and responsiveness need to improve, and the capacity for practical- and workplace training must be expanded, with more technical- and occupational supervisors made available to teach and guide learners. As stakeholders demand well-trained learners whose theoretical knowledge has been enhanced by applied learning and real-world skills, the need for adequate skills development infrastructure is very apparent. Increasingly stakeholders are looking at the HWSETA to improve the skills development system for the sector through enhanced support for educators, workplace training providers, and assessors and moderators.

Although the demand for skills in the sector is immense, the capability to supply the required skills is constrained, as is considered in Chapter 5. Budget constraints have hampered the deployment of newly trained health professionals and social workers in the public sector. The state's expanding development agenda to improve access to healthcare and social services may not be affordable in terms of the number of skilled resources that are required. Therefore, it could be argued that the demand for skills for the health and social development sector should also be measured in terms of what the state can afford, and not only in terms of service demands.

The most pertinent skills development needs of key occupational groups as they emerged from the preceding analyses are summarised below.

Table 4 8 Skills development needs of specific occupations in the sector

Target groups and occupational categories	Skills development needs
Social workers	• Occupational-specific technical training • Training at postgraduate level in specialisation areas (adoptions, probation and occupational social work) and emerging areas of social work (forensic- and clinical social work) • Services to rehabilitate and develop skills of persons who abuse substances and provide support to their families • Supervision of social workers and social auxiliary workers • Advanced writing skills for legal and court system
Social auxiliary workers	• Understand role and functions • Social auxiliary work methods and techniques • Technical skills to address areas of work entrusted to occupation • Communication and office administration
Community development practitioners	• Comprehensive community development approaches and enterprises to fight poverty and establish sustainable livelihoods in vulnerable communities; profiling • Supervision of mid-level workers and managing projects
Community development workers	• Mid-level skills to support practitioners, inform and mobilise communities to generate their own income
Child and youth care worker	• Learnerships and training at universities and universities of technology
Doctors	• General practitioners and GPs trained to supervise PHC teams and community health services
Medical specialists in selected areas	• Anaesthesiology, critical care, community health, dermatology, diagnostic radiology, emergency medicine, medicine, geriatric medicine, family medicine, neurosurgery, obstetrics and gynaecology, occupational health, oncology, orthopaedics, otorhinolaryngology, paediatrics, pathology (in all areas of specialisation), psychiatry, surgery and urology
Nurses	• Comprehensively trained professional nurses • Specialist fields: PHC, infection control, neo-natal care, critical care, trauma care, operating theatre, midwifery, advanced midwifery, obstetric care, paediatric care, orthopaedic care, psychiatry • Bridging courses for enrolled nurse to new category of registered staff nurse • Bursaries and training for nurse educators to teach under new nursing qualifications framework
Occupational therapist and physiotherapy assistants	• Rehabilitation and promoting independent living of disabled persons and the elderly
Target groups and occupational categories	• Skills development needs
Early childhood development practitioners	• Early childhood development for children aged 0 to 5 years • Child behaviour and managing children affected by social development challenges
Youth development practitioners	• Youth development, project management, supervision of community workers
Community health workers	• Promotive and preventive healthcare in community settings • HIV/AIDS awareness and basic counselling • Nutrition and substance abuse • Monitoring of STIs, TB, other diseases and directly observed treatment of TB and HIV patients; monitoring of immunisation • Occupational hygiene and safety

Target groups and occupational categories	Skills development needs
Community caregivers	• Home-community-based care for the sick, disabled and elderly and psycho-social support to families • Basic psycho-social support, child protection and supportive supervision • Occupational hygiene and safety
Emergency medical services practitioners	• Training against new qualifications framework • Advance life support training
Emergency care technician	• Train against new qualifications framework
Environmental health practitioners	• Part of new PHC teams to address social and environmental health risks associated with sewerage, refuse, vermin, food handling, waste management to prevent diseases such as pneumonia, diarrhoea and malaria
Clinical associates	• Required at district level to share tasks with/take over tasks from doctors in different units – emergency, outpatient, medical and surgical and maternity, and work as assistants to surgeons in operating theatres
Pharmacy technical assistants or pharmacy technicians	• Managing supply chain of medicines to PHC level (clinics, health centres and chronic medicines used at home) and working in PHC specialist teams • Train against new qualifications framework
Public health professionals and public health specialists	• Public health leadership, strategy and planning, epidemiology and statistical analysis, disease control, monitoring and evaluation of health programmes and health services
Pharmacy assistant (basic) and post-basic	• Bridge into new pharmacy mid-level categories
	• Bride into new pharmacy general assistant category
Forensic pathology assistants	• Train against new qualification
Managers of health hospitals and health facilities	• Finance, health services and operations, human resources, information technology, procurement and contract management, quality and performance management, facility and clinical management against mandatory standards, soft leadership skills, succession planning
Information technology professionals	• Information technology, systems engineering, systems integration; data warehousing, data analysis
Engineers & technicians	• Clinical engineers, hospital engineers, biomedical equipment technicians to maintain and repair medical and diagnostic equipment
Artisans	• Electricians, plumbers, welders to service hospital infrastructure
Managers and supervisors of NPOs and NGOs	• Leadership and general management, financial management, human resources management, internal administration, operations and service delivery, management of external environment
Veterinarians	• Comprehensive training with “day one skills” for practice
Veterinary para-professionals and workers	• Training of animal health technicians in primary animal healthcare

5 The Supply of Skills

5.1 Introduction

The previous chapters have clearly indicated that the health and social development sector (and specifically the public sector) is in crisis as a result of skills shortages. Demand for skills by far exceeds their supply. In this chapter the supply side of the labour market is considered. The different elements of supply are described, supply figures are presented (in as far as they are available), and supply-side constraints that contribute to the current shortages are highlighted.

