District-level interventions that strengthen human resources for health

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Introduction and Purpose

The availability of appropriately organised, managed and supported health workers has a profound impact on the quality and experience of health care. The importance of human resources for health (HRH) to the DHS, was further emphasised by registrants at SALAD's first webinar in 2026. Yet HRH functions are frequently described as suboptimal. This webinar explored innovations and strategies to strengthen the effectiveness and efficiency of HRH at the district level. It complemented previous webinars that have addressed aspects of leadership and leadership development.

Krish Vallabhjee set the overall frame for the webinar by outlining four key dimensions of the HRH function, emphasising the health workforce as the health system's primary strategic asset. These dimensions are:

1. Strategic & Systems: Strengthening leadership, governance frameworks, workforce planning, and the delegation of authority.
2. Administrative: Ensuring the "taken-for-granted" essentials—vacancy filling, payroll reliability, and eliminating ghost employees—function without friction.
3. Operational: Refining service delivery organisation, defining packages of care, and optimising skills deployment across platforms.
4. Organisational Culture: Prioritising the "human" in human resources—values, staff wellness, safety, and intrinsic motivation.

Krish argued that while digital transformation is essential, the "human touch" remains the irreplaceable core of the DHS, calling for a transition from a mechanistic view of HRH to "innovative business-as-usual." This shift requires systemic responses to chronic challenges like role clarification and staff shortages, ensuring that district leadership is empowered to do things differently.

Integrating CHWs into the DHS in KwaZulu-Natal (KZN)

Hlobisile Langa (Director: PHC System Development, KZN Department of Health) shared the formalisation of community health workers (CHWs) as a central pillar of primary health care (PHC). CHWs are the bridge between the community and formal PHC facilities, essential for reducing facility congestion and ensuring continuity of care.

KZN has successfully formalised 5,200 CHWs with matric certificates into full-time employment at salary level 2. These cadres are now structurally linked to PHC facilities rather than operating in

parallel systems. The province executed an 11-district roadshow for orientation and induction. Training focused on conditions of service, ethical conduct, performance management and data management.

Key challenges for integration include:

- Supervision ratios: A need to revisit the ratio of outreach team leaders (OTLs) to CHWs as defined in the ward-based outreach team policy to ensure effective supportive supervision.
- Infrastructure: Lack of dedicated office space and equipment storage at the facility level hinders professionalisation.
- Operational support: Fragmented supervision and a deficit in dedicated transport and budgets for the community health programme.
- Digital transition: The persistence of paper-based registers prevents real-time tracking and actionable data at the ward level.

Virtual medical practice capacity strengthening in the Eastern Cape

Jenny Nash presented the Buffalo City Amathole Medical Support Initiative (BAMSI), an innovation designed to mitigate clinician isolation and the high turnover of junior doctors in rural areas—some up to 230km from KuGompo (East London's) referral centres. BAMSI was supported by an external grant from the Discovery Foundation and supported by the Rural Doctors Association of Southern Africa (RuDASA).

BAMSI transitioned from traditional, resource-heavy "in-reach" attachments to a sustainable, Zoom-based weekly teaching model. The curriculum covers 50 core medical topics, utilising the Vula platform—a mobile-based tool that enables real-time specialist communication and referral support—to bridge the gap between district hospitals and tertiary specialists.

The virtual model has fostered trust across levels of care, improved referral pathways, and provided continuing professional development points to support rural retention.

Strategic manoeuvring and leadership practices in Limpopo

Muthei Dombo (DDG: District Health Services) addressed the complexities of HRH strategic management from a senior provincial manager's perspective. In a context of fiscal austerity and constrained decision authority, this requires alignment with other departments (notably Treasury and the Premier's Office), and an adaptive and agile approach, and being ready to use all available opportunities ("shovel ready"). She highlighted this through the following examples:

- Tactical recruitment & resource reallocation: Limpopo has leveraged funding to target PHC-specific growth. Notable successes include increasing the number of community service pharmacists from 86 to 152 and expanding the radiography cadres from 22 to 92. The province also advertised specifically for "night shift" roles for doctors and radiographers to reduce overtime costs and accommodate staff needs.
- Addressing "phantom shortages": Muthei emphasised a "zero-cost" efficiency potential by distinguishing between actual deficits and shortages that reflect operational inefficiencies. Solving phantom shortages without additional funding requires using available data to identify other causes of service gaps.
- Uncovering internal capacity: The province's Voluntary Medical Male Circumcision Strategy revealed "hidden trainers, hidden trainees, and hidden implementers" within the existing system, demonstrating that capacity often exists but remains underutilised.

Audience participation

Audience engagement centred on the structural and ethical realities of the DHS workforce:

- Role clarification: Participants highlighted the structural "sandwiching" of clinical associates between nurses and doctors—an indicator of unresolved scope-of-practice frameworks that require leadership to delineate.
- CHW morale: CHW morale in KZN is reportedly at an all-time high post-professionalisation, with CHWs now identifying as facility "colleagues," driving significant enthusiasm for the system.
- Public-private friction: While contracting private providers (e.g., oncology/sonography) fills specialised gaps, it presents the risk of "internal poaching," where public staff leave the sector to join the contracted private firms.
- Rural disincentives: Debate persists on whether rural allowances suffice, and whether international premium pay models for rural service would be required to ensure long-term workforce stability.

Closing reflections

The session concluded with a synthesis by Krish and Lucy, identifying the strategic requirements for a thriving DHS:

- Courageous leadership: Senior managers must be willing to make unpopular decisions to disrupt inefficient systems and manoeuvre within fiscal constraints.
- Scale and sustainability: A shift from pilots to implementation at scale (e.g., KZN's 5,000+ CHWs) is the only route to systemic impact.
- Knowledge sharing: There is a vital need to share innovations and lessons across provinces—for example, linking the virtual updates of the Eastern Cape to the rural isolation challenges identified in Limpopo—to avoid reinventing the wheel.
- Digital advances will continue to augment the health system, but the human touch remains its most critical and irreplaceable asset. The success of the DHS in 2026 depends on valuing and strategically managing the people who deliver care.