A Report of a Situational Analysis of Nine Regional Training Centres in South Africa, 2013

Approval was granted by the National Department of Health for I-TECH South Africa to conduct a situational analysis in the nine regional training centres. The report was prepared by I-TECH South Africa and presented to the National Department of Health, South Africa

ACKNOWLEDGEMENTS

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Funding

This situational analysis was conducted by the University of Washington and I-TECH with funding from the US Department of Health and Human Services, Health Resources and Services Administration (HRSA), Cooperative Agreement U91HA06801. The contents of the report are those of the authors and do not represent the views of HRSA or the US Government.

Acknowledgements

The authors acknowledge the leadership of Anthony Ambrose, Program Manager for Health Systems Strengthening who managed the fieldwork for the situational analysis. Additionally, we would like to acknowledge the contribution of Wilfred Bengnwi, Program Manager for Health Systems Strengthening, to the data analysis and the findings section of the report.

The data collection team were (in alphabetical order) Abigail Mgimeti, Anthony Ambrose; Claudia Shilumani, Lerato Radebe, Masego Seupe, Rodwell Shamu, Sharlene Govender, Vusisizwe Hlabano, Wilfred Bengnwi and Zingisa Nodada.

We are grateful to Marcia Weaver, Jay Gilvydis and Albert Bakor who reviewed the initial draft of the report. Special thanks go to Nathan Linsk who reviewed the final draft report for language and provided valuable input on content. Most importantly, we thank all RTC Managers, key officials from National and Provincial Departments of Health, Training Managers and Coordinators and front line health care professionals for participating in stakeholder meetings and for agreeing to be interviewed.

FOREWORD

This report is timely, and coincides with I-TECH's renewed commitment to support the South African government in strengthening national health systems to ensure delivery of high quality, sustainable health care services. To achieve this, South Africa requires a health workforce that is constantly updated with new skills as new evidence and approaches to prevent and manage diseases become available. The regional training centres are at the centre of efforts to prepare the existing health workforce to deliver on the current and newly introduced health initiatives such as primary health care engineering and the national health insurance.

The report is a result of collaborative efforts between the Departments of Health at the National and Provincial levels and I-TECH South Africa. In July 2012, the National Department of Health approved a concept paper by I-TECH to conduct a situational analysis in the nine regional training centres throughout the country and provide recommendations on actions that could improve their capacity to deliver high quality in-service training and capacity building for health professionals. Subsequently, the National Department of Health secured cooperation from the nine Provincial Departments of Health, an effort that proved very valuable as it allowed access to key government officials, the regional training centre premises and records for review.

While a large part of this report is based on data collected during fieldwork that was conducted over a period of 3 months in the provinces, the report also draws on notes from other events. Prior to conducting the situational analysis, I-TECH South Africa conducted provincial entry meetings followed by stakeholder meetings in all nine provinces, and discussions from these meetings helped interpret the findings from the fieldwork. Also, during October 2012, I-TECH South Africa funded a delegation of four Government officials to undertake a study tour to the United Stated of America (USA) to benchmark and learn lessons from the US' AIDS Education and Training Centre model. A report from the study tour contains recommendations that complement recommendations presented in this report.

I-TECH South Africa would like to express sincere gratitude to the National Department of Health for allowing the situational analysis to be conducted in the country. We are also grateful to the Provincial Departments of Health for allowing us access to provincial structures and for taking the time to clarify and validate findings during the provincial

feedback meetings that followed fieldwork. I-TECH South Africa presents this report to the National Department and avails itself to explain any of the findings and recommendations contained in this report as requested.

This report is not meant to capture all activities that are currently implemented at all the nine RTCs. Examples from selected RTCs are used to demonstrate findings. Provincial summary reports will be prepared for each province to help guide the development of province-specific action plans. I-TECH remains committed to providing technical assistance to the Departments of Health in efforts to implement the recommendations contained in this report.

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ACRONYMS

AETC	AIDS Education and Training Centre
ATICC	AIDS Training, Information and Counselling Centre
BOD	Burden of Disease
CDC	Centre for Disease Control (US)
CCMT	Comprehensive Care, Management and Treatment in South Africa (HIV and AIDS)
CPD	Continuing Professional Development
DG	Director General (of Health)
DHS	District Health System
DORA	Division of Revenue Act
ECRTC	Eastern Cape Regional Training Centre
FGD	Focus Group Discussion
FPD	Foundation for Professional Development
HAST	HIV, AIDS, STI & TB
HPTD	Health Professions Training and Development
HRD	Human Resources Development
HRH	Human Resources for Health
HRSA	Health Resources and Services Administration
HSRC	Human Sciences Research Council
HSS	Health Systems Strengthening
iCAM	Interactive Learning Communication and Management
IMCI	Integrated Management of Childhood Illnesses
IT	Information Technology
I-TECH	International Training and Education Centre for Health
KZN	KwaZulu-Natal
KZNRTC	KwaZulu-Natal Natal Regional Training Centre
LAC	Latin America and the Caribbean
MCWH	Maternal, Child and Women's Health
M & E	Monitoring and Evaluation
MMC	Medical Male Circumcision
MTEF	Medium Term Expenditure Framework
NCD	Non-Communicable Diseases
NDOH	National Department of Health

NHI	National Health Insurance
NIMART	Nurse-Initiated and Managed Antiretroviral Treatment
NSP	National Strategic Plan (for HIV, AIDS, STI and TB)
OSD	Occupation Specific Dispensation
PDOH	Provincial Department of Health
PHC	Primary Health Care
PPL	Provincial PEPFAR Liaison
RATN	Regional AIDS Training Network
RTC	Regional Training Centre
SAG	South African Government
UKZN	University of KwaZulu-Natal
US	United States
USA	United States of America
WCDOH	Western Cape Department of Health
WSU	Walter Sisulu University
ZHRC	Zonal Health Resources Centre (Tanzania)

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EXECUTIVE SUMMARY

South Africa's burden of HIV and TB combined with limited human resources place huge demands on its health care system. The recently launched Primary Health Care re-engineering and the National Health Insurance demands a new set of skills among health care professionals. In 2003, the National Department of Health called for the establishment of RTCs as part of the Operational Plan for HIV and AIDS Comprehensive Care, Management and Treatment for South Africa, to build capacity of health care professionals and to coordinate all health care worker trainings in the provinces.

Almost ten years later, RTCs are in different stages of development and operate differently to fulfil their mandate. The National Department of Health approved and accepted I-TECH South Africa's proposal to conduct a situational analysis of the current status of RTCs across the nine provinces.

I-TECH South Africa conducted a cross-sectional situational analysis that (i) reviewed RTCs' current operating modality and evolution; (ii) assessed programmes and interventions in place; (iii) assessed systems in place to enable the RTCs to fulfil their mandate; (iv) determined good practices and challenges; and (v) provided recommendations on strategies to strengthen RTC operations.

Fieldwork was preceded by entry and stakeholder meetings that were used to further conceptualize the situational analysis. A total of 191 Government officials and a few partner representatives participated in stakeholder meetings. During fieldwork, a total of 212 participants participated in interviews and focus group discussions.

Structured questionnaires were used to interview 123 key Government officials and partners as follows: 10 RTC Managers; 24 Training Coordinators, 15 RTC trainers; 65 Program Managers from provincial Departments of Health; 6 National Department of Health officials; and 9 representatives of training partners. A total of 97 health care professionals who received trainings from the RTCs participated in focus group discussions.

After the initial draft report was completed validation meetings were held in seven of the nine provinces (all except KZN and Eastern Cape), to ensure the findings were as accurate as possible. A total of 107 individuals participated in validation meetings.

The findings based on thematic analysis are presented according to the following seven themes: RTC model; Financing and Expenditures; Infrastructure and Human Resources; Coordination, integration and support; Education and Training Approach; Distance learning; and Planning, M & E and reporting.

FINDINGS

RTC model: The need to respond to HIV and AIDS was the driving force behind the establishment of RTCs and to a great extent shaped the model of RTCs across the nine provinces. Eight of the nine RTCs are based at the Provincial Departments of Health. RTCs reported either to the HRD or the HAST units, with a 50/50 split between the two units. The Eastern Cape RTC, due to its location within a university, has dual reporting. Some RTCs have other linages to universities; however these linkages used effectively to benefit the function of the RTCs in areas where they struggle, such as accreditation of training material. Seven of the 9 RTCs do not have functioning advisory structures or another mechanism for local input into the work of the RTC.

Financing and Expenditures: Funding for RTC operations and training are largely derived from the Conditional Grant for HIV and AIDS, although key positions in most RTCs are funded by the province through the equitable share. Only the Eastern Cape RTC has previously accessed direct funding from an external source. External support to the other RTCs is mainly through in kind donation of equipment, payment for training costs and direct purchase of small items by training partners.

Largely, RTCs reported that funds allocated funds were sufficient for the RTC to carry out its mandate although some RTCs indicated a need for additional unrestricted funds to enhance programme implementation. Lengthy processes within Provincial Departments of Health often lead to RTCs not spending their entire allocated budgets and as with the rest of the HIV and AIDS programme's unspent funds, these are often returned to the National Treasury.

Coordination, Integration and Support:
The responsibility of coordinating all training activities for health care professionals and related health workers in the provinces is still a challenge to the majority of RTCs in part due to limited human resources to coordinate and the immediate need to undertake direct training activities. In majority of RTCs, training partners still carry out training activities without the knowledge and direct collaboration with the RTCs in some provinces.

Some RTCs indicated a need for increased support from the National and Provincial Departments of Health. Support was defined as more oversight and capacity building to RTC staff to ensure they have adequate skills to carry out RTC functions.

Infrastructure and Human Resources:
Of the nine RTCs, seven have a physical structure. At a minimum, existing structures consist of training rooms and offices. Only two RTCs were found to have accommodation blocks for training participants and a limited number of RTCs has resource centres/libraries although not adequately resourced.

Staff complement varies across the nine RTCs and ranges from five in the North West RTC to 40 in the Eastern Cape RTC. Moreover, some RTCs have high vacancy rates due to qualified candidates opting not to take up positions that are not eligible for Occupation Specific Dispensation.

RTCs do not always have the necessary Information Technology and equipment to function optimally. Intermittent internet connectivity was common across majority of RTCs which leads to problems in communication as well as submitting Monitoring and Evaluation and other reports.

Education and Training Approach: While most of the educational content remains HIV related, some RTCs have taken up the expected expanded range of health related topics. The degree of standardization of curriculum and certification of courses varies among the RTCs.

Most RTCs have a mechanism in place for selecting training participants. This process involves the programme, RTC and the Human Resources Development unit. There are still instances where inappropriate participants are sent to trainings.

The majority of training sessions occurred at the district and facility levels, with only a few taking place at a centralized provincial level. During trainings, a variety of methods are used to teach which include lectures, role plays and case studies.

Trained health care professionals are given certificates at the end of training sessions. The concern is that a considerable number of training courses are not accredited; hence certificates of attendance are given as opposed to certificates of competence.

Distance Learning: Only two (2) out of the (9) provinces had distance learning programmes in place. The Free State Department of Health is implementing the Interactive Distance Communication and Management System (iCAM) and KwaZulu-Natal Department of Health is implementing a distance learning

programme in collaboration with the University of KwaZulu-Natal.

Free State RTC uses iCAM for training and for communicating with trained health care professionals throughout the province. KwaZulu-Natal RTC has recently been established and it is expected that the RTC will take advantage of the existing collaboration with the university to implement distance learning.

The Eastern Cape RTC has been developing a distance learning programme which is expected to be launched soon. Majority of RTCs expressed an interest in developing and implementing distance learning programmes to complement contact learning.

Planning, M & E and Reporting: All RTCs reported that they used a skills audit to determine training needs. A skills audit is conducted through a paper questionnaire that is sent out to facilities to be completed by health care professionals. The RTCs then determine form the returned questionnaires, the number of health care professionals (by cadre) to be offered training. This information is then used during the business planning process to determine targets for training.

Across all provinces, some form of Monitoring and Evaluation system exists at the RTCs, although provincial variations in terms of scope were noted. In KZN, the M & E system is part of a larger programme and is not managed from the RTC.

While some RTCs employ dedicated M & E staff, some M & E functioned are carried out by staff with other mentorship or training roles. M & E Reporting in most RTCs is limited to indicators linked to the Division of Revenue Act. The Eastern Cape had a reporting mechanism which included an annual report and several databases.

Many of the RTCs did not have a reliable database for training and skills data.

Conclusions & Recommendations

We found that the approach of using guidelines to govern the establishment of RTCs led to significant provincial variations. While we are cognisant of the need for provincial adaptations to suit local context, we found that Program Managers (majority in middle management) at the provincial level would prefer for some of policy to ensure that decisions related to key aspects of RTC operations are not left to discretion. Managers that are tasked with implementation are finding it difficult to progress without a policy to fall back on when decisions do not favour the RTC.

We make three key recommendations in the areas of: (i) policy; (ii) implementation; and (iii) future research.

Policy recommendation

To achieve some level of standardization on the key elements of RTCs, *we recommend that the National Department of Health develops and make into policy a model for the RTC, taking into account the need for provinces to adapt to provincial contexts within defined policy boundaries.*

The RTC model/s should be specific in the following six areas:

(i) The type of Institutional Base (Health Department, Academic Institution, hybrid or other);
(ii) The recommended locations of the RTC (Government--e.g. Provincial Health Department, Free standing structure, Government agency/trust, educational institution);
(iii) The reporting lines (line management);
(iv) the need for mechanism(s) for input by local stakeholders and partners including academic institutions are required;
(v) minimum staff requirements and levels for senior positions; and
(vi) requirements for standardized training curricula.

Implementation recommendation

To allow for provincial adaptations of some elements of the RTCs, *we recommend that the National Department of Health revises the 2003 Framework Document for establishing RTCs, to provide guidance to provinces on operationalizing the new model.*

Recommendation for future research

The first RTC to be established has been in existence for almost ten years, which is a sufficient period to review the contribution of these institutions to the improvement of health outcomes in the country. *We recommend that the National Department of Health considers working with the Provincial Departments to conduct a 10-year evaluation of the contribution of RTCs to the scale up of programme interventions, especially on the ART roll-out.*

In addition to the three key recommendations above, we make 24 additional recommendations as detailed under the Conclusions and Recommendations section and listed on table 10 (along with proposed timelines).

1. INTRODUCTION

1.1 Background

The recently launched Global Burden of Disease (BoD), Injuries and Risk Factors study confirms that HIV and AIDS are still among the leading causes of disease burden and death respectively[1]. South Africa is home to over five million people infected with HIV[2] thus carrying the majority of that burden. Moreover, the country is experiencing a potent combination of HIV and Tuberculosis (TB) with recent global reports ranking the country first and third for the two diseases respectively[2,3].

While the need to integrate HIV and TB has long been acknowledged, the need for the integration of care and treatment for HIV with that for non-communicable diseases (NCDs) at the primary care level is only beginning to get worldwide attention[4]. These developments put new and increased demands on health care systems, especially on the health care workforce. Many developing countries, including South Africa, are faced with limited health resources for health (HRH). However, South Africa is particularly more challenged due to the significant burden of disease[6].

In addition to the challenge related to health care worker quantity, new approaches to health care provision require that they have skills to successfully implement programmes. Several reports call for an increase in health care worker capacity to be part of a comprehensive development of health systems in order to increase access to health care services to populations[5,7]. Training, if managed well, is not only a means to impart new knowledge, but is increasingly seen as a retention strategy[5].

Globally, the establishment of training networks and/or centres has been seen as a strategic approach to ensure mass training of health care professionals as well as to ensure standardized and high quality training outcomes. In the USA, the AIDS Education and Training Centres (AETCs) were established in the late 1980s[8]. The AETC network is made up of 11 multi-state regional including performance sites in every state and territory as well as four national centres that provide telephone clinical consultation, evaluation coordination and coordinate curriculum resources as well as specialized support to vulnerable communities[8].

At the regional level, several kinds of training networks exist. In the Latin America and Caribbean (LAC) region for instance, the LAC Health Sector Reform initiative provides support to national health reform processes by building the capacity of key policy makers in the countries within the region to: (i) assess health care problem; and (ii) design, implement and monitor such reforms[9]. The Regional AIDS training network (RATN) is a network of training institutions in Eastern and Southern Africa coordinated through a Secretariat based at the University of Nairobi[10]. At the country level, Tanzania has a network of Zonal Health Resource Centres (ZHRCs) that are co-located with nursing training colleges and provide in-service training to health care professionals[11].

