# 9

# A profession in peril? Revitalising nursing in South Africa


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*The chapter provides an analytical perspective on nurses and nursing in South Africa, and the critical issues to be addressed by health policy-makers and practitioners in order to revitalise the profession. The chapter draws on the research findings of a four-year research programme known as Research on the State of Nursing (RESON), which aimed to develop and strengthen the research evidence for improved nursing policy development and practice in South Africa.*

*The evidence shows that nursing is a profession in peril, which requires major attention and revitalisation. The challenges faced by nurses and the nursing profession include weaknesses in the policy capacity of the main institutions responsible for the leadership and governance of nursing in South Africa, and a nursing practice environment that is fraught with resource, management and quality of care problems. The practice environment is also influenced directly by agency work and moonlighting, which in turn contribute to poor staying power, low energy levels, abuse of leave, sub-optimal nursing care, split loyalties and accountability, and erosion of professionalism. Revitalising nursing requires concerted efforts by government and key stakeholders to improve and modernise resources for a positive work environment.*

*A major crisis is looming unless issues of curriculum quality and relevance, nurse educator quality, educational resources, and governance of nursing education are addressed. This means that nursing education reforms must be implemented without further delay. There must be high-level investment in preparing nurses for and in practice through appropriate training that emphasises ethical value systems and social accountability, adequate staffing in different healthcare settings, and enabling work environments.*

*South Africa's quest for universal health coverage to improve population health and achieve equity and social justice cannot be achieved unless these issues are confronted.*



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## Introduction

Human Resources for Health (HRH) are critical to health systems development and functioning, and to patient and population health outcomes.[1] Nurses in South Africa, as elsewhere, make up the largest single group of health service providers and their role in promoting health and providing essential health services is undisputed.[2] The country has three categories of nurses: professional (registered) nurses with four years of training; enrolled nurses with two years of training; and nursing assistants or auxiliaries with one year of training. The majority of professional (registered) nurses are also midwives, and the terms 'nurse' and 'midwife' are used interchangeably in the Nursing Act.[3] In contrast, in high-income countries such as Australia, Canada, the United Kingdom and the United States of America (USA), midwifery is regarded as a profession distinct from nursing, and nursing and midwifery require separate training programmes.[4] Direct-entry midwifery is legally recognised in 29 states in the USA and is currently being debated (and hotly contested) in South Africa. Table 1 shows the numerical dominance of nurses when examined against the total number of filled posts of health professionals in the South African public health sector in 2014.[5]

As can be seen from Table 1, in 2014, 76.8% of all health professionals in the public sector (excluding general assistants) were nurses of all categories: 38.7% were professional nurses; 17.7% were enrolled nurses; and 20.4% were nursing assistants.

However, the country faces a 'nursing crisis', characterised by shortages, declining interest in the profession, lack of a caring ethos, and an apparent disjuncture between the needs of nurses on the one hand and those of communities served on the other hand.[6,7]

Statistics from the South African Nursing Council (SANC) illustrate that the existing outputs of nursing education institutions do not match the health and service demands for nurses and midwives.[8,9] In 2010, 3 595 professional nurses with four years of training registered with the SANC.[8,9] In the same year, the National Department of Health estimated a professional nurse shortage of 44 780 in the public health sector.[10] This suggests a severe shortage of professional nurses across all healthcare services. Existing SANC information also shows a decrease in the production of nurses with specialist qualifications, particularly clinical specialisations.[2] The new health sector reform policies will further increase the demand for professional nurses with specialised skills. For example, nurses are envisaged to play a key role in the re-engineering of primary health care (PHC), specifically the community-based (Ward-based) Outreach Teams, School Health Services and District Clinical Specialist Teams. The 2011 government Green Paper on National Health Insurance (NHI)[11] lays the foundation for health system reforms towards universal coverage, with PHC as the core of the proposed reforms. At the same time, the absence of national norms and standards makes it difficult to determine the real shortage and the number of nurses required of all categories.[12]

Although nurses are more equitably distributed between urban and rural areas compared to other health professional categories (e.g. doctors), the gross maldistribution between urban and rural areas is illustrated by the fact that in 2014, the urban provinces of Gauteng and Western Cape combined produced 1 234 professional nurses, compared to the three rural provinces of Limpopo, North West and Northern Cape combined that produced 501 professional nurses.[8]

Another challenge is an ageing nursing workforce. The current national nursing strategy indicates that 43.7% of professional nurses are over 50 years of age.[2] This was borne out by a large survey which found that the average age of participants was 41.5 years.[13]

The context of this nursing crisis is South Africa's quadruple disease burden,[14] the multiplicity of health sector reforms,[15] gender stratification, and the existence of strong professional silos and hierarchies.[16] Progress towards universal health coverage (UHC) in South Africa, which aims to ensure that everyone is able to access the healthcare services they need irrespective of their ability to pay,[17] is therefore dependent on addressing these nursing challenges.