The chapter starts with a discussion of the output from the secondary school system, which underlies the supply of skills to the sector. This is followed by a discussion of the institutional arrangements and capacity for skills development. The output from the higher education system comes next, followed by a short description of the output from nursing colleges and the role of the HWSETA in skills development in the sector. As the majority of employees in this sector are only allowed to practise if registered with relevant professional councils, these registration figures are presented in this chapter. The chapter concludes with a discussion of some of the most important factors that impact on the supply of skills – both positively and negatively.

5.2 The South African Secondary School System

5.2.1 Entry from secondary school into the health sector

The results of the Senior Certificate examination are key factors in determining the supply of skills to the health sector. Grade 12 mathematics is an entry requirement for most of the tertiary-level study programmes providing access to the sector. In addition, most of the tertiary institutions require prospective health sciences students to have studied either Grade 12 physical sciences or Grade 12 life sciences (previously referred to as “biology”).The subject life sciences (biology) is not necessarily a prerequisite. However, life sciences at school level could spark learners’ interest in study fields relating to health, while health support workers will most probably be sourced from candidates with at least Grade 12 in life sciences.

In 2012, a total of 511 152 learners sat the NSC examination. Of these, 377 847 (74%) passed the examination, while only 152 881 learners fulfilled the requirements for admission into diploma courses and 136 047 for admission into a bachelor’s degree. The Gauteng province had the highest overall pass rate in the country of 84%, while the Western Cape and North West provinces were second and third with pass rates of 83% and 80% respectively.

The number of Grade 12 learners who sat for examinations decreased from 533 561 in 2008 to 511 152 in 2012 and the number of learners who wrote mathematics decreased annually over the same period by 7% (Table 5-1). Fewer candidates in 2012 (n=80 716) achieved 40% or more for mathematics than in 2008 (n=91 796). More candidates in 2012 achieved 40% or more in physical sciences (n=70 083) than in 2008 (n=64 538).

From 2008 to 2012 the achievement rates in the Grade 12 examination, in mathematics, physical sciences and life sciences increased (Figure 5-1). For example, of those who wrote Grade 12 mathematics in 2008, 31% achieved 40% or more in their examination, while 36% achieved similar results in 2012.

Table 5 1 Grade 12 Statistics: 2008-2012 [558]

	2008		2009		2010		2011		2012		AG p/a
Number of matriculants who -	**N**	**% of total who wrote Grade 12**	**N**	**% of total who wrote Grade 12**	**N**	**% of total who wrote Grade 12**	**N**	**% of total who wrote Grade 12**	**N**	**% of total who wrote Grade 12**	**%**
Wrote Grade 12	533 561	100.0	552 073	100.0	537 543	100.0	496 090	100.0	511 152	100.0	-1.1
Achieved Grade 12	333 604	62.5	334 718	60.6	364 513	67.8	348 117	70.2	377 847	73.9	3.2
Wrote Mathematics	300 829	56.4	301 654	54.6	263 034	48.9	224 635	45.3	225 874	44.2	-6.9
Achieved Mathematics (40% and higher)	91 796	17.2	90 699	16.4	81 374	15.1	67 541	13.6	80 716	15.8	-3.2
Wrote Physical Sciences	220 164	41.3	225 102	40.8	205 364	38.2	180 585	36.4	179 201	35.1	-5.0
Achieved Physical Sciences (40% and higher)	64 538	12.1	49 524	9.0	60 917	11.3	61 109	12.3	70 083	13.7	2.1
Wrote Life Sciences	297 417	55.7	298 683	54.1	285 496	53.1	264 819	53.4	278 412	54.5	-1.6
Achieved Life Sciences (40% and higher)	117 787	22.1	119 069	21.6	147 601	27.5	122 302	24.7	120 734	23.6	0.6

Source: Department of Basic Education.

558 Reports on the National Senior Certificate examination results, 2009, 2010, 2011 and 2012. Department of Basic Education, SA. http://www.education.gov.za/EMIS/Statistical-Publications/tabid/462/Default.aspx. Accessed 6 June, 2014.

Figure 5 1 Grade 12 mathematics, life sciences and physical sciences achievement rates: 2008-2012[559]