In South Africa, the need to establish training centres originated in the late 1980's when then Minister of National Health called for the establishment of the AIDS Training, Information and Counselling Centres (ATICCs)[12]. The city of Johannesburg was the first to establish an ATICC in March of 1989, followed by the establishment of four additional centres in Cape Town, Bloemfontein, Durban and Port Elizabeth later the same year (See appendix 1). With the formation of new provinces in the 1990s, ATICCs were subsequently established in major cities including Polokwane, Kimberley, Pretoria etc.

Box 1: Functions of ATICCs

- Training of people to convey the message, counsellors as well as trainers;
- Serve as a source of information for enquiries and the distribution of information material;
- Generation of information material;
- Counselling of affected cases in order to keep in touch with practice *(Care should however be taken that this does not hinder any other functions and one or two sessions per week are proposed)*;
- Research should be undertaken about the methods which should be used to convey the message to the optimum *(Monogamous relationships should be encouraged and numerous sex partners should be discouraged. For those who cannot stick to a monogamous relationship, condoms should be recommended but with the warning that they do not offer 100% protection)*; and
- Co-ordination between the centres is very important and information and experience should be exchanged and shared on a regular basis.

Source: Translated letter from DG of National Health to Cape Province, 1988/9 (Courtesy to WCDOH)

A translated letter from then Director General (DG) of National Health and Population Development (See appendix 2) to the Provinces in the late 1980's described the role of the ATICCs as: (i) to distribute information about AIDS; and (ii) to offer training to members of the health family and information officers[13].

In addition, the letter listed the functions of the ATICCs (See box 1)[13]. Embedded in the functions, was additional guidance with respect to the need to balance counselling with other services as well as the kind of messages that should be provided to the public. The responsibility for ATICCs was given to the municipalities.

There are provincial variations on the fate of ATTICS. In some provinces, ATTICs were replaced by the Regional Training Centres (RTCs), while in other provinces they became health care clinics. The Western Cape maintained the ATTIC to carry out the functions of RTC. At the time of developing the National Strategic Plan (NSP) for HIV and AIDS, 2000-2005; all the nine provinces had established an ATICC and the primary role was to ensure the availability of trained counsellors, especially lay counsellors[14].

In 2003, the National Department of Health (NDOH) developed an Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa ("the Comprehensive Plan") - a roadmap on how to care, manage and treat HIV and AIDS in the country[6]. The Comprehensive Plan prescribed an injection of additional health care professionals into the public health sector and new positions were created for doctors, professional nurses, pharmacists, dieticians and social workers[6]. These positions were largely dedicated to the HIV and AIDS programme. NDOH recognized that in order to successfully implement the Comprehensive Plan, health care professionals required a new set of skills that included knowledge of HIV, AIDS and related guidelines, among others.

1.2 Establishment of the Regional Training Centres

Box 2: Health Promotion and Quality Assurance Training Centres ("Quality Training Centres")

"Quality Training Centres within each province will coordinate HIV training activities at the provincial and local levels. These may be based in a single institution or across multiple institutions. The centres will work closely with a clinical consultant team to implement training programmes based on a standardized national curriculum, particularly during the inception of the programme. The HIV, AIDS and TB Cluster will need to assign clinical experts in HIV care to assist provincial Quality Training Centres in implementing training programmes and provider certification, as necessary."

Source: Operational Plan for HIV and AIDS Comprehensive Care, Management and Treatment in South Africa, 2003

Training became a key component of the Comprehensive Plan as large quantities of health care professionals needed to be capacitated to roll out the programme. To deliver large quantities of trainings, structures needed to be put in place, hence the Comprehensive Plan called for the establishment of Health Promotion and Quality Assurance Training Centres ("Quality Training Centres")[6], one in each province.

Initial thoughts were to name these centres Regional Training Centres, but the National Department of Health opted to name them Quality Training Centres in the Comprehensive Plan.

These centres were charged with the responsibility of providing extensive training and certification of health care professionals on an on-going basis to support implementation of the programme. The expectation was that the training would include a short intensive formal module and on-going mentoring[6]. Pre-empting the establishment of the training centres, four months before the launch of the Comprehensive Plan, a Framework Document for establishing RTCs (henceforth referred to as the Framework Document) was developed to provide guidance to provinces as they established RTCs[15].

RTCs were tasked with the responsibility of coordinating all continuing education of health care professionals provincially and to ensure that health care professionals had adequate knowledge, skills and attitudes to meet the health care demands and improve patient outcomes overall.

RTCs were to be established with strong linkages to medical schools/universities[15]. The Framework Document contained terms of reference for the RTCs. In addition to the terms of reference indicated in box 3, the framework document indicated that RTCs were expected to: (i) collect relevant guidelines on HIV and AIDS, STIs and TB from the National Department of Health and disseminate to the facilities at the districts; (ii) develop training tools for health care professionals on the implementation of newly established guidelines; (iii) ensure that guidelines from the National Department of Health are adapted to meet the needs of the province; (iv) manage the accreditation of all lay workers and to ensure minimum standards in training are met; and (v) maintain updated information on HIV and AIDS care[15].

Box 3: Terms of Reference for RTCs

- To evaluate the skills of the existing cadres of health workers;
- To determine the needs for the provision of HIV/AIDS care;
- To design and implement a curriculum for training;
- To design an on-going mentoring programme for health workers;
- To ensure accreditation of health workers;
- To ensure dissemination of relevant and appropriate information on HIV/AIDS; and
- To serve as a focal point for training and capacity building for all categories of health workers in the province

Source: Framework for establishing RTCs in SA, 2003

1.3 South Africa's Changing Health Landscape

In 2007, South Africa launched a new five year National Strategic Plan for HIV and AIDS, and STI[16]. The addition of Sexually Transmitted Infections (STIs) to the NSP increased the role of the health care professionals charged with the delivery of HIV and AIDS care services. The role of RTCs also increased as HIV and AIDS training expanded to include STIs.

During 2012, South Africa launched a new NSP for HIV and AIDS spanning 2012 to 2016 which includes both STIs and TB[17]. This plan includes HIV and TB collaboration activities. In addition, the 2012 – 2016 NSP emphasizes strengthening the implementation and advisory structures needed to plan, manage and monitor interventions to control the epidemic.

Additionally, the South African health care system is undergoing substantial transformation with the introduction of new interventions to meet the health care needs of the people. These include the Primary Health Care (PHC) re-engineering and the National Health Insurance (NHI) scheme. Moreover, the need for integration of services for HIV and AIDS with that of non-communicable diseases (NCDs) at the PHC level is on top of South Africa's health agenda. At various forums, the National Department of Health has been calling for RTCs to coordinate all trainings for health care professionals in the provinces, as opposed to just HIV and AIDS training. Other trainings that the RTCs are expected to coordinate include the integrated school health programme, family planning, Integrated Management of Childhood Illnesses (IMCI) and chronic diseases.

These new interventions and approaches to health care service delivery in South Africa require substantial capacity building of health care professionals at all levels within the health system to support the implementation and overall success for the South African Government (SAG), a task entrusted to the RTCs.

1.4 The Situational Analysis

It is nearly a decade since the National Department of Health called for the development of Quality Training Centres, later named RTCs by the National Department of Health. To date, all nine provinces have established an RTC; however, each RTC operates differently towards fulfilling their mission, depending on the context, needs and resources available in the province. With the recent introduction of new health initiatives, the RTCs will be expected to play a role to support implementation. The National Department of Health approved a request by I-TECH South Africa to conduct a situational analysis of RTC operations in all nine provinces.

The goal of the situational analysis was to gain an understanding of the current status of RTCs and provide recommendations on strategies that will strengthen the RTCs capacity to provide high quality and standardized in-service training and capacity building for health care professionals at the provincial level.

Specific objectives of the situational analysis were to: (i) review the RTCs current operating modality and evolution; (ii) review the interventions and programmes in place in each RTC; (iii) review systems in place to enable the RTCs to fulfil their mandate; (iv) document good practices and lessons learnt that could be used to develop an RTC model or models for the country; and (v) provide recommendations that will guide development of strategies to strengthen and help the RTCs coordinate and provide high quality training.

I-TECH South Africa conducted the situational analysis in the nine provinces of South Africa, interviewing RTC Managers, Training Coordinators, health care professionals that received training from the RTC as well as key Government officials from the National and Provincial Departments of Health. Several training partners that support provinces with training activities were also interviewed.

Box 4: Themes presented in the findings

- RTC model;
- Financing and Expenditures
- Infrastructure and Human Resources
- RTC Coordination, integration & communication;
- Education and Training approach;
- Distance learning;
- Planning, Monitoring, Evaluation & Reporting

Findings from the situational analysis are presented in the report according to seven themes. Under the *RTC model* theme, the focus was on the role and mandate of the RTC, how the RTC is structured (including advisory structures), its location and line management as well as its functions. With the *Financing and Expenditures* theme, the situational analysis looked at the sources of funding, including access to external and or additional sources of funding as well as the RTC's ability to spend allocated funds. Under *Infrastructure and Human Resources*, the focus was on staffing levels and physical infrastructure (including Information Technology [IT] and other equipment). The *Coordination, Integration and Support* theme focused on the RTC's role and ability to coordinate all in-service training for health care professionals and related workers in the province (including those provided by partners) and support to the RTC by the NDOH and Provincial Department of Health.

Under *Education and Training Approach*, several areas were examined including processes in place for trainee selection; training methodology; where training was conducted; accreditation and Incentives for training (especially certification); and mentorship. The situational analysis looked at *Distance Learning* as a theme due to the increased interest in exploring ways to increase access to learning for health care professionals that work and live far from training venues and the renewed call to avoid disruption of health care provision. With *Planning, Monitoring, Evaluation and Reporting,* the focus was on training needs analysis; M & E and reporting practices.

This report discusses good practices and challenges across the seven themes. Although reported findings are largely generated from interviews and focus group discussions conducted during fieldwork, data gathered from provincial entry and stakeholder meetings that preceded fieldwork as well as the report of the 2012 US AETC study tour[19] were used to substantiate findings and augment conclusions and recommendations.

1.5 Purpose of the Report

I-TECH intends to support the National Department of Health to strengthen the capacity of Regional Training Centres in the nine provinces. This report presents findings from a situational analysis that will serve as baseline for future evaluations as well as conclusions and recommendations that will help inform the development of evidence-based strategies to strengthen RTCs. This report therefore:

- Highlights priority areas which need support;
- Makes recommendations on strategies to strengthen the RTCs; and
- Proposes timeframes for implementing recommendations.

Primarily, findings from the situational analysis will help the National and Provincial Departments of Health to better understand gaps in RTC operations across all nine provinces. This is a national report. Province-specific reports will be prepared for each province with the aim of guiding province-level action planning. Additionally, I-TECH South Africa will use the findings to further collaborate with key partners and stakeholders in developing strategies to support the RTC strengthening activities.

2. METHODOLOGY

The situational analysis was led by I-TECH South Africa with oversight provided by I-TECH headquarters at the University of Washington, Seattle. It was a cross-sectional and descriptive study that used both qualitative and quantitative methods to collect data for analysis. I-TECH chose to use a combination of Key Informant Interviews, Focus Group Discussions (FGDs) and records review to gather data. The use of mixed-methods allows for triangulation of information from various sources.

The situational analysis involved several steps implemented in three phases. The first phase was the period preceding fieldwork, the second phase was the fieldwork, and the third was the period subsequent to fieldwork. I-TECH South Africa: (i) Conducted provincial entry meetings with the RTC Manager and RTC line management to explain and secure cooperation for the analysis; (ii) Developed a protocol and data collection tools; (iii) Conducted provincial stakeholder meetings involving a larger group made up of programme managers and relevant support functions; (iv) Formed two situational analysis teams and conducted training for these data collection teams; (v) Piloted the tools in one province; (vi) Rolled out fieldwork to the remaining provinces; and (vii) Conducted provincial validation meetings.

2.1 Pre-fieldwork Phase

I-TECH South Africa met with the RTC Managers, together with their line managers in all nine provinces to present I-TECH's RTC strengthening project. Provincial entry meetings provided a platform to plan for follow-up stakeholder meetings, which brought together a broad range of stakeholders from Government and partners. I-TECH South Africa developed a protocol and tools that were submitted to the Human Sciences Research Council (HSRC) for ethics clearance, and these were approved (Protocol No. REC 1/18/07/12). In total, a set of six tools were developed and for use during fieldwork. These tools included: (i) questionnaire for RTC Manager; (ii) questionnaire for Training Manager/Coordinator; (iii) questionnaire for RTC trainer; (iv) questionnaire for Government Official; (v) questionnaire for training partner; (vi) FGD guide for health care professionals that benefitted from the training.

Stakeholder meetings were more elaborate than entry meetings. A total of 191 individuals participated in stakeholder meetings. The average number of participants at a stakeholder meeting was 21 (ranging from 11 in the Western Cape to 35 in KZN). Participants at

stakeholders meeting included Programme Managers from HIV and AIDS, STI & TB (HAST); Maternal, Child and Women's Health (MCWH); Human Resources Development (HRD); Primary Health Care (PHC), Partnerships and where possible the PEPFAR Provincial Liaison (PPL). With the exception of the Western Cape provinces, all other provinces invited training partners to participate at stakeholder meetings. Stakeholder meetings set out to achieve the following:

- Get buy-in from key provincial officials on the project in its entirety;
- Set up a provincial task team to oversee subsequent program implementation
- Discuss the tools with provincial stakeholders to solicit comments and tailor questions to provincial contexts (tools were sent to provinces on average one week in advance); and
- Plan for the fieldwork, including agreement on dates.

Table 1: Number of participants in stakeholder meetings by province

Province	Eastern Cape	Northern Cape	Western Cape	GP	Limpopo	North West	KZN	Free State	MP	**TOT**
Number	11	18	11	26	20	20	35	18	32	**191**

Stakeholder meetings were very helpful in shaping the approach to the situational analysis. One major outcome of stakeholder meetings was the addition of a training partner questionnaire to the list of tools. Provinces were given on average two weeks following stakeholder meetings to provide additional comments on the tools.

Two field teams were formed and consisted of I-TECH staff members from the Health Systems Strengthening (HSS) and Monitoring and Evaluation units. A fieldwork schedule was developed with 3-5 members forming any single team visiting a province. Care was taken to ensure that any team visiting a province consisted of at least one member from the two units to ensure a mixed-skill set. The teams were provided with a one-day training to refresh interviewing skills and allow them time to familiarize themselves with the tools.

The Northern Cape Province was conveniently selected to pilot the tools and both teams visited the province during the first week of October 2012 to conduct fieldwork. Criteria used to select the Northern Cape were existence of a signed Memorandum of Understanding and readiness of the province to receive the field teams. The team collected information and lessons that informed planning for the fieldwork. Experiences and notes from the field teams

led to very minimal revisions to the tools but lessons were valuable in informing the team on fieldwork approach, especially in relation to resource allocation per province.

2.2 Fieldwork Phase

Due to minimal changes to the tools following the pilot, we decided not to return to the Northern Cape for the further data collection. Instead, data collected during the pilot was included with data from other provinces for analysis. Fieldwork in the other eight provinces was conducted largely between the months of October and December 2012. A few key informants that were missed during the 3-month period were interviewed at the beginning of January 2013 and these were largely from the Gauteng Province and the NDOH.

Qualitative evaluation methods allow investigators to select and approach potential participants for inclusion in a study based on the research questions and the ability of potential respondents to provide information[18]. A purposeful sample of informants was ~~purposively~~ selected to include key Government officials from the National and Provincial Departments of Health, in particular: Officers from the HRD; HAST, PHC, MCWH, and DHS directorates. From the RTCs, informants included RTC Managers, Training Managers, Training Coordinators and RTC trainers. FGDs were conducted with health care professionals who benefited from training offered either by or through the RTCs. A handful of training partners that support training activities at the provincial level were also interviewed.

The team interacted with a total of 220 participants from across the nine provinces, the National Department of Health and training partners. Of these, 123 (56%) participated in individual face to face interviews. Table 2 below lists the respondents by province and category. A total of nine representatives of training partners that support training and related activities at the provincial level were interviewed.

In KwaZulu-Natal Province, FGDs were not conducted due to the criteria that required that participants in FGD "must have benefited from trainings offered by or through the RTC" and KZN's RTC had just become operational with no pool of RTC-trained health care professionals to draw from. No FGDs were conducted in the Eastern Cape due to time constraints. Only 6 representatives of the National Department of Health officials participated in the situational analysis. Although small in number, participants represented key Directorates in the Department to enable investigators to make a good analysis of NDOH's perspective of the RTCs.