Table 1: Number of filled health professional posts in the South African public health sector, 2014

| Category | EC | FS | GP | KZN | LP | MP | NC | NW | WC | ZA | % |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Clinical associates | 71 | 5 | 39 | 28 | 9 | 26 | 4 | 39 | | 221 | 0.1 |
| Dental practitioners | 122 | 74 | 247 | 128 | 156 | 108 | 33 | 61 | 126 | 1 056 | 0.6 |
| Dental specialists | | 1 | 116 | 1 | 4 | | 1 | | 32 | 155 | 0.1 |
| Dental therapists | 9 | 2 | 41 | 117 | 87 | 23 | 9 | 16 | 2 | 306 | 0.2 |
| Enrolled nurses | 3 124 | 839 | 6 262 | 10 784 | 4 189 | 1 769 | 220 | 909 | 2 474 | 30 571 | 17.7 |
| Environmental health practitioners | 50 | 85 | 153 | 174 | 151 | 153 | 32 | 43 | 4 | 850 | 0.5 |
| Medical practitioners | 1 489 | 716 | 3 184 | 3 537 | 1 185 | 875 | 419 | 627 | 1 541 | 13 593 | 7.9 |
| Medical researchers | | 8 | 20 | 9 | 3 | | 1 | | 34 | 103 | 0.1 |
| Medical specialists | 170 | 328 | 1 868 | 791 | 92 | 70 | 29 | 117 | 1 423 | 4 893 | 2.8 |
| Nursing assistants | 5 399 | 2 098 | 6 664 | 6 251 | 5 125 | 1 752 | 916 | 2 853 | 4 089 | 35 147 | 20.4 |
| Occupational therapists | 120 | 76 | 306 | 210 | 197 | 95 | 56 | 49 | 141 | 1 250 | 0.7 |
| Pharmacists | 408 | 297 | 1 052 | 722 | 436 | 268 | 135 | 233 | 880 | 4 516 | 2.6 |
| Physiotherapists | 145 | 68 | 200 | 299 | 160 | 88 | 59 | 73 | 147 | 1 239 | 0.7 |
| Professional nurses | 10 008 | 2 435 | 12 171 | 16 126 | 9 093 | 5 049 | 1 332 | 4 494 | 5 130 | 66 711 | 38.7 |
| Psychologists | 62 | 36 | 232 | 115 | 101 | 35 | 17 | 48 | 86 | 1 213 | 0.7 |
| Radiographers | 344 | 186 | 676 | 568 | 167 | 116 | 100 | 120 | 456 | 2 735 | 1.6 |
| Student nurses | 258 | | 4 233 | 1 815 | 443 | 765 | | 234 | | 7 748 | 4.5 |
| Public sector (filled) | 21 779 | 7 254 | 37 464 | 41 675 | 21 598 | 11 192 | 3 363 | 9 916 | 16 565 | 172 307 | 100.0 |

Source: Day, 2015.[5]

This chapter provides an analytical perspective on nurses and nursing in South Africa, and the critical issues that need to be addressed by health policy-makers and practitioners in order to revitalise the profession. These issues are: nursing education reforms; enhancing the participation of nurses in policy-making; casualisation of the nursing profession; ethics; quality of care; and the work experiences of nursing managers at primary health care clinics.

The chapter draws on the research findings of a four-year research programme, known as Research on the State of Nursing (RESON).[18] The research aimed to develop and strengthen the research evidence for improved nursing policy development and practice in South Africa.[18] Different methodologies were used to collect the data, ranging from the use of reflective diaries to large-scale surveys.

## Nursing education reforms

Globally, the discourse on the education of health professionals has gained momentum in light of the need to produce more health professionals who are workplace-ready, with relevant competencies to deliver appropriate health care.[1,19-22] The Academy of Science in South Africa (ASSAf) has added its voice by working on a reconceptualised model for educating and training an appropriate health workforce to improve the health of the nation.[23] The ASSAf proposals seek to transform the education of all health professionals to ensure a match between competencies and health priorities, improve inter-professionalism and teamwork, and enhance social accountability.[23] This would require the buy-in of key partners, which ASSAf has set out to do in a consultative workshop with professional councils, academics and education networks.

In recent years, the notion of social accountability has put medical schools and medical education under the spotlight.[24-28] However, there has been relatively little emphasis on the social accountability of nursing education institutions or their graduates. In one of the first studies that examined social accountability and nursing education,[12] the authors used the World Health Organization's six building blocks for transformative education[29] to explore key informants' perspectives on these issues in South Africa[12] (Table 2).

The key informants interviewed in the study on social accountability and nursing education acknowledged that South Africa has strategic plans on human resources for health and nursing education, training and practice.[12] There is also a well-established system of regulation and accreditation of nursing education through the SANC.[12] However, with respect to health workforce planning and governance, policy and funding, key informants criticised the lack of national staffing norms, sub-optimal governance by both the SANC and the National Department of Health, and poor co-operation between key government departments, notably Health and Higher Education. They pointed out that education transformation is difficult when SANC as the regulatory body is largely dysfunctional and provides sub-optimal leadership in policy development and implementation.[12] The study also found gaps in the building blocks focusing on national standards on accreditation, regulation, and qualifications, and curricula and faculty (staff).[12] Key informants expressed concern about the poor quality of teaching and learning, outdated curricula that are unresponsive to population and health system needs, and lack of educator preparedness.[12] Equally problematic areas highlighted were the selection of nursing students and the perceived unsuitability of the majority of nursing students.[12] Overall, this study found that there are major flaws in all six building blocks and that each of these issues would need to be addressed in order to enhance social accountability in nursing education, which is an essential component of transformative education.[12]