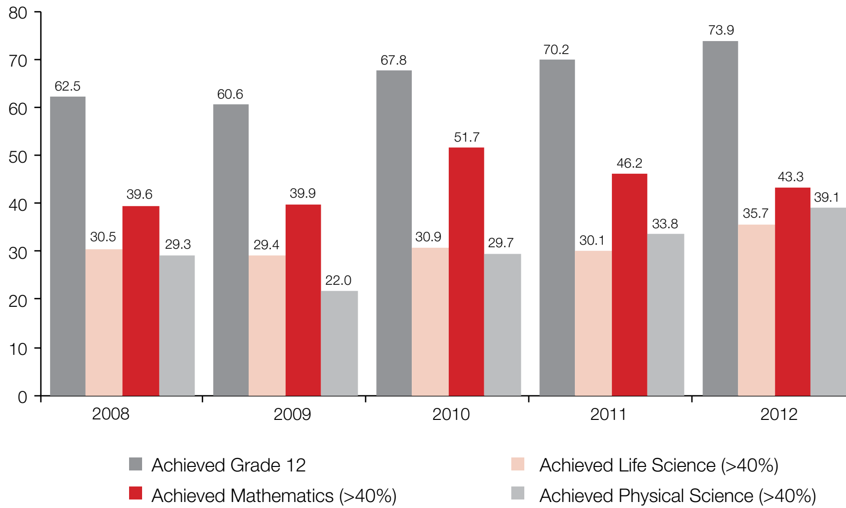
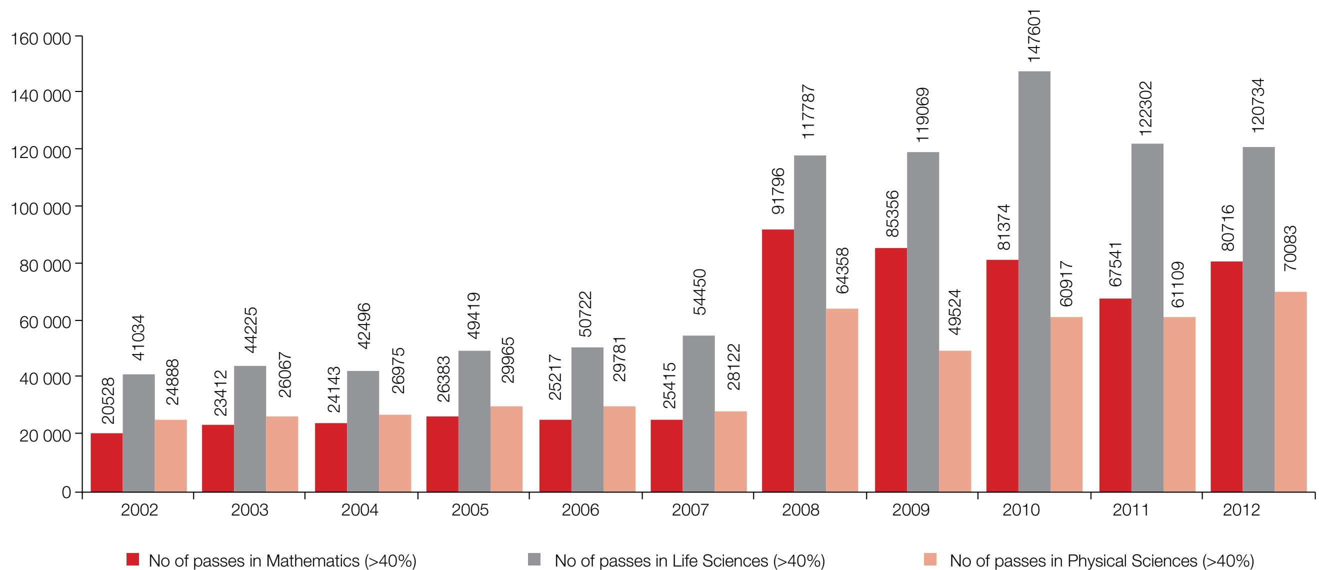


Figure 5-2 shows the trend in mathematics, physical sciences and life sciences passes from 2002 to 2012 for entry into tertiary studies. The number of passes in all three subjects increased gradually from 2002 to 2007. From 2008 the Department of Education did away with higher and standard grade subjects, resulting in a dramatic increase in the number of passes in 2008. From 2008 to 2012 passes in life sciences and physical sciences increased annually on average by 1% and 2% respectively but decreased by 3% in the case of mathematics.

559 2002-2007 Mathematics, Science and Biology higher grade.

Figure 5 2 Number of passes in mathematics, life sciences and physical sciences: 2002-2012



Source: Department of Basic Education

Analysis of the statistics cited above shows that the secondary school system is producing fewer candidates with the combination of subjects required for entering tertiary-level studies in the health sciences. Apart from the issue of insufficient numbers, there are serious concerns about the quality of matriculants. Education experts have found that the levels of literacy and numeracy in South Africa are considerably lower than those of other developing countries and several African countries. According to the DBSA Roadmap, in a comparison with developed countries the top 6% to 10% of South African students were at the same level as the top 75% of students in the advanced countries[560]. These realities confirm prevailing concerns about poor student readiness for tertiary studies. Nursing colleges report an oversupply of under-qualified learners who do not meet the academic entrance criteria[561]. These colleges also experience dropout rates of around 75%, which is an indication that prospective nurses are not properly prepared for training at post-school level[562].

560 Development Bank of South Africa. 2008. Education Roadmap: Focus on the Schooling System. Published at http://www.dbsa.org/Research/Roadmaps1/Education%20Roadmap.pdf.(Accessed Aug 2010).

561 Breier, M.,Wildschut, A. et al. 2009. Nursing in a New Era – The Professional Education of Nurses in South Africa.

562 Bateman, C. 2009. "Legislating for nurse/patient ratios 'clumsy and costly' – experts". South African Medical Journal. Aug 2009. 99 (8).Published at http://www.scielo.org.za/pdf/samj/V99n8.(Accessed Aug 2009).

5.2.2 Entry from school into social development labour market

Although mathematics and science at Grade 12 level are not barriers to entry into the social development sector, the personal characteristics of learners are important in respect of well-developed communication skills, personal trustworthiness, and a desire to serve others.

A large number of workers in the sector enter into the labour market after school without any further education or training. These are mostly volunteer workers, many of whom may not have completed their schooling. Many of these workers enter the sector via government's EPWP. According to the DSD, 41 908 community caregivers received accredited training in terms of NQF levels 1 to 4 through NGOs in 2008/09[563]. These programmes provide unemployed individuals and volunteers with a stipend, on-the-job experience, and training for a period.