Table 2: Respondents by province

Response Analysis								
Province	**RTC Manager**	**Training Coordinator**	**RTC Trainer**	**Government Official**	**No. of FGD**	**Total no. in FGD**	**Training Partner**	**Provincial total (incl. FGD)**
Eastern Cape	1	4	1	7	-	-	-	**13**
Free State	1	3	1	8	2	10	1	**24**
Gauteng	1	7	3	16	4	23	3	**53**
KZN	2*	2	-	4	-	-	1	**9**
Limpopo	1	1	1	4	2	10	-	**17**
Mpumalanga	1	2	5	6	1	30	-	**44**
North West	1	2	2	5	1	3	1	**14**
Northern Cape	1	1	1	5	2	13	1	**22**
Western Cape	1	2	1	4	1	8	2	**18**
NDOH	N/A	N/A	N/A	6	N/A	N/A	N/A	**6**
Total	**10**	**24**	**15**	**57**	**13**	**97**	**9**	**220**

*KZN was in the process of handing over RTC management from a CCMT officer to an appointed RTC Manager. Both were interviewed.

Structured questionnaires were used to conduct 40-60 minute interviews with all key informants. Fieldworkers performed walk-throughs at the RTC premises to observe, verify and in some cases supplement the information collected. FGDs lasted between 60 and 90 minutes in all provinces where these were conducted. In total, 13 FGDs were conducted and 97 health care professionals participated. Additionally, the field team requested documents from the RTC Managers and where these were made available, a review was conducted. A list of sample documents reviewed appears in table 3 below.

Table 3: List of documents reviewed

Examples of documents reviewed at selected RTCs			
Limpopo ▪ M & E tool; ▪ HIV/AIDS, STI &TB training schedule; ▪ National RTC business plan Free State ▪ Project Plan; ▪ Training program; ▪ Skills monitoring records; ▪ Attendance registers	Western Cape ▪ Participant Survey; ▪ Approval letter for fund availability; ▪ Return on investment survey 2011; ▪ ATICC organogram; ▪ Facility readiness document; ▪ Directives & Email correspondences ▪ HAST training conceptual framework ▪ Conference Note;	Eastern Cape ▪ Service Level Agreements; ▪ WSU pre-test chronic care with ART; ▪ Training participant registration form; ▪ Attendance registers; ▪ Monitoring approach ▪ Planning cycle; ▪ Organization chart; ▪ STI quality of care ▪ Quarterly report	KZN ▪ Training modules ▪ Stakeholder meeting notes North West ▪ Palsa plus module

Data collected (transcriptions, questionnaire summaries, etc.) was (and is still) stored in password-protected data files on a password-protected computer. Data cleaning and analysis were performed by I-TECH South Africa. Selected audio tapes from interviews and FGDs were transcribed to fill in gaps in data and selected quotes were extracted for inclusion in the report to substantiate findings. All transcriptions and observation notes were thematically coded and analysed. Pre-determined themes were refined based on data collected to a final seven.

2.3 Validation Phase

Following data analysis, stakeholder meetings were conducted at the provincial level to present preliminary findings for validation and fill gaps in information. Validation meetings were held in 7 provinces, namely Mpumalanga, North-West, Gauteng, Free State, Limpopo, Western Cape and Northern Cape. A total of 107 individuals participated in validation meetings and these were made up of Government officials (from RTC and Programmes) with partners participating in other provinces. It was not possible to conduct validation meetings in KZN, and Eastern Cape Provinces due to unavailability of relevant officials during the period leading up to a national feedback conference. However, the three provinces that were not able to validate findings through a meeting were sent an early draft of the complete report to afford them sufficient opportunity to do so in writing and validation meetings were planned a later date. Overall, all provinces were provided with an opportunity to validate findings and provide inputs into this report.

Table 4: Number of participants in validation meetings by province

Province	Western Cape	GP	Limpopo	North West	Free State	MP	Northern Cape	KZN	Eastern Cape	TOT
Number	10	23	11	14	15	28	6	-	-	107

Generally, validation meetings were attended by the RTC Manager, Programme Managers, representatives of districts and training partners. During these meetings, findings were presented and stakeholders interacted with those to elaborate on the meaning of some statements, fill in information gaps and confirm if the findings generally represented a true picture of the status of RTC in the province. At the national level, individual meetings were held with two senior officials to discuss the general content of the report. A final draft of the report was shared across programme Directorates, including the Human Resources Strategic Programmes, for comments.

3. FINDINGS

This report presents findings according to the seven themes: (i) RTC model; (ii) Financing and Expenditures; (iii) Infrastructure and Human Resources; (iv) Coordination, Integration and Support; (v) Education and Training Approach; (vi) Distance Learning; and (vii) Planning, Monitoring, Evaluation & Reporting.

At the time of the situational analysis, all nine provinces had established an RTC. With the recent adoption of the RTC name by the Western Cape ATTIC, all provinces call the centres Regional Training Centres.

Originally, the Limpopo Provincial Department of Health called the centre a Resource Training Centre, although legal and official documents refer to it as a Regional Training Centre. Staff at the RTC indicated that the board will be changed to read RTC as the one pictured is old.

Table 5: Profiles of the RTCs

Province	Year established	Location	Line Management	Advisory Structure	Training Activities
KwaZulu-Natal	2012	Government	HAST	No	Decentralized
Gauteng	2007	Government	HRD	No	Decentralized
Mpumalanga	2006	Government	HAST	No	Decentralized
North West	2006	Government	HAST	No	Decentralized
Northern Cape	2004	Government	HAST	No	Centralized
Free State	2004	Government	HRD	No	Decentralized
Western Cape	2003*	Government	HRD	No	Decentralized
Eastern Cape	2003	University	WSU (and HAST)	Yes	Both
Limpopo	2003	Government	HRD	Yes	Both

*It is important to note that in 2003, the Western Cape Department of Health decided to keep ATICC as the name of the training centre due to popularity of the name, and not adopt the RTC name. The RTC name was adopted toward the end of 2012.

Across all provinces, there was an understanding of the purpose of establishing RTCs; however, provinces approached the task differently based on previous experiences, the history of the centres as well as provincial needs. Table 5 above captures the profiles of RTCs in South Africa. In KZN, respondents reported that the inability of a similar structure, a regional training centre for Maternal and Child Health, to contribute to the MCHW programme led to the provincial administration's decision not to establish a training centre

dedicated to a single programme. However, the need for the roles and functions of the RTC were acknowledged as important and the HAST unit was tasked with those responsibilities. In 2012, KZN identified a structure for the RTC and transitioned the roles and functions from HAST to a newly appointed RTC Manager.

3.1 RTC Model

Under this theme, the focus was largely on the role and mandate of the RTCs and the situational analysis reviewed the structure and functions of each RTC. Specifically, the situational analysis looked at leadership and input by local stakeholders, line management and institutional arrangements (how RTCs are integrated into their host institutions). The situational analysis also reviewed the operations of the RTC in terms of decentralization of RTC structures as well as cooperation with other institutions, especially linkages to universities and colleges.

Role and mandate of the RTC: The role of the RTC is stated in the Framework Document as "coordinating all continuing education of health care professionals provincially, to ensure that health care professionals had adequate knowledge, skills and attitudes to meet the health care demands and improve patient outcomes overall"[15]. This mandate was communicated to all provinces by the NDOH. A total of 73 respondents (Government officials and RTC Managers) answered questions related to the role and mandate of the RTC. Up to 86% (63/73) of respondents across the nine provinces seemed to understand the role and mandate; however, the reality is that 8 of the 9 RTCs coordinate only or primarily HIV and AIDS trainings. Mpumalanga RTC has managed to gradually incorporate generic trainings such as project management into the scope of work of the RTC, although programme trainings are still largely on HIV and AIDS.

The NDOH continues to communicate the need for RTCs to coordinate trainings for all health programmes however, implementing this thrust has been challenging given the history and context as well as staff management issues of the current RTCs in most provinces. Hence, many times when respondents answered a question on the role of the RTC, there was almost always a reference to HIV and AIDS.

"Capacity development through the provision of high quality trainings is a critical component towards the improvement of service delivery around HIV and AIDS, TB and STIs. That is the role of the RTC." Government official, Limpopo

Among Programme Managers, there were differing views on the role of the RTC at the provincial level, with Program Managers in some provinces reporting that RTCs only coordinate training, while in some provinces Program Managers understood the role of RTCs as to coordinate and conduct trainings.

"In my province, RTCs only coordinates training and they rely on partners such as FPD, Right to Care and others to conduct the actual trainings." Programme Manager, Gauteng

The situational analysis established that the majority of RTCs, including Gauteng Province, performed dual functions of coordination and conduct of training activities. In KZN, trainings were largely outsourced to partners due to a previous lack of an RTC (including training facilities). Now that the RTC has been established and the RTC Manager has been appointed, the RTC has assumed overall coordination of trainings related to HIV and AIDS and training coordinators at the regional level continues to support training efforts. Respondents from the majority of RTCs reported that the nature of the RTC work makes it possible for the RTC to procure training services from an accredited partner and pay for it, enter into an agreement with an accredited donor-funded partner to provide training outside of the RTC budget or use Government Training Coordinators from the districts to conduct the training in-house. In almost all instance, the RTC pays for travel and accommodation for the training participants.

How RTCs are structured and functions: Of the nine (9) RTCs, only the Eastern Cape RTC (ECRTC) is based at an academic institution, the Walter Sisulu University (WSU), while being linked to the provincial health department. The other eight are part of either the Human Resource or HAST arms of the Provincial Departments of Health.

Not all RTCs reported utilizing a functional advisory body that provides input on RTC operations. However, notable good practice includes a functioning Advisory Committee for the ECRTC. The ECRTC Advisory Committee is made up of heads of academic institutions, Provincial Department of Health and community members and it provides advice on the

operations of the RTC. The committee meets on a quarterly basis and there is an almost uniform level of interest among committee members to participate in meetings to discuss RTC issues. The RTC in Limpopo Province reported having a similar advisory body, which is currently not functional as members are not able to meet due to time constraints. In the other provinces, such structures do not exist.

> *"In our province, we have an RTC oversight committee that is made up of Senior Managers, NGOs and tertiary institutions; however the committee is not able to meet due to very busy schedules. We intend to reactivate it."*
> Government official, Limpopo

Across all nine provinces, majority of respondents listed functions of the RTCs that closely matched those that are listed in the Framework Document. Respondents listed the following:

- To *build Capacity* of health care professionals (doctors, nurses, Pharmacists etc.) through quality trainings to improve health care service delivery;
- To *standardize and accredit training materials* to ensure that high standards were maintained. The obligation of RTCs is to ensure that all training programmes are accredited was emphasized;
- To *coordinate training partners' activities* in the province to ensure that all training programmes remain relevant, consistent and of a superior quality. Additionally, respondents felt that better coordination would promote synergy at all levels and resolve the challenges of duplication and competition.
- To support the *development of training plans* at the district level. Some respondents proposed that RTCs take on a lead role in the development of training plans for the province and the districts, while others preferred taking on the supporting role. The majority, however, acknowledged that the current human resource constraints limit the RTCs' ability to provide technical oversight in development of district training plans. There is consequently a need to strengthen and build the capacity of the various RTCs to be able to effectively deliver high quality services to health care professionals;
- To *align training programmes with national strategies* and keep up with developments at the National Department of Health;
- To *assess training needs* and *recruit appropriate training participants*;
- To *develop a multi-disciplinary approach* to training to ensure that training is comprehensive and include other stakeholders such as Traditional Leaders, Traditional Health Practitioners, Religious leaders etc., and includes other

programmes such as Maternal and Child Health, Medical Male Circumcision (MMC), and STIs.

Additionally, respondents felt that the following functions are important and should be added to the established functions of the RTCs:

- Maintain an *up-to-date training database* to capture all training and related information;
- Support *strengthening of programme implementation* in relation to HIV and AIDS training across the provinces;
- Strengthen the *skills audit* function of the RTC;
- Review *training curricula of partners* against NDOH policies/guidelines; and
- Respond to *new programme areas* by up-skilling and building the capacity of health care professionals.

With regard to **line management**, four out of the nine RTCs (44%) have a direct reporting line to the HAST units of the Provincial Departments of Health. The Eastern Cape RTC has a direct reporting line within the University with a dotted line reporting to the HAST unit of the Eastern Cape Provincial Department of Health. The remaining four (44%) are line-managed through the HRD units within the Provincial Departments of Health. The Western Cape Province transitioned the RTC from HAST line management to HRD in October 2012.

Government officials and RTC Managers were asked which model of line management worked best for their provinces and whether the relocation to HRD will ensure that HAST training is not given more priority over other programmes. The majority of respondents from provinces where RTCs report to HAST indicated satisfaction with the current reporting arrangements and expressed preference for the arrangement to continue.

> *"While I appreciate the benefit of reporting to HRD, the experience in our province is that the linkages with the HAST unit is much more progressive as implementation tends to move much faster."* Government official, Mpumalanga

Respondents from three provinces (Mpumalanga, North West and Northern Cape) felt that RTCs are still able to coordinate trainings for all health programmes while reporting directly to the HAST unit. On the other hand, respondents in the Western Cape felt strongly that it will not be possible for the RTC to coordinate all health care worker trainings in the province

due to the various players in in-service training for health care professionals. RTCs that reported directly to HRD at the time of the situational analysis also indicated that the relationship between the HRD (controlling RTC operations) and HAST (controlling RTC budget) was not always optimal and that the RTC was working extra hard to ensure training programme implementation. Some respondents called it "*pleasing two masters*".

HAST units in some of the Provincial Departments of Health often want to counter-sign on requests already approved by senior management in the HRD units before any money can be spent by the RTC, creating duplication and unnecessary delays. Respondents from the RTCs reported that they are *"caught in the middle".*

With the exception of both Limpopo and the Eastern Cape RTCs who implement a combination approach, the seven other RTCs either operate a centralized or a decentralized approach. Of the seven, six RTCs conduct trainings at the district and facility levels. Three out of the six provinces (North West, Gauteng, Limpopo) have established district-level RTC structures and majority of trainings in these provinces are decentralized, although Gauteng Province only has one out of the three structures established, with the other two RTCs operating from the provincial department offices. The Eastern and Western Cape Provinces have strong links with the ATICCs. The Western Cape RTC was born out of the ATICC and the ATICCs in the Eastern Cape operate as an extension of the RTC, strategically located to cover all districts within the Eastern Cape. The Northern Cape operates a centralized model with all of the trainings occurring at the provincial level.

The Framework Document noted that *"it would have been ideal to establish RTCs within academic institutions"* and called for RTCs to be established *"as an extension of the human resources development arm within the provincial department with strong links to universities and/or colleges"*. The situational analysis found that all RTCs were cooperating with academic institutions in some way (See table 6 on the next page.) Some respondents indicated that there was a higher level agreement between academic institutions and the Provincial Department of Health; however, they were not always aware of the nature of such a relationship or how the RTC can benefit from such a relationship.

The situational analysis found that provinces that do not have universities located within their provincial boundaries were still able to establish strong links with existing nursing colleges within the province and explore partnering with universities located in other provinces. Mpumalanga RTC has established strong linkages with the Universities of Witwatersrand

and Pretoria, partnerships that supports accreditation of training course offered at the RTC. Additionally, Mpumalanga RTC has strong links with the Mpumalanga nursing college and participates in the pre-service training of nurses where the nursing students are required to spend some time at the RTC to learn about all HIV and AIDS programmes.

Through the support of I-TECH, the Eastern Cape RTC has benefited from strong linkages with the University of California, San Diego (UCSD). Although I-TECH's support came to an end, a sustainable mechanism that continued the linkages is noted as good practice. The ECRTC continues to hold clinical tele-seminars with UCSD, targeting medical doctors from Mthatha Hospital Complex. Participation in these seminars is broad and includes medical doctors from outside the Eastern Cape Province. Medical doctors from the Gauteng Province and Botswana have participated at these seminars. The purpose of the tele-seminars is to learn from each other and share experiences through case discussions and presentations. More than 30 medical doctors are participating in the tele-seminars on a continuous basis. Continuous Professional Development (CPD) points are awarded for participating in these sessions. This has attracted medical doctors to continue participation.