In South Africa, as elsewhere, nursing education reforms are seen as an important strategy for enhancing health workforce performance, and thereby improving the functioning of health systems.[19,30-33] A policy analysis study to examine the 2013 Framework for Nursing Qualifications in South Africa found contestations about the proposed nursing curricular reforms.[33] The two most important elements of the reforms are the requirement for a baccalaureate degree to qualify as a professional nurse, and abolishing the enrolled nurse with two years of training in favour of a staff nurse with a three-year diploma.[33] These changes were part of the post-apartheid transformation of nursing but were also influenced by changes in the higher education sector.[33] Opponents of the reforms suggested that the new nursing qualifications have not been well considered and that university education for registered nurses is inappropriate.[33] Proponents, on the other hand, viewed the reforms as a way of modernising nursing practice and according nurses their well-deserved professional status, as well as ensuring international comparability of qualifications.[33]

Table 2: WHO building blocks of transformative health professional education

| Building Block | Description |
|---|---|
| Health workforce planning | Measures the existence of information on population health status, and detailed information on health workforce demand and need, as these impact on health professional education |
| Governance, policy and funding | Focuses on broad governance arrangements for health professional education (including collaboration across government ministries), policy development, and information on the funding of health workforce education |
| National standards on accreditation, regulation and vocational qualifications | Highlights the need for accreditation, regulation and quality control mechanisms for health workforce education in the country |
| Curricula, faculty and education | Focuses on appropriate curricula, community participation in health workforce education, the demographic profile of faculty and teaching staff, support for educators to engage in lifelong learning and continuing professional development, community-based, inter-professional education based on principles of primary health care, and focusing on the social determinants of health |
| Career and retention | Underscores the need to retain health workers particularly in underserved areas and to encourage their career development, as reflected in policies and plans, and supportive measures in the workplace |
| Student selection | Student recruitment based on a combination of formal qualifications and transversal skills, and reflective of under-served populations |

Source: World Health Organization, 2014.[29]

Importantly, the study pointed to the gap between policy and implementation – the policy process took over 10 years to complete and the final Regulations were promulgated in 2013.[33] At the time of writing, the phasing-out of the legacy qualifications was postponed yet again. The SANC has set a new date in 2018 for the phasing-out of the programme leading to registration as a nurse (general, psychiatric and community) and midwife.[12]

## Nurses and policy-making

Globally, there has been an increased emphasis on nurses' involvement in health policy and health systems development, and progress in this area is illustrated by an increasing number of nurses elected as political office-bearers and/or appointed to national and international boards.[34,35]

In South Africa, the Ministry of Health has underscored the essential role of nurses in the implementation and success of proposed health sector reforms.[2] In light of this, a policy analysis study was done to analyse the dynamics, strengths and weaknesses of nurses' participation in four national health workforce policies: the 2008 Nursing Strategy; revision of the Scope of Practice for nurses; the new Framework for Nursing Qualifications; and the Occupation-Specific Dispensation (OSD) remuneration policy. The study found that although the policy space has widened since the advent of democracy in South Africa, nurses' participation in policy-making is both contested and complex.[36] There is a disjuncture between nursing leadership and front-line nurses in their levels of awareness of the four policies.[36] Unsurprisingly, the OSD remuneration policy was the most well known to all categories of nurses. Their reasons for lack of policy awareness ranged from inadequate feedback from those who are involved to deliberate exclusion from the policy table.[36] Overall, the majority of participants were of the opinion that nurses' involvement in policy-making is insufficient, and in some instances where they have been included, their views were disregarded.[36] There is also limited consensus on which nursing group legitimately represents nursing issues in the policy arena. The tension between public and private sector nurses and between university and college educators is captured in nurses' views that those nurses with power and status are more likely to influence policy.[36] Notwithstanding consensus on the importance and inclusion of frontline nurses in policy-making, study respondents acknowledged the practical difficulties of involving thousands of front-line nurses in broader health policy development, and of overcoming the barriers to their active participation in fora which include their managers.[36]

## Casualisation in nursing

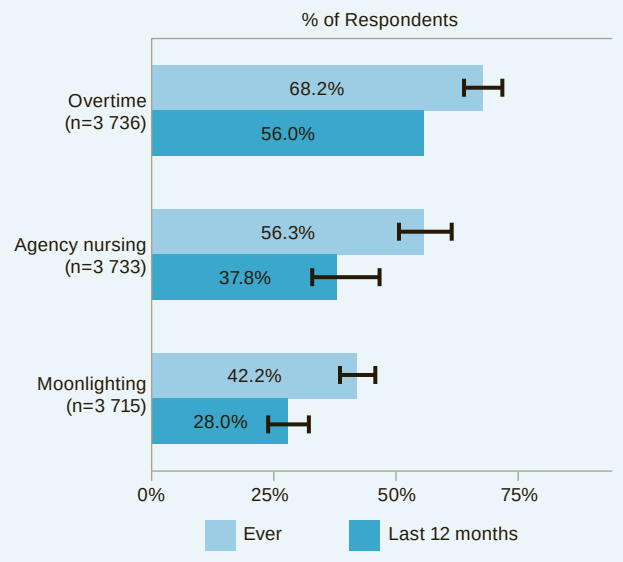
The term 'casualisation' refers to the employment of workers on short-term contracts, without the rights and benefits associated with full-time, permanent jobs.[37] Although there are different types of casual work arrangements, the most visible form of casual work is through temporary nursing agencies[38] and 'moonlighting' (the latter defined as having a second job in addition to primary full-time employment). Despite the implications of casualisation for the nursing profession and for health system performance, the concept has received inadequate attention by policy-makers and implementers.[1,39,40]