5.3 Institutional Arrangements and Capacity to Train Health Workers

Post-school training for the nearly 100 registered health professions takes place at public and private HEIs, provincial training colleges, and nursing- and ambulance colleges. Factors impacting on the supply of health professionals by the different institutional streams are discussed in the following paragraphs. Apart from physical infrastructure, the training of health professionals also requires a clinical health service teaching platform to develop clinical skills, patient care, and delivery of care services. It takes many years to train and equip health professionals with the required knowledge, skills and competencies[564].

5.3.1 Academic health complexes

Most prospective health professionals are trained in academic health complexes established under the National Health Act that aim to provide comprehensive training in primary-, district- and tertiary-level care. Each of these academic health complexes consists of health facilities at all levels of the national health system, including peripheral facilities and one or more educational institutions[565]. By providing the platform for clinical- and in-service training, as well as clinical research, academic health complexes play an important role in the development of healthcare and the health system[566].

Although there are many calls for increased output from the academic health complexes, training capacity is limited as a result of constraints related to infrastructure, restrictions on the number of clinician posts, bed count, laboratories, and other resources. Despite the high demand for placement in healthcare educational programmes, the annual intake remains restricted.

Leading health academics, in a presentation to the Parliamentary Portfolio Committee on Health, warned that the academic health complexes are in a state of crisis because of the lack of a national governance structure and an appropriate funding framework. According to these academics, although provincial health departments are responsible for funding the complexes, very little money is allocated to them. These complexes compete with other priorities in the provincial budgets, such as PHC and district healthcare[567]. As a result, fewer healthcare workers are produced and the quality of tertiary-level healthcare and training is reduced. Central hospitals are experiencing resource challenges in particular[568]. There are fears that some academic hospitals may lose their accreditation as teaching institutions unless funding is made available to maintain infrastructure, provide adequate standards of service, and supply medication. There is a real risk that the numbers of undergraduate medical students may be cut and intern training posts may be reduced[569]. Owing to budget constraints the bed count in several tertiary hospitals has dropped, and this has resulted in a diminished capacity to train health professionals.

Historically, integrated planning on the development of health professionals between the health sector and education sector has been lacking. Such training has not necessarily been linked to actual healthcare needs and adequate financing mechanisms. Furthermore, a trend emerged over the last 15 years to retrench academic clinicians and clinical supervisors and to freeze their posts. As a result, growth in the training of doctors, medical specialists, nursing specialists and the therapeutic sciences was significantly affected[570]. The quality of all undergraduate and postgraduate training is also affected. The HWSETA baseline study reported that the brain drain of academic and experienced personnel leads to deficiencies within training institutions. These deficiencies impact on the professional attachment and supervision of new graduates and the production of future health personnel.

Government acknowledges the above-mentioned realities as factors that constrain the education and development of health professionals and recognises that the infrastructure for clinical training and service development (i.e. the academic health complexes, nursing colleges and other training platforms) must be better managed, strengthened, and organised[571].

Teaching capacity in pharmacy schools and nursing colleges is also under strain due to the ageing of academics and educators, and the closure of nursing colleges in the past[572]. Since the new qualifications in nursing, pharmacy support personnel and emergency medical care services are based on a higher education platform, the capacity of training institutions to meet new accreditation requirements and the ranks of current academics who train at the TVET level will have to be strengthened.

For many years the annual intake of veterinary science students has been limited to 140 and the selection process is structured to reflect government policy and the veterinary needs of the country. Owing to the recent restructuring of the veterinary science programme into a core-elective six-year single-degree structure, there was no intake of first-year students

563 DSD. 2009. Annual Report 2008/09.
564 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17. Published at http://www.doh.gov.za.(Accessed 10 August 2012).
565 Section 51 of the National Health Act, 61 of 2003.
566 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.
567 Bateman, C. 2010. "Academic health complexes bleeding in 'no man's land'". South African Medical Journal. January 2010. 100 (1).DBSA. 2008. A Roadmap for the Reform of the South African Health System.
568 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.
569 Bateman, C. 2010. "Academic health complexes bleeding in 'no man's land'". South African Medical Journal. January 2010. 100 (1).Published at http://www.scielo.org.za/pdf/samj/V100n1.(Accessed August 2010).
570 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.
571 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.
572 Interviews with the SAPC and SANC in October 2012; SAPC, 2011.Pharmacy Human Resources in South Africa 2011.

in 2011[573]. Owing to the acute shortage of skills and increasing pressure to train more veterinarians, the annual intake will be increased to 190 in 2015[574].

5.3.2 Private higher education and training institutions

Although South Africa has dynamic and well-established private HEIs they may be challenged in meeting the extensive accreditation requirements for the training of health professionals set by the professional councils and the HEQC of the CHE. Many private providers argue that for the training of health professionals accreditation requirements are not the constraining factors but, rather, the restrictions placed by government on the private sector[575].

Role players in the private health sector have expressed concerns that the private higher education sector is, to a large extent, barred from producing certain health professionals[576]. They observed that even though the DoH acknowledges skills shortages in almost all categories of healthcare professionals, previous human resources health plans neither addressed strategies to include the private sector in training nor plans to increase learner intake at tertiary academic institutions[577]. However, the 2011 national strategy, Human Resources for Health for South Africa 2030, indicates government's intention to investigate cooperation with the private sector to ensure that the academic sector grows, is sustainable, and produces quality health professionals and academics. For this purpose the DoH is evaluating mechanisms by which the private sector can contribute to health professional development[578].

Several private HEIs are accredited to train in qualifications required for registration with the AHPCSA. In November 2012 the accredited training providers in the allied health professions of therapeutic aromatherapy, therapeutic reflexology and therapeutic massage therapy were all private HEIs[579]. The South African Faculty of Homeopathy offers an accredited programme that leads to the Postgraduate Diploma in Homeopathy, which is aimed at medical practitioners already registered with the HPCSA who wish to specialise in homeopathy[580].