Table 6: Linkages of RTCs with academic institutions

Province	Academic Institutions
Gauteng	University of Witwatersrand, Baragwanath & Lesedi nursing colleges
Western Cape	University of Cape Town, Stellenbosch university, University of the Western Cape
Eastern Cape	Walter Sisulu university, Fort hare university, University of California San Diego, Lilitha nursing college
Free State	University of the Free State
Limpopo	University of Limpopo (MEDUNSA) in Polokwane campus, Polokwane nursing college
Mpumalanga	University of Witswatersrand, University of Pretoria, Mpumalanga nursing college
KZN	University of KwaZulu-Natal
North West	University of the North West
Northern Cape	Wits Health Consortium

In KZN, the respondents reported that the Department of Health has an agreement with the University of KZN to implement distance learning programmes for health care professionals. Respondents from the Mpumalanga RTC reported that the RTC has collaborated with the Mpumalanga nursing college to develop and implemented a pre-service training program aligned to 4th Year Curriculum for nursing students before exit. The students spend the last

month of their training at the RTC to be trained on all HIV and AIDS programmes including preparation programs to enable them to assume their duties as professional nurses. Due to demand the Program is now commenced at 1st Year and continues as students progresses.

Respondents in Limpopo reported that the RTC collaborates with the medical school of the University of Limpopo to develop training curriculum, which will automatically be accredited because the university is an accredited institution of higher learning. Other provinces reported similar kinds of arrangements, but the collaboration is not always systematic. Respondents in majority the of RTCs indicated that they have not fully taken advantage of the expertise that exists within academic institutions, despite the fact that a large portion of the budget for Medical Schools and Health Sciences Departments at Universities are funded by the National Department of Health.

> *"We are certain that the RTC has contributed significantly to the health outcomes of the Gauteng people; however, we are yet to enter into meaningful partnerships with universities and our target is to immediately explore this possible with the University of the Witwatersrand."* HRD cluster, Gauteng

3.2 Financing and Expenditures

Financing in the health context is defined as "a function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system[20]". It is an act of making financial resources available as well as to set the right financial incentives to providers, to ensure that all individuals have access to effective health care services[20,21]. The situational analysis looked at how money is made available *(source of funding)* for RTCs for operational and training expenses, *funding flow* as well as *access to external and/or additional sources of funding.* In addition, *the RTC's ability to spend* allocated funds was reviewed.

Source of funding and funding flow: The major source of funding for all nine RTCs is the South African Government that provides financial support through (i) equitable share (for salaries of permanent staff); and (ii) a Conditional Grant for HIV and AIDS (henceforth referred to as the Conditional Grant). A Conditional Grant is a vehicle through which the National Treasury finances special activities in the country[22] and there are several such grants existing in the country i.e. Conditional Grant for HIV and AIDS, Conditional Grant for NHI, among others. In the health sector, Conditional Grant funds are transferred from the

National Treasury to the National and Provincial Departments of Health and these are earmarked for HIV and AIDS activities. By definition, a Conditional Grant comes with conditions. The Conditional Grant for HIV and AIDS is no exception, and it comes with expenditure restrictions and resource allocation criteria although provinces can decide on allocation per HIV and AIDS activity (programme implementation, training etc.) Conditional Grant funds can be used to fund salaries of staff and training activities.

Respondents stated that the biggest challenge with this funding model is ability of the RTCs to stretch the funds that are earmarked for HIV and AIDS across all other health programmes such as MCWH, IMCI, School health, PHC etc. In addition, practical expenditures that could benefit the RTC could be restricted by the conditions attached to the Conditional Grant.

> *"I find that it is easier to use funding outside of Government to procure services that are not allowed in the Conditional Grant. For instance, an RTC may decide that it is easier to purchase a vehicle which could be used for travel between several training locations that are not far apart, and a Conditional Grant would not allow that. Donor funds would be appropriate for that purpose."* RTC respondent, Eastern Cape

The fiscal year for the Government of South Africa runs from 01 April to 31 March. Respondents indicated that funds are usually received at the Provincial Departments a few months into the fiscal year, causing delays in implementation of training programmes.

Other sources of funding: With the exception of the Eastern Cape RTC which was able to secure a PEPFAR grant through the Centre for Disease Control and Prevention (CDC) South Africa, the other RTCs receive funds only from the Government to support RTC functioning. The CDC grant enabled the ECRTC to expand the training programme and RTC operations.

There were conflicting reports from respondents across the provinces with some respondents reporting that the level of fund allocation to the RTC was not sufficient to cover their annual needs, while other respondents indicated otherwise. Often, training partners support RTCs to cover the shortfall. Majority of respondents from all provinces acknowledged the *"invaluable"* support of training partners. Western Cape RTC reported concerns on its inability to stretch the budget to cover indirect costs. These costs related

paid leave for staff that goes on study leave and those related to provision of relief staff to cover for the absence. Often the indirect costs far outweigh the direct costs of training and respondents indicated a variation of 3:1.

> *"The estimated cost of a training in between R25,000 and R30,000 (direct cost) and R75,000 in indirect cost. So far, the total relief costs spent on nurses who go on paid study leave is between R10 and R12 million."*
> Government official, Western Cape Province

In the Free State province, respondents reported that the RTC often have to motivate for additional funding to support activities not originally in the work plan, but we noted that the HAST unit does reallocations to find funds for the RTC and that eventually, all trainings are conducted. A handful of respondents from RTC that are located within Provincial Departments of Health felt that it was not practical to source additional funding outside of Government because the funds would still need to be channelled through National Treasury and RTCs would still face challenges with delayed disbursements.

Partner support: Respondents reported that partners that are providing training support to provinces do not give funds directly to the RTCs. The approach of partners is to support training activities through payment for items such as: (i) equipment; (ii) participation of training participants (travel, accommodation); and (iii) costs of training facilitators and training material.

Respondents reported that some partners do support RTCs through secondment of staff that helps fill the gap of staff shortages. Examples cited by respondents include instances where PEPFAR-funded partners placed fellows and/or M & E Assistants Mpumalanga and Free State Provinces to help the RTC with the M & E function. The challenge that is shared across all RTCs is that this approach is only useful to address short term bottlenecks, but it is not sustainable as partners are dependent on availability of funding.

In the North West Province, academic institutions also provide financial support to training activities. For example, a training grant of R10 000 000 has been made available for the Dr Kenneth Kaunda district and a portion of the funds was used at that time for outsourcing facilitators such as nurse training experts.

Expenditures: The situational analysis did not attempt to perform financial management capacity of RTCs, neither did it look in detail at the cost of training in terms of cost per training participant. In addition to the review of the adequacy of funds allocated to the RTC, the situational analysis looked at the ability of RTCs to expend allocated funds. The information provided and the level of detail was not uniform across the nine provinces.

Respondents from the National Department of Health reported that every year, RTCs return unspent Conditional Grant funds back to the National Treasury.

> *"Every year, all provinces return unspent funds from the Conditional Grant. Some of that money that is returned is money allocated to the RTC."* Government official, NDOH

This conflicts with earlier reports that the funds made available through the Conditional Grant are not sufficient for some RTCs. Reports from the National Treasury and Parliament indicate that there is a general inability to spend Conditional Grant funds for HIV and AIDS across all provinces[22,23]. However, it is not clear from these reports whether the returned funds are those allocated to RTCs.

Several reasons were reported for the low levels of spending in some RTCs. In Limpopo, respondents cited the placement of the Provincial Department of Health under administration as the main reason for the low expenditure rates in 2012. In December 2011, Cabinet placed several provincial Departments in Limpopo under administration, including the Department of Health. According to section 100 (1) of the South African constitution, when a province cannot or does not fulfil an executive obligation in terms of the constitution or legislation, the national executive have the power to assume responsibility for the relevant obligation in that province[25]. In Limpopo, the national executive took over management and administration of the Department of Health.

In Limpopo, respondents reported that procurement of any sort, including hiring of staff, purchasing items, salaries and other costs needed prior approval from the National Department of Health. This additional requirement has increased the turn-around time for approval of requests. With only a few months left in the 2012/13 financial year, respondents did not anticipate substantial increase in expenditure, meaning that funds allocated to the RTC will return to the National Treasury. The Eastern Cape Province was also placed under administration around the same time as Limpopo province, thus facing similar challenges.

Another reason for low expenditures was bottlenecks within the Provincial Departments of Health. Respondents from some RTCs reported that the centralized approach to financial management caused delays in movement of funds generally to programmes and that the RTC is often facing such challenges. The capacity of RTC to manage finances was also reported as an area that needs strengthening, with respondents expressing a need for capacity building among RTC staff.

> *"If you work with a big budget and you want to squeeze it into a bottle……."*
> *You need to allocate resources for proper Financial Management."*
> Programme Manager, Northern Cape

Other RTCs are faced with the same challenges of centralized control of funds, and this poses a challenge of delays in funds reaching the districts. As a result, RTC allocation is part of the unspent Conditional Grant funds that are returned to the National Treasury every year by the HAST unit.

In Gauteng Province, respondents reported that several training partners, including FPD, Right to Care and others support the province with training activities. Sometimes the training activities were originally planned for as part of RTC trainings with an allocated budget. Respondents indicated that savings from training partners supporting trainings in RTC business plans can be up to 60%. In order to free some of the money to allocate to other priorities, respondents suggested that partners' trainings be included in training plans for the RTC and costed so that the RTC does not over-budget and tie up funds that could be allocated to other activities.

> *"We know that there are restrictions to Conditional Grant, but whoever is making decisions, they should think of using that unspent money to support us with a structure for training. We currently do trainings in appalling spaces."*
> Training Coordinator, Gauteng Province

For all provinces, we could not establish the Conditional Grant amounts that were returned to the National Treasury over the years. Neither were we able to determine the RTC portion of the funds returned.

3.3 Infrastructure and Human Resources

The availability of resources in any institution determines its ability to succeed. The situational analysis reviewed resources at the RTC in terms of the staffing levels and infrastructure (physical structure, IT and other equipment). Table 7 below provides a comparison of available resources across the nine RTCs.

Human Resources: The situational analysis reviewed staffing levels in terms of the number of staff working at the RTC. According to reports from the field, the number of staff at the RTCs ranged from 5 in the North West to 40 in the Eastern Cape.

> *"Currently, only the RTC Manager has been appointed and he will establish an organogram after recruitment of other key staff members. There are training officers per district but they are not yet linked to the RTC and their job descriptions are not clear. Currently they focus on managing administration staff and conducting interviews."* Programme Manager, North West Province

In contrast, other respondents in the North West province reported that there are four decentralized RTC structures, one in each district, but that only one of the four is fully functional. Each decentralized RTC structure is reportedly headed by a Manager. At the time of the situational analysis, the Eastern Cape RTC had a total of 40 staff members. Respondents from the ECRTC indicated that a few positions would not continue the following year due to the end of the CDC grant.

Table 7: Comparison of infrastructure, IT (and other equipment) and staff complement by province

Province	No. of staff	Physical structure	No. of offices	No. of classrooms	Computers	Accommodation & Capacity	Resource Centre/Library
Eastern Cape	40	Yes	13	2	40	Yes (40)	Yes
Mpumalanga	15	Yes	6	3	10	Yes (148)	Yes
Limpopo	7	Yes	6	3	8	No	No
North West	5	Yes*	N/A	7	-	No	No
Free State	23	No	N/A	N/A	7	No	Yes
Gauteng	17	Yes**	9	10	22	No	Yes
Northern Cape	7	Yes*	N/A	N/A		No	No
Western Cape	20	Yes	-	11	18	No	Yes
KwaZulu-Natal	24	Yes	13	3		No	No

Notes: All RTCs were found to have training equipment such as laptops, flipcharts, LCD projectors etc.

*Provincial RTC structure under development.

**Gauteng has a structure for the Tshwane region which was launched on 29 January 2013. The other two regions still do not have physical structures. The Tshwane structure is used by the other regions to conduct trainings as well.

At the time of the situational analysis, only KZN had an RTC Manager that was recruited outside of the nursing profession. In all the other provinces, the positions of RTC Manager and Training Coordinators have generally been recruited from a pool of candidates with a nursing background. Performing a duty of a nurse within a facility makes the incumbent eligible for Occupation Specific Dispensation (OSD). OSD is a mechanism introduced in 2007 by the South African Government to curb the migration of skilled public health sector employees[22]. It is meant "to provide a unique salary structure per occupation, prescribe grading structures and job profiles to eliminate inter-provincial variations"[24]. Positions established for the RTCs are not eligible to benefit from the OSD and because RTCs recruited largely from a poll of nurses, these positions remain vacant as nurses move back to facilities in order to benefit from OSD.

RTC Managers from majority of rural provinces reported that the ineligibility of RTC staff to benefit from OSD is a major challenge to the operations of the RTCs. For instance, in Limpopo Province alone, the RTC was reported to have a provision for 5 Training Coordinators, but none were in place at the time of the situational analysis as the RTC was unable to find candidates that were willing to take up the posts.

> *"When we decentralized training way back, we had training coordinators in all the districts. Now they are all gone because there was no OSD and all the nurses who were training coordinators returned to the facilities as those posts come with OSD. There is currently no one to do training at the districts."*
> Government Official, Limpopo

Respondents reported a need to review the job specifications of RTC Managers and the required qualifications to ensure that other professionals outside of nursing are considered for such positions.

Infrastructure: We observed provincial variations in terms of availability of a physical structure for the RTCs. With the exception of the Free State Province, the other eight provinces were found to have permanent RTC structures that were either fully functional or being renovated.

The Eastern Cape RTC was erected at Walter Sisulu University grounds. The physical structure is detached from the university buildings and consists of several blocks with accommodation for trainees, training rooms and offices. The other seven provinces have structures that are outside the Department of Health buildings. Mpumalanga RTC is in Evander which is 250KM away from the Provincial Department of Health building. The RTC consist of rooms for accommodating students, trainings rooms and offices. In Gauteng, only the Tshwane region has a physical structure which is located at Kalafong hospital, while the other two regions operate from the Provincial Department of Health. We established that the other two regions can use the Tshwane region RTC to conduct trainings.

KZN is located in Amatikulu which is about 200KM from Pietermaritzburg, where the Provincial Department of Health is located. Pictures of the newly established KZN RTC appear below.

KZN Regional Training Centre, Amatikulu (Courtesy of KZN Department of Health)

Most RTCs do not have accommodation facilities for trainees. KZN respondents reported a need for a construction of a block at the RTC for this purpose. Respondents in Mpumalanga reported that there was a need for some level of upgrading to ensure that structures meet the training requirements, especially in relation to accommodation and canteen.

> *"Training participants are forced to share rooms due to limited number of rooms…. Some trainings are conducted at Bed and Breakfast or hotel facilities, as a result trainees compare the RTC training venue to those facilities. This is discouraging potential participants from coming to training."*
> RTC Manager, Mpumalanga

IT and other equipment: Almost all RTCs were found to have a combination of desktops, laptops, printers, LCD projectors and training related material (flipcharts, blackboards etc.) The biggest challenged reported by most RTCs was related to internet connectivity which was not always reliable. Additionally, some RTCs reported that they still faced challenges with telephone connections, including limited access to portable devices. Some respondents mentioned that there were several layers of management through which communication must go and this contributed to breakdown in communication.

3.4 Coordination, Integration and Support

In the face of the HIV epidemic in South Africa, there are many NGOs that are donor-funded to support the Government to achieve better health outcomes. Many of these NGOs come with budgets for training of health care professionals and related health workers. This scenario makes effective coordination and communication very critical for programme success. Additionally, integration of training initiatives with overall programme delivery ensures that health care professionals receive adequate skills at the right time to support programme implementation. Under this theme, the situational analysis looked at the coordination function of RTCs in relation to training for all health care programmes and the coordination of partners' training activities within the province. The situational analysis also looked at the level of support provided to RTCs by the NDOH and the Provincial Departments of Health. All 212 respondents were asked questions related to coordination, integration and support.

Coordination and Communication: In-service trainings for health care professionals in some provinces are not integrated. With the exception of Mpumalanga where the RTC coordinates all health care worker trainings, different programmes coordinate their own training as the RTCs focus on HIV and AIDS training.

> *"There are different master trainers for different programmes in the province."*
> Training Coordinator, North West Province

Some respondents indicated that integration of trainings for all health programmes and coordination by the RTC will not be possible mainly due to staffing challenges at the RTC. Another challenge reported across majority of provinces was related to lack of coordination of partners' training activities. Respondents in some RTCs reported that several partners approach the districts directly with proposals for training, without the knowledge of the RTC.

This is particularly a concern as partners come with their own training material to use during the trainings. Respondents indicated that it is important that the RTC be consulted in order to verify the standard and quality of the training content proposed.