A provincial survey of provincial health expenditure on nursing agencies from 2005 until 2010 found that 1.49 billion South African Rand was spent on nursing agencies in the public health sector in the 2009/10 financial year.[41] The highest expenditure (R1.53 billion) occurred in the 2007/8 financial year,[41] which could be related to the closure of nursing colleges in 1997/8, with the effects of the reduced output of trained nurses only felt a decade later. During this decade, the output of nurses from the four-year programme at nursing colleges declined dramatically, with Gauteng Province suffering the greatest decline from 887 newly qualified registered nurses in 1996 to 413 in 2006.[8] In 2014, the registered nurse output in Gauteng appears to have stabilised at 842.[8] In the 2009/10 financial year, agency expenditure ranged from a low of R36.45 million in Mpumalanga Province to a high of R356.43 million in the Eastern Cape Province.[41] Overall, the study found that each of the nine provincial health departments, albeit variable, paid considerable amounts of money to nursing agencies for the provision and placement of temporary nursing staff in the health services.[41] Agency expenditure as a percentage of personnel expenditure ranged from 0.96% in KwaZulu-Natal Province to 11.96% in the Northern Cape Province.[41] The provincial survey found wide variations in the utilisation and management of nursing agencies across the nine provinces, despite the growth in public sector staff numbers in the last decade.[42] In the utilisation survey, North West and Limpopo Provinces reported that there was no utilisation of nursing agencies, and therefore no need for policies and/or the management of these agencies.[41] However, this was contradicted by the costing study as expenditure was recorded in all provincial health departments. In that 2009/10 financial year, a total of 5 369 registered nurses could have been employed in lieu of nursing agency expenditure.[41]

However, there are also indirect costs associated with agency nursing, which include time spent on administrative issues such as pre-employment checks and nurse recruitment, orientation and supervision.[43] A study in two public sector hospitals found that the indirect cost activities at both hospitals in one week exceeded the weekly direct costs of nursing agencies.[43] Agency nurses assisted the selected hospitals in dealing with problems of nurse recruitment, absenteeism, shortages and skills gaps in specialised clinical areas. However, the problems experienced with agency nurses included their perceived lack of commitment, unreliability, and providing sub-optimal quality of patient care.[43] Upon further analysis, deficiencies in agency nurses' attitudes and skills dominated the negative experiences or disadvantages reported by hospital managers.[43] Poor attitudes manifest in unco-operative behaviours, poor relationships with doctors, disloyalty and reluctance to take on extra duties or perform certain nursing interventions.[43] With reference to the competence of agency nurses, hospital managers reported that they lacked skills to care for high-risk patients and required constant checking and supervision.[43] In areas such as critical care and maternity, where they are most utilised, this may have dire consequences for patient care.

Expenditure on nursing agencies is but one piece of the puzzle of casualisation in the nursing profession. The first large cross-sectional survey on the extent of moonlighting, agency nursing and overtime in sub-Saharan Africa found that these practices are widespread in the South African healthcare system (Figure 1).[13]

Figure 1: Prevalence of overtime, agency nursing or moonlighting




Source: Rispel et al., 2014.[13]

Figure 1 shows that in the year before the study, overtime was the most prevalent practice (56%) followed by agency nursing (37.8%) and moonlighting (28%).

Twenty-eight per cent[13] of nurses had done moonlighting in the 12 months preceding the survey. More private sector nurses engaged in moonlighting (40.6%) compared with provincial government nurses (24.2%).[13] Critical care nurses reported higher moonlighting rates (38.2% in paediatrics; 59.0% in adult critical care), followed by maternity units (31.9%).[13] Private sector nurses and those with children were about 1½ times more likely to moonlight. Gauteng had the highest moonlighting rates (37.1%), followed by Free State (30.3%), Western Cape (28.7%) and Eastern Cape (11.1%).[13] Although the majority of nurses cited non-financial reasons such as taking care of patients, learning new skills and relationships with co-workers as reasons for moonlighting, over 70% of nurses agreed that more income was a factor.[13]

Nearly 40% of nurses had worked through a commercial nursing agency in the 12 months preceding the survey.[13] The agency nursing rate was higher among private sector nurses (58.4%) than government nurses, and was highest in Gauteng (53.6%), followed by the Western Cape (37.9%), Free State (33.1%) and Eastern Cape (11.9%). Nurses working in adult critical care units reported the highest rates of agency nursing (72.4%).[13] The heavy reliance of critical care (intensive care) units on agency nurses and the high rate of moonlighting among critical care nurses reflect the demand for skilled nursing care in both the public and private health sectors.