The Foundation for Professional Development (FPD) is a private HEI established by the South African Medical Association (SAMA). The FPD offers a comprehensive curriculum of training and development courses aimed at health professionals, practitioners, allied workers, health sector managers, and non-medical professionals. It offers programmes that lead to undergraduate- and postgraduate qualifications, and short courses. Among the key focus areas are leadership and management in a health environment, and clinical and multi-disciplinary courses, some of which are designed to meet the needs of health professionals and practitioners working in rural areas. The FPD also develops institutional capacity within the public sector[581].

5.3.3 Private further education and training institutions

Private TVET institutions produce nursing auxiliaries (NQF Level 3), enrolled nurses (NQF Level 4), and pharmacy assistants (basic level) at NQF Level 3, and pharmacy assistants post-basic at NQF Level 4. The nursing schools of several of the large private hospital groups and independent private nursing schools are accredited by the Department of Higher Education as TVET providers.

5.3.4 Private hospitals

Private hospitals contribute to skills development and training across many fields[582]. Various learning centres in the larger hospital groups are registered as private higher education institutions and TVET colleges. These institutions train pharmacists and pharmacist assistants (basic and post-basic) as well as professionals in emergency- and critical care ranging from basic to undergraduate and postgraduate levels. Ancillary healthcare professionals are trained in infection control and as surgical technologists. Several hospital groups support technical training programmes to address shortages in technical skills, such as artisans in the electrical field.

Private hospitals are permitted to train nurse practitioners but constraints in meeting regulatory and accreditation requirements limit their ability to produce certain qualifications and, therefore, the required number of nurses. Private hospitals mainly train nursing auxiliaries and enrolled nurses and offer a two-year bridging programme towards full registration as a professional nurse for general nursing functions. Because the private sector offers limited clinical experience to trainee nurses, it has not been successful in attaining accreditation to offer comprehensive training for registered nurses. Even larger private hospitals are not able to offer access to chronic psychiatric care, community-based nursing, or midwifery – all of which are required to complete a comprehensive four-year programme[583]. The private sector does offer specialist training in intensive care, neo-natal care and operating theatre units. Role players in the private hospital sector dispute general allegations that such hospitals offer limited clinical experience and maintain that valuable learning opportunities can be provided, including in midwifery and psychiatric care[584].

573 UP. 2011. Faculty Brochure: Veterinary Science 2011/12. Published at http://web.up.ac.za/... Brochures/....(Accessed 26 Aug 2010).

574 UP. 2014. Undergraduate Faculty Brochure: Veterinary Science 2014/15.

575 Worrall-Clare, K. 2009."Partnering Sectors" in Private Hospital Review 2009.Hospital Association of South Africa. Published at: http://www.hasa.co.za/.... (Accessed Aug 2010); Life Healthcare Company. 2010. "Commentary on the Draft 2011 – 2016 Sector Skills Plan".

576 Wolvaardt, G., Van Niftnik, J. et al. 2008. "The Role of Private and Other Non-Governmental Organisations in Primary Health Care". South African Health Review 2008. Published at www.hst.org.za/publications..(Accessed Aug 2010).

577 Wolvaardt, G., Van Niftnik, J. et al. 2008. "The Role of Private and Other Non-Governmental Organisations in Primary Health Care". South African Health Review 2008.

578 DoH. 2011. Human Resources for Health for South Africa 2030 – Draft HR Strategy for the Health Sector: 2012/13 – 2016/17. Published at http://www.doh.gov.za. (Accessed 16 Aug 2011).

579 AHPCSA. 2012. Published at http://www.ahpcsa.co.za/... (Accessed 12 November 2012).

580 South African Faculty of Homeopathy. 2012. Published at http://www.homeopathysouthafrica.co.za/. (Accessed 12 Nov 2012).

581 Foundation for Professional Development. 2012. Published at http://www.foundation.co.za/. (Accessed 12 Nov 2012).

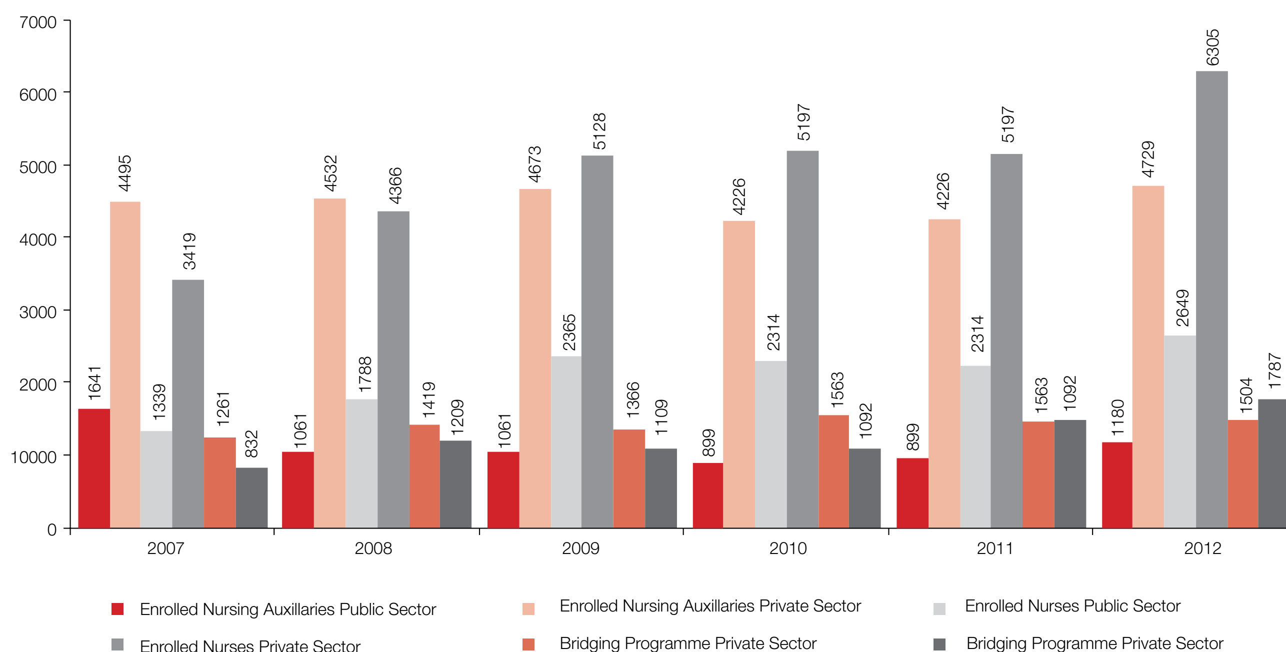
582 Netcare. 2013 Annual Report; Mediclinic International. 2013 Annual Report; Life Healthcare Group. 2013 Annual Report.