> *"Some partners go directly to the districts, and before you know it, training is taking place at a particular district without the knowledge of the RTC. It is important for the RTC to check and verify that the training material that a partner uses is aligned to national guidelines."* Government Official, Limpopo

It is also important to report that respondents acknowledged the support of partners in implementing training activities at the provincial level and wished for this support to continue, however respondents called for such support to be more coordinated and channelled through the RTC. One challenge that was reported by respondents was that partners do their planning separately from the RTC and often the RTC is not given an opportunity to give input. Some Training Coordinators indicated that it would be ideal to develop a joint training calendar to improve coordination. Mpumalanga RTC reported that it is already developing a joint plan with partners that enable the RTC to coordinate the work of partners in the province.

> *"We have managed to regulate all PEPFAR funded Development Partners to ensure standardization of training activities whereby joint training calendar is done and approved by RTC and implementation is monitored to ensure that whatever content that is presented is in line with our learning outcomes."* RTC Manager, Mpumalanga

Respondents at the district level reported delays in receiving information from the RTCs. One of the reasons for slow communication was limited working IT infrastructure for communication.

Integration: Majority of respondents across all provinces indicated that the RTCs were fully integrated within the structure of the institution where they were located, ECRTC within the WSU organogram with a clear mechanism to communicate with the HAST unit at the Eastern Cape Provincial Department of Health. The other eight RTCs are extensions of the Provincial Department of Health. On the one hand, the reported challenge was limited integration of trainings for the various programmes within the Provincial Departments of Health. On the other hand, respondents from the RTCs reported limited capacity at the RTC

as a bottleneck to integration as the current staffing levels for some RTCs makes it impossible to coordinate all health care worker trainings.

Support to the RTCs: Responses varied with respect to the adequacy of support to the RTCs from the National and the Provincial Departments of Health. Closely linked to the challenge related to non-functioning advisory structures in some provinces where these exist, respondents felt that the RTCs were generally not a priority within the Provincial Departments of Health, despite the important responsibility entrusted to them.

Respondents reported that when there are calls for budget cuts, the training budget is usually the first to on the list. Some respondents mentioned that the support received from the National Department of Health was adequate.

> *"We appreciate the support from the National Department of Health, which is largely in the form of organizing the bi-annual RTC conference which provides a platform for sharing of information. This keeps RTCs up to date with new developments."* RTC Manager, Mpumalanga Province

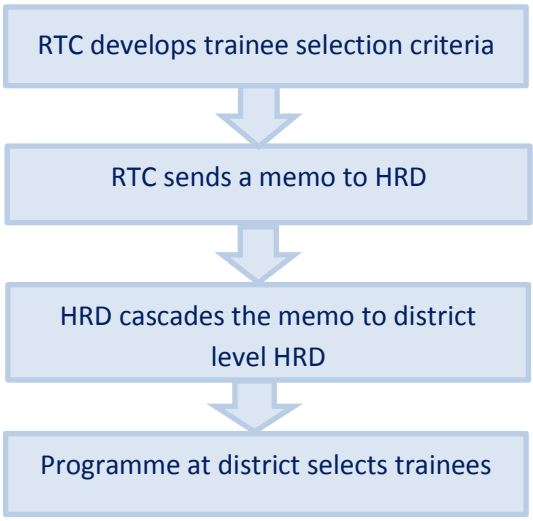
However, some respondents from a few RTCs indicated a need for additional support through transfer of skills by the National Department of Health to ensure RTCs have adequate capacity to carry out their mandate. The need for capacity building for RTC staff has been mentioned several times throughout the interviews with RTC staff.

3.5 Education and Training Approach

Under the Education and Training Approach theme, several areas were looked at including *(i) process for trainee selection; (ii) training methodology; (iii) where trainings occur; (iv) Incentives for training* (especially certification)*; and (v) mentorship.* All 212 respondents were asked questions relating to this theme.

Distance learning was listed as one of the training approaches by two RTCs. We decided to make distance learning a separate theme on its own (see 3.6 below) due to the challenges that arise when health care professionals are taken out of health care facilities for extended periods of time for purposes of education and training.

Trainee selection: A similar selection pattern was reported across a majority of the RTCs. The selection process involves a close collaboration between the RTC and HRD and is depicted below:



Respondents indicated that the need for training is usually a result of either a skills audit or a directive from senior management due to national priorities. Depending on the programme and what the training is for, the RTC develops selection criteria. The criteria are communicated to the HRD and the information gets cascaded to the districts requesting them to select participants based on the criteria provided.

Once names of potential participants are shared with the RTC, it then reviews the list against the pre-determined criteria to ensure that those participants are suitable. Participant selection processes differ slightly in some provinces. For instance, respondents in the Western Cape indicated that the ATICC follows a similar process, except that the selection of participants is done by the NGOs and the HAST Coordinator, not by ATICC.

Since RTCs have a mandate to train a diverse group of health care professionals (Medical Doctors, Professional Nurses, Pharmacists, Social Workers, Dieticians as well as non-professionals such as home-based carers, DOTS supporters, Information officers, community health care professionals and Data capturers), the RTC indicates, as part of the selection criteria, the categories of health care professionals that should be selected for a particular training.

Teaching methods and aids: Training methodologies were found to be similar across the provinces. Teaching methods commonly used by the RTCs (as well as training partners) included; (i) lectures, (ii) role-plays, (iii) case studies, (iv) group work, and (v) facilitated discussions. Amongst a list of frequently used teaching aids, respondents listed the following: (i) data projector, (ii) flip chart, (iii) visual aids, (iv) Power Point slides, (v) booklets and manuals, iCAM etc. In addition to these, Limpopo province uses a large flat screen television set in the training rooms with a DVD player and training content loaded on USBs for participants' use.

Trainings are generally **decentralized** in majority of the RTCs, which largely occur at the district and facility levels. Respondents from the Eastern Cape and Limpopo provinces reported that trainings occur both at the provincial and lower levels. Respondents indicated that trainings that were conducted at the provincial level included those targeted at health care professionals that are in limited quantities such as Medical Doctors and Pharmacists. In the Northern Cape Province, trainings were centralized and all trainings occurred at the provincial level.

Accreditation, Incentives for training and certification: The framework document indicates that RTCs should ensure that training programmes for health care professionals are accredited and that upon completion of training, health care professionals receive certification. Not all RTCs have been accredited as training institutions. Mpumalanga RTC has received accreditation with the Health and Welfare Sector Educational Training Authority as per South African Qualifications Authority requirement. This accreditation allows Mpumalanga to award certificates of completion to training participants.

> *"We are busy with University of Pretoria for accreditation of our learning material at NQF level 5 for all Professionals who will qualify to enable them to get credits building up to a qualification like Diploma in HIV and AIDS for each course they attend."* RTC Manager, Mpumalanga

Across the majority of RTCs, respondents indicated that health care professionals receive some form of a certificate ~~ion~~ at the end of training. The challenge reported by respondents from most RTCs was that majority of the certificates that were given to health care professionals at the end of training were for "Attendance" as most of the training courses offered at the RTC were not accredited. Respondents felt that this was not a sufficient incentive.

> *"We are faced with a challenge of not having funds to print certificates, and when we do, we give certificates of attendance. These certificates do not mean anything to health care professionals."* Programme Manager, North West Province

On the one hand, some respondents reported a preference among health care professionals for certificates of "competence" and a few RTC Managers concurred with the need to do better to incentivise health care professionals to attend trainings. In contrast, some participants in FGDs reported a deeper sense of purpose that drives them to work in the HIV and AIDS field.

> *"I am a heroine in my home. My daughter is HIV, and started treatment when her CD4 count was only 2. I played a role in her life. You won't believe the person you see today, is that lady that started treatment with a CD4 count of 2. I don't want that to happen in my household only. It's not just a job; it is deep in my heart."* Health Care Worker, FGD

> *"I lost three family members to HIV. Had I known what I have learnt at these courses, I feel my family members may still have been alive."* Health Care Worker, FGD

This was seen to some extent as a big enough incentive to some health care professionals who participated in the focus group discussions. In most provinces, respondents reported that certificates of completion were given to health care professionals who completed courses that are accredited, such as Nurse Initiated and Managed Antiretroviral Treatment (NIMART). The accreditation of training courses was reported to be generally labour-intensive with a possibility of taking several years. An example is the ECRTC, where the accreditation process still takes an average of three years despite RTC's affiliation to WSU.

Respondents reported difficulty in getting Medical Doctors to attend trainings offered at the RTC. Respondents from the National Department of Health indicated that the inability of RTCs to attract Medical Doctors to attend training is the main reason they are not reaching training targets for this category of health care professionals. Respondents from Mpumalanga RTC reported that the RTC has developed a pre-service training program for Doctors, Medical Interns and Community Service Doctors, a programme that is facilitated by selected experts from Universities over a period of 5 days. On the contrary, the National Department of Health indicates that provinces are not meeting training targets for Medical Doctors, with respondents from provinces indicating a need for innovative ideas to attract Medical Doctors to attend trainings as newly available information is applicable to them as well.

"RTCs are not meeting training targets for doctors." Human Resources Strategic Programmes, NDOH

Mentorship: With the exception of the Western Cape, all other RTCs reported implementing a mentoring programme. We noted provincial variations on the approach to mentoring. In Gauteng province, respondents reported that mentorship programmes are implemented through partners.

In the Eastern Cape, RTC trainers conduct mentoring and visit facilities twice a week at a minimum. The Eastern Cape has over 100 mentors that have been trained[26]. During a visit, a mentor tailors the kind and level of support to the need of the mentored health care worker[26].

Although respondents from the Western Cape reported that there were no mentorship programmes being implemented in the province at the time of the situational analysis, they also indicated that facilities received adequate support through the annual and post-training visits from the RTC that were systematically conducted across the province. During these visits, health care professionals have an opportunity to share their challenges and assistance is provided either immediately or during a follow up visit.

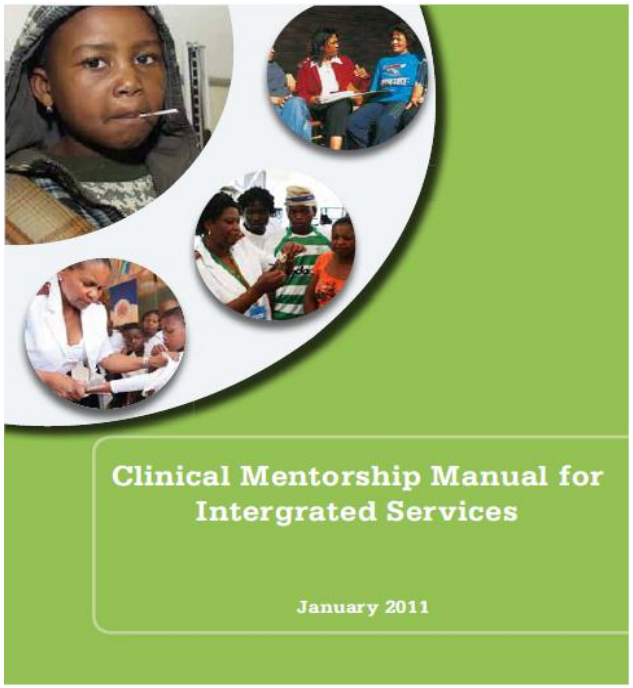
In most provinces, respondents reported that there were no full time mentors. RTCs use facility level staff to perform mentoring activities and as a result, mentoring has not fully taken off in some provinces due to competing priorities.

"The biggest challenge is that trained mentors were also Facility Managers and that they have not been able to conduct mentoring activities due to competing work schedules." Programme Manager, Northern Cape

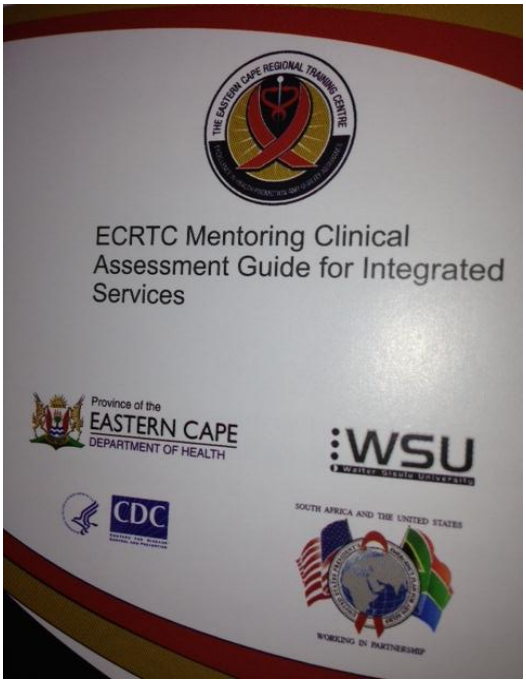
In Limpopo, respondents reported that mentoring has almost come to a standstill due to inability of provinces to access resources, including pool cars for use by the trained mentors to visit facilities. At the time of the situational analysis, mentoring was conducted through training partners and these were coordinated by the RTC.

"The need for mentoring is great and we appreciate the support of partners in this regard, but a lot still needs to be done. Foundation for Professional Development has been providing mentoring services directly to facilities."
RTC Manager, Limpopo

Mentoring was reported to occur for several programmes in the Mpumalanga province. Respondents reported that although regular meetings across the programmes took place to coordinate mentoring plans, the coordination of mentoring activities still needed to be strengthened. In the Free State, mentors are appointed by the province and they visit the facilities mostly for NIMART. A mentoring schedule exists and several programmes are covered, although emphasis is still on NIMART. In KZN, mentorship was reportedly started as a follow up to NIMART training in 2010 and the province appointed mentors for the programme. In the North West Province, respondents indicated that the RTC only engages in NIMART mentoring. Partners also support mentoring activities, especially at the district level.



National Mentorship Manual



Eastern Cape Mentoring Clinical guidelines

In the Eastern Cape, the RTC adapted the National Guidelines for mentoring into province-specific guidelines. In other provinces, respondents reported that the National Mentorship guidelines were used. The support of training partners for mentoring in provinces such as Limpopo and Gauteng was acknowledged throughout the interviews.

Although there were provincial variations, all RTCs, were found to conduct and coordinate trainings related to HIV and AIDS, STIs and TB. Table 8 below indicates the training courses that were provided at the Mpumalanga and Northern Cape RTCs during 2012. Courses provided by the same RTCs in previous years are similar to those listed for 2012.

Table 8: Courses provided at the RTCs: Examples from Mpumalanga and Northern Cape

Mpumalanga	Northern Cape
Clinical HIV Management	Tier 1,2 & clinical stationery
Mentorship	Orientation on clinical mentoring
Paediatric AIDS Management	HIV and AIDS in the workplace
Adherence Counselling	STIs and Barrier Methods
NIMART	*Research Methodology*
TB/HIV Collaboration	Paediatric NIMART
Basic HAST Course	*PHC re-engineering*
Basic HAST Information	*Psychosocial training*
Skills Programme	Palliative Care
Specialised MCH IMCI ToT	New curriculum on HIV and AIDS, STI
Specialised Counselling	I-ACT training
PMTCT Update	ART data cleaning
Pre ART Register	NIMART
Male Medical Circumcision	TB infection control
Data Capturers Project	TB/HIV care Management
Sexually Transmitted Infections	Risk Re-Assessment
Post Exposure Prophylaxis	Briefings: New curriculum on HIV and AIDS
*Pre Service Training (on HIV and AIDS)	Training on Clinical mentoring
Peer education High Transmission Areas	Drug resistance and adherence counselling
Peer Education for Inmates in prisons	TB training
Barrier Methods	*IMCI*
Logistics Management Information System	Pulsa Plus
Clinical Symposium (on HIV and AIDS)	Clinical Management of HV, STI and TB
Project Management	Electronic TB register

*This course is targeted at Nurses, Medical Officer Interns and Medical Officer Comm. Service

Only a few courses (in italics) could be seen as outside of HAST. During FGDs, participants expressed satisfaction with the quality of facilitation at trainings, indicating that most facilitators were knowledgeable and subject matter experts in topics covered.

Availability of training data presented a challenge for majority of the RTCs. Training data was not always readily available and only a few of the RTCs performed some analysis for trends. Table 9 shows the number of health care professionals that have been trained by the RTCs since 2006, in the six provinces that provided training data.