The concept of casualisation is not only of academic importance, but has many potential and actual negative health system consequences. Almost one-third of 3 784 survey participants (30.9%) indicated that they planned to leave their jobs within the 12 months following the survey.[44] Intention to leave was higher among the moonlighters (39.5%) compared to non-moonlighters (27.9%) and highest (37.7%) in the 25–34 years age group.[44] Significantly more professional nurses (36.2%) than enrolled nurses (32.5%) indicated their intention to leave.[44] Among the study participants, 51.5% reported feeling too tired to work, 11.5% paid less attention to nursing work on duty, while 10.9% took sick leave when not actually sick in the year preceding the survey.[45] In a multiple logistic regression analysis, the differences between moonlighters and non-moonlighters were not statistically significant after adjusting for other socio-demographic variables. Although moonlighting did not emerge as a statistically significant predictor, the reported health system consequences are serious, and should be addressed by health managers and policy-makers.[45]

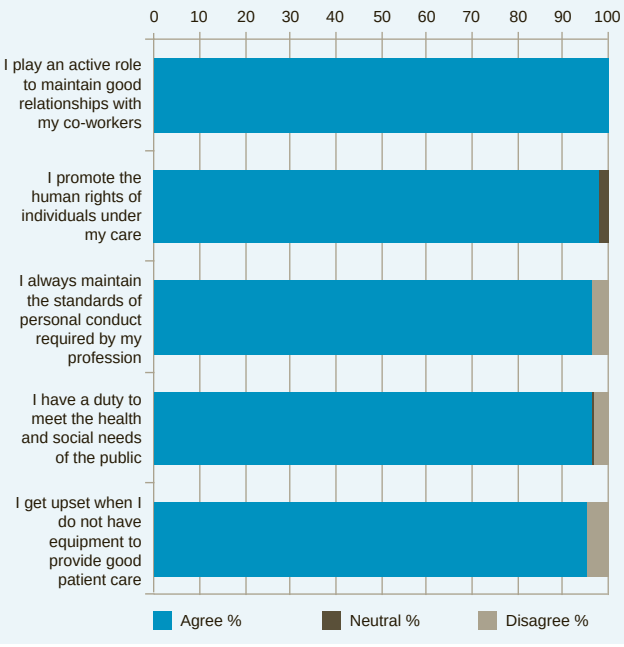
## Ethics, quality of care and work experience of nursing managers

There is increasing global attention on the importance of positive practice environments (PPE),[31,46-48] defined as "settings that support excellence and decent work, and that strive to ensure the health, safety and personal well-being of staff, support quality patient care and improve the motivation, productivity and performance of individuals and organisations".[49]

The International Council of Nursing (ICN) has argued that healthcare settings that address the challenges of physical and psychological violence, and workloads, and that offer professional support and prospects for professional development, influence job satisfaction and individual performance,[50] while a local South African study has found that positive practice environments influence the job satisfaction of nurses at the PHC level.[51]

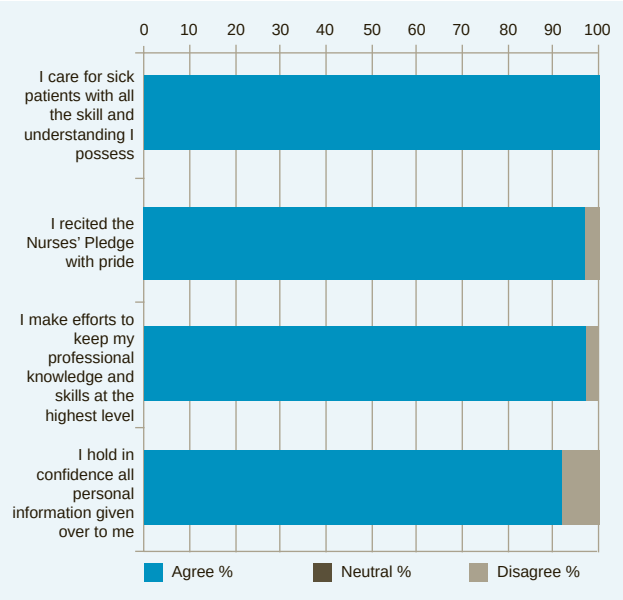
In a study that explored hospital nurses' views of contemporary ethical practice,[52] it was found that study participants were very familiar with the content of the International Code of Ethics for nurses, and the South African Nurses' Pledge of Service, [52] shown in Figures 2 and 3.

Figure 2: Nurses' responses to elements of the International Code of Ethics




Source: White et al., 2015.[52]

Figure 3: Nurses' responses to the Service Pledge




Source: White et al., 2015.[52]

The majority of study participants agreed with a statement that they would promote the human rights of individuals (98%), and that they have a duty to meet the health and social needs of the public (96%).[52] More nuanced responses were obtained for some questions, with 60% agreeing with a statement that too much emphasis is placed on patients' rights as opposed to nurses' rights, and almost a third (32%) agreeing with a statement that they would take part in strike action to improve nurses' salaries and working conditions. Responses to the Nurses' Pledge of Service showed similar consensus patterns – with the vast majority of nurses agreeing with commitment to caring for the sick (100%) and keeping their professional knowledge and skills up-to-date (98%), while disagreeing with the statement that people who pay for care should receive better services (94%).