583 Breier, M., Wildschut, A. et al.. 2009. Nursing in a New Era – The Professional Education of Nurses in South Africa.

584 Life Healthcare Group. 2010. "Commentary on the Draft 2011 – 2016 Sector Skills Plan"; Worrall-Clare, K. 2009. "Partnering Sectors" in Private Hospital Review 2009. Hospital Association of South Africa.

The private sector has assumed a prominent role in contributing to the output of enrolled nursing auxiliaries and enrolled nurses, and in bridging programmes to upgrade enrolled nurses to be registered as nurses (Figure 5 3). In 2013, compared to the public sector, the private sector trained most enrolled nursing auxiliaries (80%) and enrolled nurses (70%). From 2007 to 2013 the number of enrolled nurses trained by the private sector increased annually by 10.7% from 3 419 to 6 305, while the number of nurses on bridging programmes provided by the private sector increased annually by 13.6% over the same period.

Figure 5 3 Comparison of output in basic nursing training between public and private sectors: 2007 to 2013



Source: SANC, 2014

Currently, private hospitals are not accredited to train doctors and, in an article, HASA expressed concerns about this situation – especially with respect to capacity constraints at academic health complexes[585]. Several of the private hospital groups offer bursaries to support research and training at postgraduate level for medical specialists through the Colleges of Medicine of South Africa[586].

5.3.5 Provision of Continuous Professional Development

Health professionals are obliged to undergo CPD in order to retain their registered status with their respective regulatory councils. Increasingly CPD is viewed as an opportunity to update the knowledge and skills of social workers and health professionals in their respective professional fields[587]. Policy makers in both the health and welfare sectors are calling on the statutory councils to strengthen the requirements for and monitoring of CPD. Therefore CPD plays an important role in skills formation in the sector.

Most of the professional bodies accredit providers to offer CPD and various voluntary organisations within the organised profession facilitate access to CPD and keep members' records of CPD participation. Government has recommended that CPD for the health workforce should take place in line with a national competence framework that sets out priority competencies[588]. The SAPC will introduce mandatory CPD for pharmacists and pharmacy support personnel in the near future, while the SANC aims to do the same for the nursing profession. In 2012 the DoH recommended that a CPD system for all nurses and midwives, linked to registration and professional progression, be introduced urgently. Training in professionalism and ethics must be a compulsory component of the CPD system for all nursing levels[589]. The DoH also urged the SANC to design a national framework for the education and training of nurse educators and nurse managers and to set standards for their CPD[590].

5.3.6 Non-profit organisations

Generally, NGOs offer non-accredited training to volunteers, CHWs and community caregivers, as the organisations lack capacity to seek accreditation to offer the formal qualifications registered on the NQF. The HWSETA's capacity to facilitate skills development for NGOs is hampered by funding constraints because the NGOs are levy-exempt organisations. Participants in the baseline study acknowledged the HWSETA's role in financing skills development for NGOs and called for increased support and capacity building in rural areas and CBOs. As discussed in paragraph 4.5.2, respondents from NGOs and academics whom the HWSETA interviewed in October 2012 and July 2014, emphasised the urgent need to support and capacitate NGOs to supply skills to the health and social development sector. A specific suggestion is that the HWSETA should provide funding to appoint external, experienced practice supervisors to oversee experiential learning.

585 Worrall-Clare, K. 2009."Partnering Sectors" in Private Hospital Review 2009. Hospital Association of South Africa.

586 Econex. 2013. The South African Private Healthcare Sector: Role and Contribution to the Economy.

587 Interviews with stakeholders in October and November 2012.

588 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.

589 Interviews with stakeholders in October and November 2012.

590 DoH. 2013. The National Strategic Plan for Nurse Education, Training and Practice 2012/13-2016/17.

5.4 The Supply of New Graduates by the Higher Education System

5.4.1 Higher education and training

As indicated above, health professionals mostly receive their academic education from the public higher education sector. The analysis of the supply of skills at HET level is based on information obtained from the Department of Education's Higher Education Management Information System (HEMIS). This database contains data required for quality assurance, national and institutional higher education planning, and the allocation of Government funds to HEIs. After its inception in 2000, HEMIS used the subject matter classifications of the old South African Post-Secondary Education (SAPSE) system. In 2008, the system was revised and the broad subject matter category "Health Care and Health Sciences" with 10 second-order categories was replaced by the broad category "Health Professions and Related Clinical Sciences" with 25 second-order categories. From 2010 HEMIS collected data according to the revised Classification of Education Study Material (CESM) categories. In the absence of official information on correspondence between the two systems (mapping) only 2010 to 2012 output from the HEIs in health-related fields of study are shown in Table 5 2.