Table 9: Number of health care professionals trained by year (in selected provinces)

Province	2006/7	2007/8	2008/9	2009/10	2010/11	2011/12	Overall
Gauteng	1 157	1 004	930	3 887	5 521	7 094	19 593
E. Cape	1416	N/A	2328	N/A	N/A	3680	7424*
Free State	1 036	826	305*	1 626*	3 451	2 900	8 213
Limpopo	N/A	N/A	N/A	N/A	N/A	1266	1266*
N. Cape	N/A	N/A	N/A	410	1 753	3 016	5 179
W. Cape	-	-	-	-	-	-	7 320**
Mpumalanga	2 298	2 289	5 672	4 613	5 283	6 930	27 085

*Not all records were available **Cumulative figure provided for period 2004 - 2012

3.6 Distance Learning

As indicated earlier, distance learning was pulled out of the Education and Training Approach to be a separate theme due to the wide interest in limiting disruptions to the service provision at the facility, in order to give it more emphasis. Distance learning is defined as improved capabilities in knowledge and/or behaviours as a result of mediated experiences that are constrained by time and/or distance such that the learner does not share the same situation with what is being learned[27]. The situational analysis explored the existence of distance learning across the nine provinces and determined whether or not those in existence were streamed live.

Review of records and interviews revealed that only two out of the nine provinces had some form of distance learning in place. Distance learning programmes were found to be operational in Free State and KwaZulu-Natal provinces. Both provinces also reported using tele-health to deliver educational information.

Free State: Respondents from the province reported that the Free State RTC provides training to health care professionals in all five districts and this was posing a challenge for the province to coordinate. The province opted for distance learning to supplement contact training sessions. Distance learning is provided through a well-established distance based training infrastructure[27], the Interactive Distance Communication and Management System (iCAM). This is a television broadcasting medium which enables the Free State Department of Health to disseminate information and communicate with health workers from a central studio located in Bloemfontein, the province's capital. The system reaches 38 receiving satellite sites spread across the entire province[28]. Additionally, respondents in the Free State indicated that health care professionals use laptops to access web-based trainings.

The control rooms for iCAM, Free State Department of Health

iCAM is a live system and it allows health care professionals to interact with the course facilitator during sessions. Initially, the course facilitator was able to get the details of the participants when they asked questions, through a sophisticated touch pad that was linked to the PERSAL system; however, due to financial constraints, the province scaled down and currently health workers interact with the facilitator through a telephone. Respondents from the Free State reported that only trainings related to HIV, especially ART, were streamed through iCAM. The impact of iCAM was almost immediate as the proportion of nurses trained on ART was recorded at 46.5% in 2005 - one year after the launch of iCAM[27]. From the pictures above (a sample of several that shows the design of the system) and discussions with employees overseeing the system, iCAM is a sophisticated system that requires a large capital investment in installation costs and additional maintenance costs.

KwaZulu-Natal: According to respondents, a distance learning programme was introduced in the province in 2006 linked to satellite colleges for undergraduate studies. The programme is led by the UKZN and faculty is responsible for selecting facilitators, ensuring that the training provided is of high quality. Respondents also reported that UKZN received funding from the Global Fund to Fight AIDS, TB and Malaria to host various tele-medicine sites for postgraduate students. According to reports from the field, video conferencing enables linkages to the satellite colleges and facilitates a live learning environment with immediate interaction.

Respondents from provinces that do not have distance learning programmes were asked if there were any plans to develop these in the future. Only the Eastern Cape RTC elaborated on a distance learning programme currently under development which will be launched in the near future.

Eastern Cape: Respondents indicated that the ECRTC has been developing a distance learning programme over the past year and plans to use the current clinic nodes as satellite sites. The RTC reported that resources currently available include laptops (already procured). A Modular Object-Oriented Dynamic Learning Environment (MOODLE), which is a free source e-learning software platform, was reportedly being set up and the RTC has applied for CDC funding to further develop this programme. The intention of the ECRTC is to focus the distance learning on case discussions via telecom and telephonic consultations.

Respondents from other provinces reported that they lacked resources to develop and implement distance learning programmes although they did see its value.

> "*Distance learning, if standardized, can assist with training health care professionals in rural areas, reducing time away from service delivery."* RTC employee, Mpumalanga.

Overall there was interest among most RTCs to develop and implement distance learning programmes to complement (but not replace) contact classroom sessions. It was clear that respondents still valued contact sessions.

> *"The student is in contact with the teacher, questions can be clarified immediately, guidelines can be explained better by the facilitator and the student can get diverse viewpoints from fellow participants."* RTC Manager

"The type of training provided at the ATTIC suits face to face interaction with the participants. Distance learning facilities should only assist with follow up courses and individuals who may need 'touch ups' after classroom training at the ATTIC." Government official, Western Cape

Respondents suggested that as health workers are used to contact sessions, it will be very important to create awareness on distance learning and the benefits. Road shows were suggested as a mechanism to reach as many health care professionals as possible. In contrast, some respondents reported that training partners such as the FPD is providing distance learning for health care professionals in several provinces, which brings familiarity to the concept among health care professionals.

3.7 Planning, Monitoring, Evaluation and Reporting

Over the last decade, the need to show impact of programmes has gained momentum among governments and donors worldwide. A good evaluation of programme impact depends on availability of reliable routine monitoring data. The situational analysis looked at the ability of the RTCs to plan, especially the use of training needs analysis to inform target setting and development of training plans. Additionally, the situational analysis looked at the availability of monitoring and evaluation plans and the level of reporting.

Training Needs Analysis: All RTCs reported that they use a skills audit to determine training needs for health care professionals. A paper-based questionnaire is sent to the facilities through district training coordinators and these are completed by health care professionals. The RTCs are able to determine the number of health care professionals that have been trained on the courses offered and/or coordinated by the RTC. From discussions with respondents, this process also captures health care professionals' interest in other training courses outside of what is currently offered.

Planning: Respondents reported that a business plan is the main planning tool that the RTCs use. On an annual basis, the RTC engages in a business planning process as part of the province-wide initiative and the plan contains training targets for the year as determined by the programme units at the provincial level, usually HIV and AIDS due to the model and

the nature of most RTCs' operations. Respondents indicated that the National Department of Health provides assistance during the business planning process.

Monitoring and Evaluation: During interviews and from the review of records, it was established that some forms of monitoring and evaluation systems exists across all nine RTCs. These are characterized by routine visits to facilities to ascertain that recently trained health care professionals are practicing the newly acquired skills; availability of M & E tools for reporting and availability of M & E staff to coordinate all M & E activities for the RTC. In selected provinces where dedicated M & E staff does not exist, training coordinators and/or managers take on the M & E function.

The Eastern Cape RTC was found to have an advanced monitoring and evaluation system in place that is able to generate reports specific for the donor (CDC South Africa) and the Provincial Department of Health simultaneously. According to the ECRTC's annual report, the RTC had and M & E Manager and an M & E officer in place[26]. Due to the conclusion of the CDC grant toward the end of 2012, the M & E function is managed by a Programme Manager, with the M & E officer still in place. Respondents from the ECRTC reported that one database crashed leaving a 6-year information gap.

The Western Cape RTC was also found to have a functional M & E system, which is managed through a committee of 5 people, tasked with oversight to M & E activities. Respondents in KZN reported that an M & E system exists; however, it is part of the Strategic Health Programmes' overall M & E system and is managed from that office. In KZN, Training Coordinators reported that they capture training data on excel spread sheets and submit to the RTC Manager (a role previously assumed by HAST Programme Manager).

A challenge that was reported by RTCs that do not have dedicated M & E staff was that the focal points appointed to perform tasks of M & E officers had other competing priorities and the juggling between their own job functions with the additional functions of reporting was resulting in data quality issues.

> *"The same person that is doing M & E is also responsible for training and coordination, which places a burden on his shoulders and he is thus overwhelmed with tasks."* Government official, Limpopo Province

Evaluation of impact at the RTC level has been reported as largely focusing on the scale of trainings that have been conducted which is not a good measure of outcomes and impact. When asked to list some outcomes that could be attributed to the RTC, respondents listed changes in health outcomes as indicators of the contribution of the work of the RTCs and quotes below are direct reports from respondents:

"Training of large numbers of health care professionals"

"Reduction in mortality and complications for people living with HIV"

"Positive impact of reduction of stigma"

"Progress made in getting accreditation of courses (90%) for some RTCs"

"Improvement in turnaround time and waiting times have been shortened"

Although it was not part of the original scope of the situational analysis, with the exception of a few provinces, the majority of respondents did not fully comprehend the concepts of monitoring and evaluation and the factors of attribution. Upon clarification of concepts, respondents in those provinces indicated that there has never been an impact evaluation done at the RTCs. Gauteng Province expressed an interest in conducting an impact evaluation of the RTC at previous meetings prior to the situational analysis and repeated this interest during interviews.

Reporting: All RTCs are required by the National and Provincial Departments of Health to report on quarterly basis although more frequent reports were reportedly prepared for internal use. Majority of RTC Managers reported that the level of reporting expected is mainly on the Division of Revenue Act (DORA) indicators which for the RTCs relate to numbers and categories of staff trained. Respondents from all RTCs indicated that this level of reporting is a requirement and that data flows from districts (for most RTCs) to the provincial level to the National Department of Health. RTCs are able to report qualitative information on the comment section of the DORA spread sheet. Except for the Eastern Cape RTC, respondents from the other RTCs did not indicate any additional reporting.

The Eastern Cape is the only RTC that produces an annual report[26] and reports additional data across several databases (Training Information and Coordination System, Partner Information Management System, Training Information Management System and many others) to inform additional reporting such as that required by the CDC. The annual report

captures training data for the past year, good practices and challenges experienced, and the other databases capture similar information tailored to the audience.

Respondents also reported that to facilitate timely reporting, quarterly meetings are held with the decentralized RTC structures such as ATICCs in the Eastern and Western Cape provinces and RTCs at the districts for North West province. Mpumalanga and Limpopo Provinces reported support from I-TECH to implement the Training System Monitoring and Reporting Tool (TrainSMART) for capturing training data. Respondents reported that the tools enable them to generate reports on training data.

Mpumalanga Province reported that training data is analysed and graphs such as depicted in figure 1 below are used by the RTC Manager for planning and strengthening RTC operations.

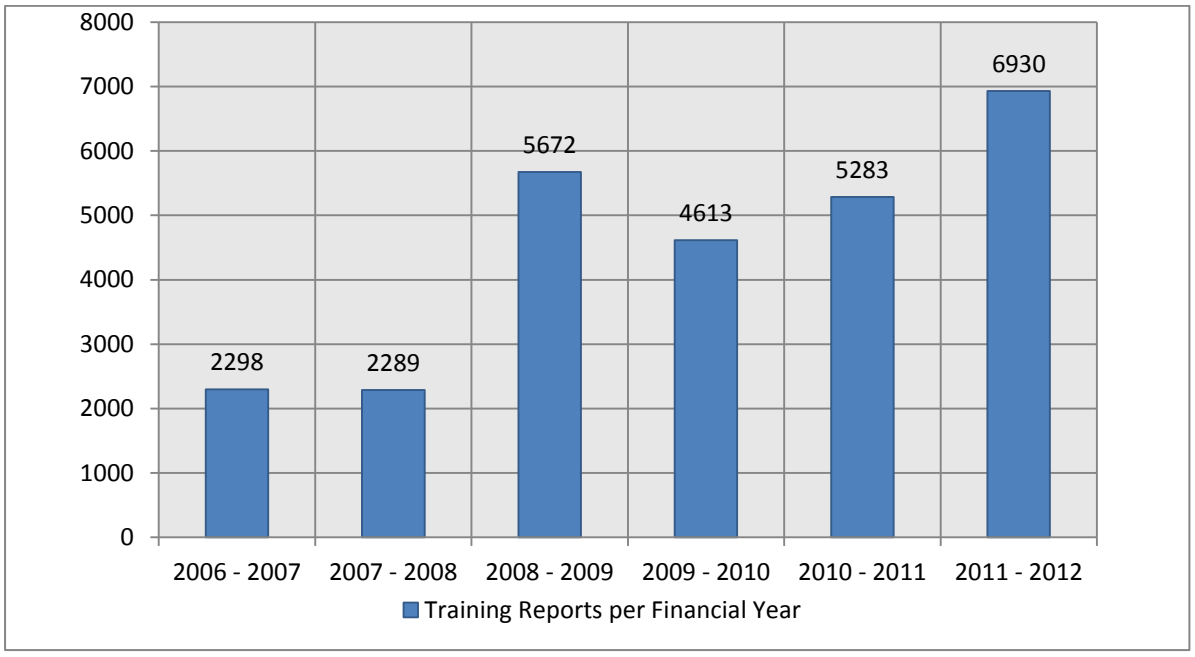


Figure 1: Number of health care professionals (and other categories) trained by year, Mpumalanga (courtesy of the Mpumalanga RTC)

4. CONCLUSIONS & RECOMMENDATIONS

This section is meant to provide recommendations to address challenges identified and provide a basis for the recommendations. Table 10 (at the end of this section) indicates the proposed timeframe for implementation of recommendations.

It has been 10 years since the NDOH called for establishment of RTCs; hence it was timely that a situational analysis of this nature was undertaken. However, the situational analysis was not a formal assessment of RTC operations in a true sense of an evaluation. To a large extent, the situational analysis focused on where the RTCs are today, good practices and challenges they face. Although RTCs were established at various points during the last 10 years, with RTCs established between 2003 and 2012, we believe that the range provides a good enough timeline for the National and Provincial Departments of Health to review the contribution of the RTCs toward the improvement of health outcomes in the country. *We recommend that the National Department of Health considers working with the Provincial Departments to conduct a 10-year evaluation of the contribution of RTCs to the scale up of programme interventions, in particular the ART roll-out.*

RTC Model: The guidance provided to provinces by the National Department of Health back in 2003 was adequate at that time to get the process for establishment of RTCs going and it allowed provinces sufficient room to contextualize the approach to provincial to suit local needs. A major disadvantage of providing guidelines as opposed to policy directives is that guidelines are equivalent to advice and the receiver is left with a lot of choice on how to take it. The Framework Document was not intended to be a policy for provinces to follow when establishing RTCs. While it contained a lot of proposals on many aspects of RTC operation, it did not provide for an RTC model from which provinces could base decisions related to the RTC.

We also noted that some parts of the Framework Document provided sufficient guidance for provinces to come up with some kind of a model and that this largely contributed to provincial variations. The Framework Document proposed that, *as a preference*, the RTCs be part of Provincial Departments of Health as one of its Human Resources arms. We found that majority of RTCs were established as one of the HAST arms and with recent transition of Limpopo and Western Cape RTCs to HRD, there was at the time of the situational analysis, a 50/50 split between RTCs reporting to HRD and those reporting to HAST. The

Eastern Cape RTC has a dual reporting mechanism to the university and to the HAST unit within the Provincial Department of Health.

We recommend that the National Department of Health develops and make into policy a model for the RTC, taking into account the need for provinces to adapt to provincial contexts within defined policy boundaries. The RTC model/s should be specific in the following six areas: (i) the type of Institutional Base (Health Department, Academic Institution, hybrid or other); (ii) the recommended locations of the RTC (Government--e.g. Provincial Health Department, Free standing structure, Government agency/trust, educational institution); (iii) the reporting lines (line management) (iv) mechanism(s) for input by local stakeholders and partners including academic institutions; (v) minimum staff requirements and levels for senior positions; and (vi) requirements for standardized training curricula. Additionally, *we recommend that the National Department of Health considers revising the 2003 Framework Document to provide guidance on how to operationalize the new RTC model/s, which will allow provinces to contextualize operations to suit local needs.*

We found that most RTCs coordinated and provided trainings that covered a broad range of topics; however, there was still a huge emphasis on HIV and AIDS trainings. We noted the call from the National Department of Health that RTCs should coordinate all in-service trainings for health care professionals and other health care workers in the province. Coordinating all in-service training for health care professionals in the province is doable; however, it will require sufficient resources at the RTC, especially human resources, to be able to deliver.

Not all RTCs had a dedicated advisory structure or a mechanism for advice and oversight from local stakeholders, including universities. Skills development is a critical component of programme implementation in order to achieve better health outcomes, more so in public health where new evidence becomes available more frequently, requiring that health care professionals and related community workers to be trained and re-trained. This is such an important function, entrusted to the RTC. Input from local stakeholders is critical if RTCs are to remain relevant and address the needs. *We recommend that each province establishes an advisory committee or other body that should be tasked with the responsibility of oversight, advice and input on RTC activities.*

We found that the majority of RTCs conducted trainings at the district and facility levels, although limited centralized trainings still occurred in a few provinces. We found that senior officials at national and provincial levels preferred for trainings to occur at the local level to minimize disruptions to health care service provision. To ensure maximum decentralization of trainings to the districts and facilities, *we recommend that all RTCs recruit sufficient trainers (based on number of facilities to be supported) and deploy them to conduct majority of trainings on-site with limited centralized trainings at a location within the district.* This approach will minimize delivery to service provision as on-the-job training ensures training can occur concurrently with service provision. However, where this is not feasible, limited centralized trainings should still occur as part of a mixed approach.