The dilemmas encountered by nurses in upholding the Code of Ethics and the Pledge in the face of workplace constraints or poor working conditions were revealed in nurses' responses to open-ended questions.[52] Nurses find it difficult to provide care in the face of disrespectful patient behaviours and bad attitudes; this is compounded by managers blaming nurses for errors despite health system inefficiencies and staff shortages, which make it difficult for nurses to maintain their morale.[52]

The PHC setting as a work environment has become the focal point of nurses' work experiences. This is largely because of the global repositioning of PHC to achieve universal health coverage and to improve health system performance.[22,29] In the broader understanding that competent managers are essential in the delivery of PHC, a qualitative study focused on the work experiences of PHC clinic nursing managers through the use of reflective diaries.[53] Although inter-related and not mutually exclusive, the main themes that emerged from the diary analysis were: health system deficiencies; human resource challenges; unsupportive management environments; leadership and governance issues, and the emotional impact on the manager.[53] Most health system deficiencies reported by PHC nursing managers are inextricably linked to the delivery of essential services and dependence on the local municipality for uninterrupted services such as water supply.[53] Staff shortages due to vacancies and absenteeism accounted for most of their human resource woes – clinic managers often have to step in to perform clinical tasks in addition to their management responsibilities.[53] All of these challenges hold negative consequences for patients: failure to rescue patients when there is delayed Emergency Medical Services (EMS), poor infection control measures when there is no water, and protracted waiting times for patients when there is insufficient staff at the clinic.[53] Leadership, management and governance were reportedly complex, layered and fraught with difficulties. Nurses' reflective diaries revealed that they do not hold the chain of command and decision-making power as clinic managers, because of several layers of bureaucracy (clinic supervisor, area manager, district manager) that stifle the work environment of clinic managers and contribute to a great deal of personal distress experienced.[53]

Although PHC and hospital settings are vastly different, a study that examined whether the activities of hospital nursing unit managers facilitate the provision of quality patient care in nine South African hospitals found that these hospital managers faced similar challenges.[54] A time and motion study found that nursing unit managers spent 25.8% of their time on direct patient care, 16% on hospital administration, 14% on patient administration, and 11.8% on miscellaneous activities, which included walking around in search of equipment.[54] The interviews in turn revealed that staff shortages, sub-optimal staff performance, poor communication, resource constraints, unplanned activities, and numerous interruptions and distractions influenced the time spent by these managers on different activities, as well as their own time management.[54] Many tasks performed by nursing unit managers were of short duration, fragmented and unplanned, with at least 36 different activities performed per hour.[54] Both the PHC[53] and hospital[54] studies with nursing managers underscore the importance of positive practice environments to the work performance of these managers, and ultimately their ability to implement health sector reforms successfully.

## Conclusion

The evidence presented in this chapter shows that nursing is a profession in peril, which requires major attention and revitalisation.

A common finding is the importance of leadership, governance and management from three important policy actors: national government; the Nursing Council, and the national nursing association.[12,33,36,41,43-45,52-55] The appointment of the Chief Nursing Officer in 2014 is encouraging. A revised Strategic Plan for Nurse Education, Training and Practice is in place in South Africa.[2] The existence of SANC and a strong regulatory framework are positive aspects, as is the presence of a strong national nursing association. Hence, there is a good foundation to provide stewardship in the critical areas of policy implementation, improving nurses' practice environment, and nurse education. At the same time, the weaknesses in the policy capacity of the main institutions responsible for the leadership and governance of nursing in South Africa will need to be addressed if health sector reforms are to be realised.[33]

The capacity of registered nurses must be strengthened to enable them to participate in policy development, implementation and feedback. Undergraduate education must therefore include political

(contextual), policy and planning competencies. There is also need for more focused leadership development programmes for registered nurses that include advocacy, accountability and policy participation.

This chapter has pointed to the nursing practice environment that is fraught with resource, management and quality of care problems. This is compounded by workforce concerns – suitability of new entrants, admission and selection of nursing students, training, competence and work ethos. The practice environment is also influenced directly by agency work and moonlighting, which in turn contribute to poor staying power, low energy levels, abuse of leave, sub-optimal nursing care, split loyalties and accountability, and erosion of professionalism. Revitalising nursing requires that there be concerted efforts by government and the office of the Chief Nursing Officer, the Democratic Nursing Organisation of South Africa (DENOSA), and management to improve and modernise resources for a positive work environment. Although nursing agencies play an important role in providing temporary staff to health services, governance of these agencies by both the Health Department and the SANC must be improved.

