morbidity, there are no alternative services nearby and the people most affected are poor rural patients
District Priority	In this column indicate the priority of the post for the district by giving it a ranking where 1 is the most important
District and Facility (for provinces consolidated lists)	In the final two columns indicate in which district and facility the post is located

Annexure A: Equity Considerations for priority-setting

South Africa has committed itself to the goals of the National Health Insurance and the National Development Plan, each of which seek to reduce the entrenched inequities in the health system and society at large. Ensuring that everyone accesses health care based **on need** and not socio-economic conditions such as based on ability to pay and geographical location is an important imperative. The persistent inequities facing South Africa's provinces have historical roots and are highest in the former homelands. This also applies to North West Province and is illustrated in the map below:



This multi-level ward-based deprivation map (SASPRI, 2011) shows that the most deprived district is Dr RSM District, where distances to facilities are also the highest. Dark blue is most deprived and yellow is least deprived. Multi-level Ward-based Deprivation includes the four dimensions of material deprivation, employment deprivation, education deprivation and living environment deprivation. Other districts also have pockets of high levels of deprivation, this is referred to as intra-district deprivation. What is known is that unmet need is higher in areas where communities face access barriers such as catastrophic health expenditures. Other considerations to look at is the % insured population and presence of private sector facilities in a district, which point at lower public demand on services as well as access to alternative points of care. To the contrary, a district with a disproportionately high uninsured population and little to no private sector facilities, point at a high level of reliance on the public health system. This is illustrated in the following map of Kagisano-Malopo District in Dr RSM District:



This map shows the distances from clinics and community health centres to the one single public hospital in the Sub-District. There is no private sector hospital and in the sub-district there are few GPs; who are based in the town of Ganyesa. The map shows that some communities live as far as between 80 and 150 kilometres from the nearest hospital. We also see a very thin spread of clinics in the upper region of the sub-district. To make access even more difficult, there is little to no public transport in this region. Patients, many from poor farming communities, needing to access the clinic or hospital wait alongside the roads for a full day without success. As with many remote rural hospitals, the local hospital finds it difficult to recruit

Access constraints are further compounded for people with disabilities, a category prioritized in the NHI district preparations and hence an important consideration for all districts. According to StatsSA (2011), 10% of the population in NW have a disability, amounting to a total of 253 963. Under 10's and over 50's are most affected. A common mistake made in health planning is to base decisions solely on population density and utilisation rates and to plan on the basis of economies of scale. This would disadvantaged communities in a highly deprived sub-district as Kagisano-Malopo. To illustrate the point, the following scenario is provided:

The PAJA principle of proportionaility and decision-making explained:

- There is funding to fill one nursing post in a district. Management need to decide whether to:
- Rationalise 1 nurse post in a small clinic (1) currently only staffed by one nurse due to a recent resignation and which is serving a farming area in a deeply rural area in the district. The catchment population is small, but farm workers have no alternatives of care, distances are large and even public transport to the clinic is scarce and expensive. The nearest alternative clinic is 50 kms away.
- Rationalisation 1 nurse post in clinic in an urban area of the district (2) which has 4 nurses and serves a large population. The nearest alternative clinic is 8 kms away.
- Based on utilisation rates, one might decide to **rationalise** the post in clinic 1
- However, based on access and equity, one would **prioritize** clinic 1 as if this clinic is at risk of collapse with only two nurses in place.

Budget constraints

South Africa as many countries worldwide is faced with budgetary constraints in realizing the right to health with immediate effect. South Africa's Constitution promises a progressive realization of this right, while the Promotion of Administrative Justice Act stipulates that decision-making on scarce resources must be informed by a rational process, based on evidence and which is proportional. The WHO has released a document assisting governments in making such choices, named Making Fair Choices on the Path to Universal Health Coverage (2015). The WHO states that, when making decisions on resource prioritization and expansion of services, services can be usefully categorized into three classes: high-priority, medium-priority, and low-priority services. Relevant criteria for ranking and categorizing services include those related to cost-effectiveness, priority to the worse off, and financial risk protection.

A three-part strategy is recommended in seeking fair, progressive realization of access to health care for all. WHO recommends categorising services into priority classes: cost-effectiveness, priority to the worse off, and financial risk protection. In the expansion (and protection) of services, WHO calls for countries to first primarily first expand coverage for low-income groups, rural populations, and other groups disadvantaged in terms f service coverage, health, or both. This is especially important for high-priority services as defined by government policy and local population data.

Read more about priority-setting in the context of a South African National Health Insurance promoting health for all:

- World Health Organisation (2014): 'Making fair choices on the path to universal health coverage. Final report of the WHO Consultative Group on Equity and Universal Health Coverage'.
- Norheim, O. 'Ethical Perspective: Five Unacceptable Trade-offs on the Path to Universal Health Coverage', in International Journal of Health Policy and Management. 2015 Nov; 4(11): 711–714.

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