As indicated in the Framework Document, it would have been *more logical* to establish RTCs within academic institutions. This was not possible at that time for various reasons. To date, only the Eastern Cape RTC is based within a university. There are unquestionable benefits to a strong collaboration of a training centre with a university or a college, including the ability of faculty members to input into training programmes and the accreditation of training courses. We found that all RTCs did have linkages with academic institutions, some stronger and more systematic, others not as strong and less systematic. Most RTCs did not fully engage academic institutions and are missing out on an opportunity to strengthen RTC-offered training programmes. Regardless of location of an RTC, it is possible to forge strategic partnerships with universities, colleges and technical training institutes to take advantage of the added benefits. *We therefore recommend that all RTCs clarify the nature of the current partnerships with academic institutions and document clearly the terms and deliverables in some form of a partnership framework (i.e. service level agreements, memorandum of understanding etc.) that is co-signed by the academic institution and a duly authorized representative of the RTC.*

Some of the RTCs' functional areas that the universities and colleges can assist with include: (i) evaluation of skills (and gaps) of existing cadres of health care professionals and health care workers; (ii) designing curriculum for training and providing resource persons during trainings; (iii) designing and participating in mentoring programmes; and (iv) accreditation of training courses.

Financing and Expenditures: We found that RTCs are largely funded by the South African Government through the Conditional Grants for HIV and AIDS. The situational analysis found that respondents equated the restrictions to procure some items with Conditional

Grant funds with inadequacy of fund allocation. For the intended purposes of the Conditional Grant, the analysis found that allocation to the RTCs was generally adequate. However, RTCs had needs beyond the scope of the Conditional Grant that needed to be covered from other sources.

The challenges associated with using the Conditional Grant for HIV and AIDS for RTC operations is the need to remain compliant with its requirements and the expectation from the National Department of Health to conduct and coordinate trainings beyond HIV and AIDS. Some RTCs have been able to include very limited trainings outside of HIV and AIDS; however, many RTCs still coordinate and conduct only HIV and AIDS trainings using the Conditional Grant funds. With the call from the National Department of Health for RTCs to move beyond HIV and AIDS and coordinate and provide in-service training for all categories of health care professionals, and the increased move by the National Treasury to ensure compliance on usage of Conditional Grants[21], *we recommend that the National Department of Health review the funding model for RTCs and either seek guidance from National Treasury on expansion of the scope of the Conditional Grant for HIV and AIDS or find an alternative funding source to augment the Conditional Grant.* The alternative funding source could cover the RTC operations related to non-HIV and AIDS related trainings.

We found that the majority of RTCs do not have direct access to external sources of funding. Due to the requirement that external financial support to Government must pass through National Treasury, accessing external funding may not be the perfect solution for RTCs based in Government. However, *we recommend that all RTCs explore creative solutions to benefit from external support currently available from NGOs, donors and the private sector.* Some ideas include continuing with the current practices of accepting support as in kind donation and the inclusion of training partner support in RTCs' business plans as a way of meeting financial resource needs.

Other indirect financial support from partners was contributed in the form of secondment of staff to RTCs, an approach that has helped address staff shortages in the short term. Given that a large number of partners seconding staff to RTCs are PEPFAR-funded and the increased PEPFAR focus on transition, this approach is not sustainable.

We found that RTCs are not always able to spend all the allocated funds and reasons for low expenditure levels ranged from *"province under administration"* to *"delays in receiving Conditional Grant funds"* which lead to either trainings not conducted at all or that trainings scheduled for the first quarter of the fiscal year not implemented. *We recommend that RTCs anticipate delays in disbursement of Conditional Grant funds and tailor the training plans to fit the reality.* Additionally, *we recommend that RTCs use the mid-year review opportunity to revise their plans accordingly and develop ways to accelerate training programmes as necessary.*

Infrastructure and Human Resources: We found that eight out of the nine provinces have physical structures (buildings) identified to house the RTC. Of the eight, two were still under development at the time of the situational analysis and six were fully functional. To a large extent, RTC facilities have a combination of offices and training rooms with the Eastern Cape and Mpumalanga having accommodation for training participants as well. The existence of a physical structure with training rooms enables the RTCs to conduct trainings on site and to save on costs associated with hotels and renting of training venues. In other countries like Tanzania, the ZHRCs, which are the equivalent of South Africa's RTCs, rent out training rooms as a means of income generation to support further strengthening of ZHRCs operations[27].

Given the benefits that come with RTCs having a physical structure, *we recommend that provinces that do not currently have a physical structure to house RTCs consider identifying or developing such facilities, and that the RTC building consists of training rooms at a minimum*. Adequate space is particularly important as RTCs move beyond HIV and AIDS to coordinate all in-service trainings for health care professionals and other health care worker categories in the provinces.

Another area that posed challenges for RTCs was the limited availability of IT and other equipment required for trainings. While some computers are generally available at all RTC facilities (mostly for staff use rather than training), the challenge noted across most RTCs was the limited availability of training and evaluation-related equipment and internet connectivity, which was not always reliable. Some RTCs did not have enough blackboards while others had a limited number of LCD projectors. *We recommend that RTCs be supported with necessary IT and equipment (including reliable internet connectivity) to allow for optimal functioning.*

We found staff shortages at the RTC was the reason most of the RTCs were unable to function. The absence of staff at the RTCs was found to result from two shortcomings: (i) Some RTCs have inadequate staff complement; (ii) Most RTC were finding it difficult to fill vacant positions due to ineligibility of RTC positions for OSD; and (iii) some provinces use Conditional Grants for HIV and AIDS to contract the core staff at the RTCs and suitable candidates prefer permanent positions.

We found that only the ECRTC had a staff establishment that closely matched that proposed in the Framework Document in quantity and technical requirements. *We recommend that the National Department of Health determines a practical minimum number of staff for an RTC as part of the development of an RTC model. We further recommend that the National Department of Health determines the extent to which ineligibility of RTC positions to OSD impacts on the overall operations of RTCs in all nine provinces and support provinces to address the challenge.*

Coordination, integration and support: At the district level, we learned that there are district health plans that come with district training plans. In some provinces, the district health training plans are communicated to the provinces and these form the basis for the development of the provincial training plan at the RTC level – although mostly the HIV and AIDS components. In other provinces, this is not always the case. We also found a recurring challenge across most provinces on coordination of training activities conducted by partners, who often do not consult the RTCs when planning and conducting trainings in the provinces, especially at the levels below the province. We found that the RTCs have been communicating the need for coordination of all in-service trainings that occur in the provinces through the RTC. This has not resulted in the desired change of practice as partners continue to go directly to the districts to conduct or support trainings, without the knowledge of the RTC.

We recommend that the requirement that an RTC "serve as a focal point for training and capacity building for all categories of health workers in the province" be institutionalized and championed by senior officials at the Provincial Departments of Health and District Management Teams. In addition, we recommend that the National and Provincial Departments of Health consider including a clause in all Memoranda of Understanding with partners that states that "the RTC must be consulted and provide oversight on all training activities that will be conducted as part of the programme proposed by partners".

In order to integrate all health care ~~worker~~ training programmes within the province, *we recommend that once the RTCs are sufficiently resourced to manage overall coordination of all in-service trainings for health care professionals and other categories within provinces, they institutionalize an annual planning session as a mechanism of bringing together all health care programmes to develop a comprehensive training plan (including a training schedule) as an outcome, for the entire Provincial Department of Health*. Training partners may either be requested to communicate planned training support to the province in advance or invited to participate during the session to ensure that their trainings are included in the comprehensive training plan. To allow for trainings that are not in the comprehensive training plan to still be allowed, *we further recommend that the Provincial Departments of Health develop a mechanism for approving such requests.*

We found provincial variations in terms of the adequacy of support provided to the RTCs by the National and the Provincial Departments of Health. RTC Managers are tasked with a responsibility to manage the operations of an RTC and there are expectations that they should have generic management skills i.e. financial, human, interpersonal and reporting capabilities. Given the demand, *we recommend that a gap analysis of the skills of RTC Managers be conducted and that a capacity building programme be developed to address findings. NDOH and the Provincial Departments of Health should lead efforts to ensure that necessary resources are made available for this purpose.*

Education and Training Approach: We found that training curricula is not always standardized across provinces. As part of the development of the RTC model/s, *we recommend that the National Department of Health be specific on the need for standardization and what aspects of the curricula can be adapted to suit local context.*

We also found that the process for selecting training participants that is in place in all RTCs was robust enough. We also noted that the RTCs understood the importance of ensuring that appropriate participants are selected to participate in trainings. However, we also found that the vetting of participants was not always conducted diligently. Some partners expressed concern that lower level positions were sent to trainings. *We recommend that RTCs build into the selection process, a two-stage vetting process that would occur when lists of training participants are submitted to the RTC, and on the first day of the training. We also recommend that selected participants, mostly replacements, who do not meet the selection criteria, should not be allowed to participate in training sessions.*

We found that majority of training courses offered by the RTCs were not accredited. As a result, health care professionals that undergo training receive certificates of attendance as opposed to certificates of competencies. *We recommend that the National Department of Health makes a decision on the level of training required for RTCs: (i) accredit the RTCs as a training institution; (ii) accredit trainers from RTCs; and/or (iii) accredit training courses.* Once a decision is made, RTCs should be supported accordingly to pursue the type of accreditation that will optimize their operations.

Mentoring: We found that all RTCs, except the Western Cape RTC, implemented mentoring programmes. Mentoring was mainly for HIV and AIDS programmes, especially NIMART. The Western Cape RTC sees the follow up support that is provided to facilities as sufficient. We also found that the approach to mentoring varied across provinces. It was clear that the availability of resources determined the ability of an RTC to roll out the mentoring programme. We also found that training partners played a significant role in supporting mentoring programmes at the provincial level. We did not find linkages of mentoring programmes with clinic supervision at the provincial level and we noted that in some provinces, clinic supervision is not implemented effectively. *We recommend that the National and Provincial Departments of Health consider strengthening the routine clinic supervision programme. Subsequently, the Departments of Health should consider gradually integrating mentoring to routine clinic supervision as a strategy toward integration of services, minimizing verticalization of programmes and maximizing health care professional time.*

Distance Learning: Distance learning is generally not a well-established approach in the public health sector as a means to provide in-service learning to health care professionals. Only the Free State and KZN Provincial Departments of Health had distance learning programmes in place and the Eastern Cape RTC had plans in place to launch one in the near future. We found that the Free State was able to reach a large number of nurses in a very short period of time through the iCAM system. We have not come across a cost-benefit analysis of the iCAM system, to enable us to recommend that other provinces adopt a similar approach.

Although a few of the RTCs indicated preference for contact sessions, majority of the RTCs expressed interest in developing distance learning programmes and indicated readiness to start looking at options. Furthermore, those that were sceptical also acknowledged that distance learning can complement contact learning. We also found that distance learning can be implemented using more affordable platforms.

We recommend that an assessment of technology needs be conducted across selected RTCs that do not have these programmes in place and expressed interest in developing them. We also recommend that those RTCs be supported with (i) required technology; (ii) development and/or adaptation of educational content; and (iii) limited scale implementation of the distance learning programmes. We further recommend that these programmes be evaluated post implementation for effectiveness prior to scale up.

Planning, Monitoring, Evaluation and Reporting: We found that all RTCs had processes to conduct training needs analysis to inform target setting and business planning. The processes in place did not focus on patient level data to inform training needs, but relied on self-reported skills by health care professionals. *We recommend that all RTCs augment existing mechanisms of determining training needs by implementing a combination of approaches i.e. skills audit, asking topics of interest as part of evaluation at the end of all trainings, analysis of patient level data (including health outcomes) etc.* Outputs from all the processes described could be pulled together at a minimum on an annual basis prior to training target setting and business planning processes.

We found that most of the RTCs do not have M & E systems in place. There were variations across provinces with the Eastern Cape RTC demonstrating a multi-layered system while others had only a simple reporting tool. Another challenge that is linked to the limited human resources overall is the lack of dedicated staff to perform M & E functions. In most RTCs, either the Training or Programme Manager and in some cases Training Coordinators performed M & E functions. *We recommend that RTCs review existing and/or develop M & E systems that will guide them in monitoring training program implementation and guide them in allocation of resources for the M & E function.* Regardless of who at the RTC performs the M & E function, we recommend that they be capacitated with M & E skills in order to perform all M & E functions, ranging from developing training needs analysis, development of training plans, developing and/or adapting indicators, developing evaluations to assess outcomes of trainings and reporting.

With the exception of a few RTCs, we found that most RTCs do not have reliable databases to capture training and skills data. As the National Department of Health has approved and will soon be rolling out SkillSMART for capturing training and skills data across all provinces, *we recommend that RTCs hold off plans to develop new and/or expand on existing databases in anticipation of the roll out.*

Table 10: Proposed timelines for implementing recommendations

Immediate – 12 months	6 -18 months	12-24 months
1. NDOH develops and make into policy a model for the RTC, taking into account the need for provinces to adapt to provincial contexts within defined policy boundaries. The RTC model/s should be specific in the following six areas: (i) the type of Institutional Base (Health Department, Academic Institution, hybrid or other); (ii) the recommended locations of the RTC (Government--e.g. Provincial Health Department, Free standing structure, Government agency/trust, educational institution); (iii) the reporting lines (line management) (iv) mechanism(s) for input by local stakeholders and partners including academic institutions; (v) minimum staff requirements and levels for senior positions; and (vi) requirements for standardized training curricula.	12. Each province establishes an advisory committee or other body that should be tasked with the responsibility of oversight, advice and input on RTC activities.	
2. NDOH considers revising the 2003 Framework Document to provide guidance on how to operationalize the new RTC model/s, which will allow provinces to contextualize operations to suit local needs.	13. All RTCs clarify the nature of the current partnerships with academic institutions and document clearly the terms and deliverables in some form of a partnership framework (i.e. service level agreements, memorandum of understanding etc.) that is co-signed by the academic institution and a duly authorized representative of the RTC.	25. Provinces that currently do not have a physical structure to house the RTC should consider identifying a physical structure consisting of training rooms at a minimum.
3. All RTCs recruit sufficient trainers (based on number of facilities to be supported) and deploy them to conduct majority of trainings on-site with limited centralized trainings at a location within the district.	14. All RTCs explore creative solutions to benefit from external support currently available from NGOs, donors and the private sector.	26. As soon as RTCs are sufficiently resourced to manage overall coordination of all in-service trainings for health care professionals within provinces, they should institutionalize a mechanism of bringing together all health care programmes into an annual planning session to develop a comprehensive training plan for the provincial department.
4. As part of developing RTC model/s, NDOH should review the funding model for RTCs and either seek guidance from National Treasury on expanding the scope of the Conditional Grant for HIV and AIDS or find an alternative funding source to augment the Conditional Grant.	15. NDOH makes a decision on the level of training required for RTCs: (i) accredit the RTCs as a training institution; (ii) accredit trainers from RTCs; and/or (iii) accredit training courses.	
5. The Provincial Departments of Health should support RTCs with necessary IT and equipment (including reliable internet connectivity) to allow for optimal functioning.	16. All RTCs should anticipate delays in disbursement of Conditional Grant funds and tailor the training plans to fit the reality.	27. To allow for trainings that are not in the comprehensive training plan to still be allowed, we further recommend that the Provincial Departments of Health develop a mechanism for approving such requests.