Existing evidence suggests that there has been a steady disinvestment in nurse education.[12,33] A major crisis is looming unless issues of curriculum quality and relevance, nurse educator quality, educational resources, and governance of nursing education are addressed. This means that nursing education reforms must be implemented without further delay. High-level investment in preparing nurses for and in practice is essential, through appropriate training that emphasises ethical value systems and social accountability, adequate staffing in different healthcare settings and enabling work environments. Continuing professional development for nurses is imperative to enable nursing managers at all levels of the health system to lead the provision of consistent and high-quality patient care.[53,54]

South Africa's quest for UHC to improve population health and achieve equity and social justice cannot be achieved unless the issues facing nurses and nursing in South Africa are confronted.

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## References


1 Global Health Workforce Alliance and World Health Organization. A universal truth: No health without a workforce. Geneva: World Health Organization; 2013.

2 National Department of Health. Strategic Plan for Nursing Education, Training and Practice 2012/13–2016/17. Pretoria: National Department of Health; 2013.

3 Republic of South Africa. Nursing Act No. 33 of 2005. Pretoria: Government Printer; 2005.

4 Nichols BL, Davis CR, Richardson DR. International models of nursing. Washington: The National Academies Press; 2010.

5 Day C. Health personnel data 2014. Durban: Health Systems Trust; 2015.

6 Breier M, Wildschut A, Mgqolozana T. Nursing in a new era. The profession and education of nurses in South Africa. Cape Town: HSRC Press; 2009.

7 Rispel LC, Barron P. Valuing human resources: Key to the success of a National Health Insurance System. Dev South Afr. 2012;29:616–35.

8 South African Nursing Council. SANC registration and enrolment figures. Pretoria: SANC; 2014. [Internet]. [cited 16 September 2015].
URL: http://www.sanc.co.za/stats_an.htm

9 South African Nursing Council. Geographical Distribution of the Population of South Africa versus Nursing Manpower. Pretoria: SANC; 2014.

10 National Department of Health. Human Resources for Health South Africa: HRH Strategy for the Health Sector: 2012/13–2016/17. Pretoria: National Department of Health; 2011.

11 National Department of Health. National Health Insurance In South Africa Policy Paper (Green Paper). Pretoria: Government Printer; 2011.

12 Armstrong SJ, Rispel LC. Social accountability and nursing education in South Africa. Glob Health Action. 2015;8:27 879. [Internet]. [cited 16 September 2015].
URL: http://dx.doi.org/10.3402/gha.v8

13 Rispel LC, Blaauw D, Chirwa T, de Wet K. Factors influencing agency nursing and moonlighting among nurses in South Africa. Glob Health Action. 2014;7. [Internet]. [cited 16 September 2015].
URL: http://dx.doi.org/10.3402/gha.v7.23585

14 Coovadia H, Jewkes R, Barron P, Sanders D, McIntyre D. The health and health system of South Africa: historical roots of current public health challenges. Lancet 2009;374:817–34.

15 Rispel L, Moorman J. Health policy reforms and policy implementation in South Africa: A paradox? In: Daniel J, Naidoo P, Pillay D, Southall R, editors. New South African Review 3: The second phase-tragedy or farce? Johannesburg: Wits University Press; 2013:239–60.

16 National Planning Commission. National Development Plan: Vision 2030. Pretoria: National Planning Commission; 2011.

17 World Health Organization. World Health Report 2010. Health system financing. The path to universal coverage. Geneva: World Health Organization; 2010.

18 Rispel LC. Transforming Nursing Policy, Practice and Management in South Africa. Glob Health Action. 2015;8. [Internet]. [cited 16 September 2015].
URL: http://dx.doi.org/10.3402/gha.v8.28005

19 Frenk J, Chen L, Bhutta ZA, et al. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. Lancet 2010;376:1923–58.

20 Mullan F, Frehywot S, Omaswa F, et al. Medical schools in sub-Saharan Africa. The Lancet 2010;doi: 10.1016/S0140-6736 (10) 61961–7.

21 World Health Organization and Global Health Workforce Alliance. Scaling up, saving lives: Task force for Scaling Up Education and Training for Health Workers. Geneva: World Health Organization; 2008.

22 World Health Organization. Transforming and scaling up health professionals' education and training. World Health Organization guidelines. Geneva: World Health Organization; 2013.

23 Academy of Science in South Africa (ASSAf). Report on health professional education and training in South Africa. Pretoria: ASSAf; 2015.

24 Global consensus for social accountability of medical schools. Consensus Document – December 2010. [Internet]. [cited 16 September 2015].
URL: www.healthsocialaccountability.org

25 Boelen C, Woollard B. Social accountability and accreditation: a new frontier for educational institutions. Med Education. 2009;43:887–94.

26 Woollard RF. Caring for a common future: medical schools' social accountability. Med Education. 2006;40:301–13.

27 Boelen C, Woollard R. Social accountability: The extra leap to excellence for educational institutions. Med Teacher. 2011;33:614–9.

28 Celletti F, Reynolds TA, Wright, Stoertz A, Dayrit M. Educating a new generation of doctors to improve the health of populations in low- and middle-income countries. PLoS Med. 2011;8:e1001108.

29 World Health Organization. Transforming the Health Workforce in Support of Universal Health Coverage: Global Toolkit for Evaluating Health Workforce Education. Geneva: World Health Organization; 2014.

30 Kinfu Y, Dal Poz MR, Mercer H, Evans DB. The health worker shortage in Africa: are enough physicians and nurses being trained? Bull World Health. 2009;87:225–30.