If all the health-related fields of study are considered, the total output from the higher education and training (HET) sector grew on average from 2010 to 2012 by 3.9% at first three-year B Degree level and at 6.0% at first four-year B degree level. Medicine (1.8%), nursing (2.0%), pharmacy, pharmaceutical sciences and administration (9.7%) and social work (19.5%) have been fields with positive average annual growth in professional (four-year) degrees since 2010. In contrast, output in the fields of dentistry, advanced dentistry and oral sciences (2.6%), and medical clinical sciences (0.8%) showed negative growth from 2010 to 2012.

Table 5 2 Number of health-related qualifications awarded by the public higher education sector: 2010 to 2012

CESM* Category	Qualification Type	2010	2011	2012	AAG**
Chiropractic	First Bdegree (3 years)				
	First Bdegree (4 years)	48	44	52	4.1
Communications Disorders Sciences and Services	First Bdegree (3 years)				
	First Bdegree (4 years)	114	153	141	11.1
Dentistry, Advanced Dentistry and Oral Sciences	First Bdegree (3 years)	50	38	52	2.0
	First Bdegree (4 years)	212	157	201	-2.6
Dental Support Services and Allied Professions	First Bdegree (3 years)				
	First Bdegree (4 years)	46	36	24	-27.8
Health and Medical Administrative Services	First Bdegree (3 years)	200	179	230	7.3
	First Bdegree (4 years)	258	290	270	2.3
Medicine	First Bdegree (3 years)	1	25	40	628.0
	First Bdegree (4 years)	637	704	660	1.8
Medical Clinical Sciences	First Bdegree (3 years)	55	65	102	36.0
	First Bdegree (4 years)	1 015	936	999	-0.8
Nursing	First Bdegree (3 years)	302	271	278	-4.0
	First Bdegree (4 years)	891	958	927	2.0
Optometry	First Bdegree (3 years)	1			
	First Bdegree (4 years)	127	115	90	-15.9
Pharmacy, Pharmaceutical Sciences and Administration	First Bdegree (3 years)	1			
	First Bdegree (4 years)	466	509	561	9.7
Podiatric Medicine/Podiatry	First Bdegree (3 years)				
	First Bdegree (4 years)	6	16	3	-29.3
Public Health	First Bdegree (3 years)	20	23	63	75.8
	First Bdegree (4 years)	172	201	210	10.4
Rehabilitation and Therapeutic Professions	First Bdegree (3 years)	57	52	41	-15.2
	First Bdegree (4 years)	526	555	578	4.9
Veterinary Medicine	First Bdegree (3 years)	25	25		
	First Bdegree (4 years)	32”	29”	32	-0.4
Veterinary Biomedical and Clinical Sciences	First Bdegree (3 years)	25	25	0	
	First Bdegree (4 years)	97”	86”	95	-0.9
Dietetics and Clinical Nutrition Services	First Bdegree (3 years)	16	24	20	11.5
	First Bdegree (4 years)	110	127	118	3.5
Alternative and Complementary Medicine and Medical Systems	First Bdegree (3 years)	10	6	7	-14.2
	First Bdegree (4 years)	24	26	28	9.2
Somatic Bodywork and Related Therapeutic Services	First Bdegree (3 years)	10	5	8	-8.2
	First Bdegree (4 years)	47	42	40	-7.9
Movement and Mind-Body Therapies And Education	First Bdegree (3 years)	0	14	20	
	First Bdegree (4 years)	7	6	6	-7.4
Medical Radiologic Technology/Science (Radiography)	First Bdegree (3 years)	29	41	33	5.9
	First Bdegree (4 years)	77	106	98	13.1
Health Professions and Related Clinical Sciences, Other	First Bdegree (3 years)	7	0	0	
	First Bdegree (4 years)	11	45	47	107.7
Social Work	First Bdegree (3 years)	65	85	48	-14.1
	First Bdegree (4 years)	1 169	1 297	1 671	19.5
TOTAL	**First Bdegree (3 years)**	**872**	**878**	**941**	**3.9**
	First Bdegree (4 years)	**6 091**	**6 436**	**6 850**	**6.0**

**Classification of Education Study Material*
***Average annual growth.*
Postgraduate Baccalaureus degree.
Source: Calculated from DHET, HEMIS.

5.5 The Supply of New Entrants Through Nursing Colleges

Public and private nursing colleges play an important role in the supply of nurses to the health sector. According to the SANC, there were 97 active accredited private nursing education institutions and 140 public institutions in August 2013[591]. The accredited institutions comprised: public sector institutions (attached to provincial- and military hospitals); universities and universities of technology; private hospital academies; private hospitals; training academies of mining companies; private academies and colleges; and institutional care facilities for the elderly and handicapped persons. Gauteng and KwaZulu-Natal had the most private training institutions while most public training institutions can be found in KwaZulu-Natal and Limpopo. No training institution is registered in the Northern Cape.

591 SANC. 2013. Published at http://www.sanc.co.za/neis.htm(Accessed 7 October 2013).

The number of nurses who qualified at the various levels can be seen in Table 5 3. In 2013 a total of 20 764 nurses qualified at the nursing colleges. The total output of the colleges increased on average by 7.1% per year over the period 2003 to 2013. The highest average growth in output was in the pupil nurse category (11% per annum). From 2003 to 2013 the output of nurses who had done four-year programmes increased from 1 100 to 2 610 at an average annual growth rate of 9%.