Immediate – 12 months	6-18 months
6. Institutionalize the coordination role of RTCs through champions in Provincial Department of Health's executive management committee and District Health Management Teams.	17. All RTCs should use the mid-year review opportunity to revise training plans accordingly and develop ways to accelerate training programmes as necessary.
7. NDOH and PDOH consider including a clause in all Memoranda of Understanding with partners that require that RTCs be consulted and provide oversight on all training activities that will be conducted as part of the programme proposed by partners.	18. National and Provincial Departments of Health develops a longer-term strategy for human resources within RTCs and support the RTCs with sufficient personnel. This process should also review the challenges faced by provinces due to the ineligibility of RTC positions to benefit from OSD
8. NDOH conducts a gap analysis of the skills of RTC Managers and that a capacity building programme is developed to address findings. NDOH and the Provincial Departments of Health should lead efforts to ensure that necessary resources are made available for this purpose.	19. NDOH and PDOH consider consider strengthening the routine clinic supervision programme. Subsequently, the Departments of Health should consider gradually integrating mentoring to routine clinic supervision as a strategy toward integration of services, minimizing verticalization of programmes and maximizing health care professional time.
9. RTCs employ a two-stage vetting process for trainee selection that would occur when lists of training participants are submitted to the RTC, and on the first day of the training. In addition, selected participants, mostly replacements, who do not meet the selection criteria, should not be allowed to participate in training sessions.	20. RTCs interested in distance learning programmes are supported with (i) required technology; (ii) development and/or adaptation of educational content; and (iii) limited scale implementation of the distance learning programmes. We further recommend that these programmes be evaluated post implementation for effectiveness prior to scale up.
10. RTCs hold off plans to develop new and/or expand on existing databases in anticipation of the roll out of SkillSMART for capturing training and skills data	21. All RTCs augment existing mechanisms of determining training needs by implementing a combination of approaches i.e. skills audit, asking topics of interest as part of evaluation at the end of all trainings, analysis of patient level data (including health outcomes) etc.
11. An assessment of technology needs be conducted across selected RTCs that do not have distance learning programmes in place and expressed interest in developing them.	22. RTCs develop M & E systems that will guide them in monitoring training program implementation and guide them in allocation of resources for the M & E function.
	23. All staff charged with M & E functions is capacitated with M & E skills in order to perform all M & E functions, ranging from developing training needs analysis, development of plans, developing and/or adapting indicators, developing evaluations to assess outcomes of trainings and reporting.
	24. NDOH considers working with the Provincial Departments to conduct a 10-year evaluation of the contribution of RTCs to the scale up of programme interventions, in particular the ART roll-out.

REFERENCES

1. Murray CJL, Vos T, Lozano R, et al. Disability-adjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990–2010: a systematic analysis for the Global Burden of Disease Study 2010. Lancet 2012. 380**:** 2197–223.
2. UNAIDS. UNAIDS report on the global AIDS epidemic. 2012. UNAIDS. Geneva.
3. World Health Organization. WHO's Global Tuberculosis Report. WHO. Geneva. 2012
4. Michel Sidibé, Peter Piot, Mark Dybul. AIDS is not over. The Lancet 2012. 380: Commentary.
5. Management Sciences for Health and World Health Organization. Tools for planning and developing human resources for HIV/AIDS and other health services. Cambridge, Massachusetts & Geneva, Switzerland. 2006.
6. National Department of Health. The Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment in South Africa. Pretoria. 2003
7. Schneider H, Blaaw D, Gilson L, Chabikuli N, Goudge J. Health systems and access to antiretroviral drugs for HIV in Southern Africa: service delivery and human resource challenges. Reproductive Health Matters, 2006. 14(27):12-23.
8. US AIDS Education and Training Centres. 2012. Available online, Accessed on 07 January 2012 on http://www.aidsetc.org/aidsetc?page=ab-00-00
9. Berman P, Bossert TJ. A decade of health sector reform in developing countries: What have we learned? Harvard School of Public Health. 2000.
10. Regional AIDS Training Network. Available online at http://www.ratn.org/index.php?option=com_content&view=article&id=321&Itemid=690. 2012. Accessed on 12 January 2013
11. South West Highlands Zonal Health Resource Centre. Available online. http://swhzhrc.webs.com/ Accessed on 12 January 2013
12. National Health and Population Development. Announcement by Dr Willie Van Niekerk, Minister of National Health and Population Development. Pretoria. 1988
13. National Health and Population Development. Letter from DG to Cape Province. Pretoria. 1989
14. National Department of Health. National Strategic Plan for HIV and AIDS (2000 – 2005). Pretoria. 2000.
15. National Department of Health. Framework for establishing RTCs in South Africa. Pretoria. 2003

16. National Department of Health. National Strategic Plan for HIV, AIDS and STIs (2007 – 2011). Pretoria. 2007
17. National Department of Health. National Strategic Plan for HIV, AIDS, STIs and TB (2012 – 2016). Pretoria. 2012
18. FHI 360. Qualitative Research Methods: A Data Collector's Field Guide. Available online, Available online at http://www.fhi360.org/nr/rdonlyres/etl7vogszehu5s4stpzb3tyqlpp7rojv4waq37elpbyei3tgmc4ty6dunbccfzxtaj2rvbaubzmz4f/overview1.pdf Accessed on 14 January 2012
19. I-TECH South Africa. US AETC study tour for government officials. Pretoria. 2012
20. McIntyre D, Thiede M. Health Care Financing and Expenditures. South African Health Review. Health Systems Trust. 2007. Available online. http://www.hst.org.za/uploads/files/chap3_07.pdf Accessed on 15 January 2013
21. World Health Organization. Human Resources for Health. Geneva: World Health Organization, 2005. http://www.who.int/hrh/en/
22. National Treasury. Accounting guidelines. Available online at http://oag.treasury.gov.za/Publications/06.%20GRAP/02.%20Manuals/Accounting%20Guideline_GRAP%20024%20Presentation%20of%20Budget%20Information%20in%20Financial%20Statements.pdf Accessed on 12 January 2013
23. Parliament of the Republic of South Africa. Announcements, Tabling and Committee reports. November 2012. Available online at http://www.parliament.gov.za/live/commonrepository/Processed/20121115/475122_1.pdf Accessed on 12 January 2013
24. George G, Quinlan T, Reardon C. Human resources for health: A needs and gaps analysis of HRH in South Africa. Health Economics and HIV & AIDS Research Division (HEARD); Durban. 2009.
25. The Constitution of the Republic of South Africa No. 108 of 1996. Statutes of the Republic of South Africa – Constitutional Law. South Africa. 1996
26. Eastern Cape Regional Training Centre. Annual Report 2011/12. Eastern Cape Regional Training Centre. Mthatha. 2012
27. King FB, Young MF, Drivere-Richmond K, Schredaer PG. 2004. Defining distance learning and distance education. Submitted to Education Technology Review. University of Connecticut, USA

28. Van Rensburg DHCJ, Steyn F, Schneider H, Loffstadt L. Human Resources development and antiretroviral treatment in the Free State province, South Africa. Human Resources for Health, 2008. 6:15
29. Free State Department of Health. Implementation of the Comprehensive Care, Management and Treatment of HIV and AIDS Programme Quarter Four Report 2006 FSDoH. Bloemfontein. 2006

APPENDICES

Appendix 1: Announcement by Minister of National Health, 1988

ANNEXURE "A"

ANNOUNCEMENT BY DR WILLIE VAN NIEKERK,
MINISTER OF NATIONAL HEALTH AND
POPULATION DEVELOPMENT
AT NEWS CONFERENCE

Pretoria

Wednesday 30 November 1988 - 15h30

AIDS initially occurred mainly amoungst White male homosexuals in metropolitan areas. The virus has now been identified in both sexes of all population groups. In the past 12 months, 20 cases of AIDS have been diagnosed amoungst Black people of both sexes. I recently released information which points to the increased heterosexual distribution of the virus and suggests that in some parts of the country it may occur amongst thousands of Black people of both sexes.

A new data base on the distribution of the Human Immunodeficiency Virus (HIV) in South Africa is now being launched in co-operation with the National AIDS Advisory Group to provide all health authorities with information on the occurrence of the HIV. In the past information on the occurrence of the disease in South Africa placed the emphasis on clinical cases of the disease AIDS.

The new monitoring action which the group has developed will keep anonymous information on the occurrence and distribution of the HIV. This will assist in determining the occurrence of the virus as well as trends.

The monitoring action is one of five steps initiated by the Department of National Health. An additional sum of R2,15 million has recently been made available to sharpen and supplement the Department's on-going health education programme.

The other steps which are envisaged are:

1. Supplementation of the existing centre in Johannesburg with information centres for health information officers in Cape Town, Port Elizabeth, Durban and Bloemfontein. These new service points will be equipped as information bureaux and training centres for information officers.

   Local authorities are involved in countering infectious diseases, including AIDS, and this special action is intended to support them.

2. Additional condoms are being made available at clinics and are available free of charge on request. Although condoms do not provide absolute safety, they are a means of countering the transmission of AIDS.

3. A popular information brochure will be produced in various languages and distributed countrywide.

4. An information brochure for doctors has also been prepared and will be sent to all doctors in January 1989. Brochures for other classes of health workers will follow.

AIDS has not yet obtained a serious hold on South Africa, and now is thus the time to take preventive measures. There are basically two ways in which the general public can contract AIDS namely through contaminated blood and sexual contact.

Regarding sexual contact (and this is the most common way in which AIDS is spread), prevention is not only a medical problem. It is a problem arising from people's conduct, in which the entire community is involved. It is, specifically, moral licentiousness which leads to the spread of the disease.

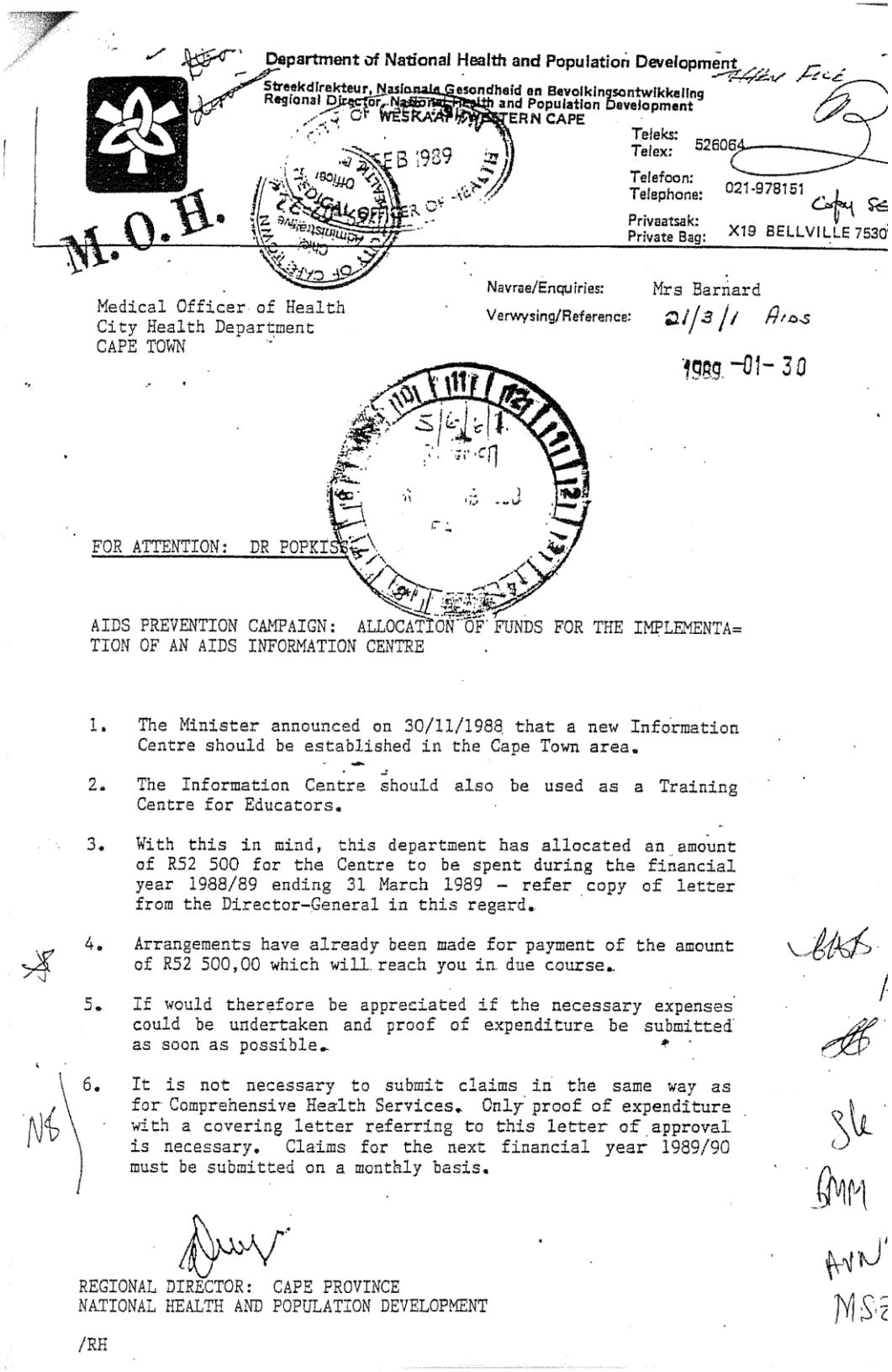
We must thus encourage and mobilise the full spectrum of both the public and private sectors in the country, not only to heighten awareness of the problem but also to become active in preventing exposure to the virus.

The basic steps have already been taken through the establishment of an AIDS Foundation. The object of the foundation will be to mobilise the resources of the private sector, to co-ordinate actions and to generate funds for projects which might be necessary to counter AIDS. This foundation must function independently. It is however important that co-ordinated (and sometimes even joint) actions be launched with the public sector. The State will thus have an advisory role. It is envisaged that the foundation will take shape early in 1989.

A postmark to promote public awareness of AIDS is already being applied to postal matter as part of the on-going awareness action.

Thursday, 1 December 1988 is World AIDS Day. It will see actions throughout the world to increase public awareness of AIDS and make information available. The Department of National Health and Population Development has, in co-operation with the National AIDS Advisory Group, urged local authorities and other branches of the health service sector to become actively involved in World AIDS Day.

Appendix 2: Translated letter from DG for National Health, 1989



Department of National Health and Population Development
Streekdirekteur, Nasionale Gesondheid en Bevolkingsontwikkeling
Regional Director, National Health and Population Development
WESKAAP/WESTERN CAPE

Teleks: Telex: 526064
Telefoon: Telephone: 021-978151
Privaatsak: Private Bag: X19 BELLVILLE 7530

M.O.H.

Navrae/Enquiries: Mrs Barnard
Verwysing/Reference: 21/3/1 Aids

1989 -01- 30

Medical Officer of Health
City Health Department
CAPE TOWN

FOR ATTENTION: DR POPKISS

AIDS PREVENTION CAMPAIGN: ALLOCATION OF FUNDS FOR THE IMPLEMENTATION OF AN AIDS INFORMATION CENTRE

1. The Minister announced on 30/11/1988 that a new Information Centre should be established in the Cape Town area.

2. The Information Centre should also be used as a Training Centre for Educators.

3. With this in mind, this department has allocated an amount of R52 500 for the Centre to be spent during the financial year 1988/89 ending 31 March 1989 - refer copy of letter from the Director-General in this regard.

4. Arrangements have already been made for payment of the amount of R52 500,00 which will reach you in due course.

5. If would therefore be appreciated if the necessary expenses could be undertaken and proof of expenditure be submitted as soon as possible.

6. It is not necessary to submit claims in the same way as for Comprehensive Health Services. Only proof of expenditure with a covering letter referring to this letter of approval is necessary. Claims for the next financial year 1989/90 must be submitted on a monthly basis.

REGIONAL DIRECTOR: CAPE PROVINCE
NATIONAL HEALTH AND POPULATION DEVELOPMENT

/RH

Appendix 3: Ethics clearance letter

HSRC
Human Sciences Research Council

Human Sciences Research Council
Lekgotla la Dinyakisišo tša Semahlale tša Setho
Raad vir Geesteswetenskaplike Navorsing
Umkhandlu Wezokucwaninga Ngesayensi Yesintu
Ibhunga Lophando Ngenzulu-Lwazi Kantu

HSRC Research Ethics Committee
FWA Registration: Organisation No. 0000 6347
IRB No. 00003962
NHREC No. REC-290808-015

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21 August 2012

Dr Scott Barnhart
University of Washington
Training and Educaton Centre for Health (I-TECH)
232 Bronkhorst Street
Suite 203, Optiplan House
Nieuw Muckleneuk
Pretoria
0181

Dear Dr Barnhart

Ethics Clearance of HSRC Research Ethics Committee Protocol No REC 1/18/07/12: A Situational Analysis of the Regional Training Centres in Nine Provinces of South Africa

Thank you for your application for ethics approval of the above study. This was considered by the Research Ethics Committee at its meeting on 18 July 2012.

Ethics clearance of the study is hereby granted.

The Committee wishes you success in your research.

Yours sincerely,

Prof. D R Wassenaar PhD
Chairperson: HSRC REC

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