31 nstitute of Medicine. The future of nursing: Leading change, advancing health. Washington: The National Academies Press; 2011.

32 World Health Organization. Transforming and scaling up health professionals' education and training. World Health Organization guidelines. Geneva: World Health Organization; 2013.

33 Blaauw D, Ditlopo P, Rispel LC. Nursing education reform in South Africa: lessons from a policy analysis study. Glob Health Action. 2014;7:26401. [Internet]. [cited 16 September 2015].
URL: http://dx.doi.org/10.3402/gha.v7

34 Ferguson SL. An activist looks at the nursing's role in health policy development. JOGNN. 2001;30.

35 Myers L. Health policy analyst: an advanced practice registered subspeciality. Perioperative Nursing Clinics. 2007;2:69–74.

36 Ditlopo P, Blaauw D, Penn-Kekana L, Rispel LC. Contestations and complexities of nurses' participation in policy-making in South Africa. Glob Health Action. 2014;7:25327. [Internet]. [cited 16 September 2015].
URL: http://dx.doi.org/10.3402/gha.v7

37 International Labour Organization. Changing Patterns in the World of Work: Report of the Director-General to the International Labour Conference, 95th session. Geneva: International Labour Organization; 2006.

38 Connelly CE, Gallagher DG. Emerging trends in contingent work research. Journal of Management. 2004;30:959.

39 World Health Organization. Strategic directions for strengthening nursing and midwifery services 2011–2015. Geneva: World Health Organization; 2010.

40 World Health Organization Regional Office for Africa. WHO guidelines for implementing strategic directions for strengthening nursing and midwifery services in the African region 2007–2017. Brazzaville: World Health Organization Regional Office for Africa; 2007.

41 Rispel LC, Angelides G. Utilisation and costs of nursing agencies in the South African public health sector, 2005–2010. Glob Health Action. 2014;7. [Internet]. [cited 16 September 2015].
URL: http://dx.doi.org/10.3402/gha.v7.25053

42 Integrated Support Teams. Review of health over-spending and macro-assessment of the public health system in South Africa: Consolidated Report. Pretoria: ISTs; 2009.

43 Rispel LC, Moorman J. The indirect costs of agency nurses in South Africa: A case study in two public sector hospitals. Glob Health Action. 2015;8:26494. [Internet]. [cited 16 September 2015].
URL: http://dx.doi.org/10.3402/gha.v8

44 Rispel LC, Chirwa T, Blaauw D. Does moonlighting influence South African nurses' intention to leave their primary jobs? Glob Health Action. 2014;7:25754. [Internet]. [cited 16 September 2015].
URL: http://dx.doi.org/10.3402/gha.v7

45 Rispel LC, Blaauw D. The health system consequences of agency nursing and moonlighting in South Africa. Glob Health Action. 2015;8:26683. [Internet]. [cited 16 September 2015].
URL: http://dx.doi.org/10.3402/gha.v8

46 Institute of Medicine. Crossing the quality chasm: A new health system for the 21st century. Washington, DC: National Academy Press; 2001.

47 Aiken LH, Sloane DM, Bruyneel L, Van den Heede K, Sermeus W. Nurses' reports of working conditions and hospital quality of care in 12 countries in Europe. Int J Nurs Stud. 2013;50:143–53.

48 You L-M, Aiken LH, Sloane DM, et al. Hospital nursing, care quality, and patient satisfaction: Cross-sectional surveys of nurses and patients in hospitals in China and Europe. Int J Nurs Stud. 2013;50:154–61.

49 International Centre for Human Resources in Nursing. Positive Practice Environments. Geneva: International Council of Nurses; 2007.

50 Baumann A. Positive practice environments: Quality workplaces = quality patient care. Information and Action Tool Kit developed for ICN. Geneva, Switzerland: International Council of Nurses; 2007.

51 Munyewende P, Rispel LC, Chirwa T. Positive practice environments influence job satisfaction of primary health care clinic nursing managers in two South African provinces. Hum Resour Health. 2014;12.

52 White J, Phakoe M, Rispel L. "Practice what you preach": Nurses' perspectives on the Code of Ethics and Service Pledge in five South African hospitals. Glob Health Action. 2015;8:26341. [Internet]. [cited 16 September 2015].
URL: http://dx.doi.org/10.3402/gha.v8

53 Munyewende P, Rispel LC. Using diaries to explore the work experiences of primary health care nursing managers in two South African provinces. Glob Health Action. 2015;7:25323. [Internet]. [cited 16 September 2015].
URL: http://dx.doi.org/10.3402/gha.v7

54 Armstrong SJ, Rispel LC, Penn-Kekana L. The activities of hospital unit managers and quality of patient care in South African hospitals: A paradox? Glob Health Action. 2015;8:26243. [Internet]. [cited 16 September 2015].
URL: http://dx.doi.org/10.3402/gha.v8

55 Olojede OI, Rispel LC. Exploring the characteristics of nursing agencies in South Africa. Glob Health Action. 2015;8:27 878. [Internet]. [cited 16 September 2015].
URL: http://dx.doi.org/10.3402/gha.v8