Table 5 3 Number of graduates at nursing colleges: 2003 to 2013 (with average annual growth)

Programme	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	AAG
Four-year Programme	1 100	1 288	1 058	1 493	1 628	1 701	1 967	2 337	2 376	2 473	2 610	9.0
Bridging Course*	1 841	2 103	2 352	2 364	2 093	2 628	2 475	2 655	2 964	3 929	3 291	6.0
Pupil Nurses	3 158	4 273	4 565	4 816	4 758	6 154	7 493	7 511	7 391	7 732	8 954	11.0
Pupil Auxiliaries	4 390	6 698	6 754	5 422	6 136	5 593	5 779	5 125	5 232	5 009	5 909	3.0
Total	10 489	14 362	14 729	14 095	14 615	16 076	17 714	17 628	17 963	19 143	20 764	7.1

**Bridging into professional nurse category.*

Source: SANC, 2013. Published at http://www.sanc.co.za/stats.htm. (Accessed June 2014).

Production of registered nurses in nursing colleges dropped significantly between 2001 and 2008, and only started to regain 1996 levels by 2010. Output of enrolled nurses from public training colleges grew from a low base of 70 in 1996 to 2 489 in 2012 while output from private institutions increased exponentially from 33 to 5 243 over the same period[592]. According to the DoH, outputs of nursing education institutions do not match the health and service demands for nurses and midwives[593].

Analysis of data from the SANC shows that specialist nursing output in areas such as intensive care, operating theatre, advanced midwifery, paediatric nursing and psychiatry has declined and led to reduced capacity for service in tertiary hospitals[594].

592 SANC. 2013. Published athttp://www.sanc.co.za/stats.htm(Accessed 4October 2013).

593 DoH. 2012. Strategic Plan for Nursing Education, Training and Practice 2012/13 -2016/17.

594 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.

5.6 The Role of The HWSETA in the Supply of Skills

5.6.1 Changes in the skills development landscape

An important change in the skills development landscape was brought about by the The National Qualifications Framework Act (Act 67 of 2008) which came into effect in December 2010. The Act provides (among others) for a third sub-framework to the National Qualifications Framework (NQF), namely the Occupational Qualifications Framework (OQF). This sub-framework co-exists with the General and Further Education and Training Qualifications Framework (GFETQF, overseen by Umalusi) and the Higher Education and Training Qualifications Framework (HETQF, overseen by the Council on Higher Education (CHE)) and is overseen by a new quality council, the Quality Council for Trades and Occupations (QCTO). The QCTO is ultimately responsible for the development and quality assurance of occupational qualifications and currently it works with the SETAs on the quality assurance of existing qualifications that fall within their respective scopes and on the development of new occupational qualifications according to the QCTO specifications.

5.6.2 The registration of qualifications and learnerships

By mid-2014, the HWSETA had 35 registered qualifications for the health and welfare sector, nine more than in 2012 (Table 5 4). The SETA is responsible for the quality assurance of these qualifications as mandated by SAQA and the QCTO. At the time of this update the HWSETA's ETQA division managed the transition from legacy SAQA qualifications to occupational qualifications until the QCTO takes over full responsibility.

Table 5 4 Qualification matrix of the HWSETA

SAQA ID	Qualification title	NQF level	Credits
49606	GETC Ancillary Healthcare	1	134
73250	GETC ABET Ancillary Healthcare	1	120
64749	NC Community Health Work	2	140
64149	NC Occupational Health, Safety and Environment	2	120
74289	NC Occupational Health, Safety and Environment: Health	2	120
74290	NC Occupational Health, Safety and Environment: Safety	2	120
74291	NC Occupational Health, Safety and Environment: Environment	2	120
48891	NC Theology and Ministry	2	120
49279	NC Victim Empowerment and Support	2	120
50062	NC Occupational Hygiene and Safety	3	144
64769	NC Community Health Work	3	140
49688	NC Victim Empowerment	3	127
60209	FETC Child and Youth Care Work	4	165
67509	FETC Community Development	4	125
76986	FETC Community Development: HIV/AIDS	4	125
76988	FETC Community Development: Victim Empowerment	4	125
64697	FETC Community Health Work	4	156
49256	FETC Counselling	4	140
49836	FETC Gender Practice	4	152
80447	FETC Institutional-Based Care	4	120
50063	FETC Occupational Hygiene and Safety	4	145
79807	FETC Occupational Hygiene and Safety	4	145
50041	FETC Probation Work	4	142
74410	FETC Public Awareness Promotion of Dread Diseases and HIV/AIDS	4	166
23993	FETC Social Auxiliary Work	4	180
48960	FETC Social Security Administration	4	140
49057	FETC Theology and Ministry	4	120
49872	FETC Victim Empowerment Coordination	4	146
58786	National Diploma: Occupational Safety	5	242
21128	Certificate: Basic Counselling Skills	5	120
21133	Certificate: Methods of Counselling	5	120
66389	Higher Certificate: Diagnostic and Procedural Coding	5	120
83386	National Certificate: Community Development: General	5	147
83387	National Certificate: Community Health	5	147
83397	National Certificate: Community Development: Victim Empowerment	5	147

Source: HWSETA, July 2014

Plans to develop five new occupational qualifications during 2013/14 were hampered by a moratorium introduced by the QCTO. Two new qualifications were developed and further development will commence from 1 October 2014 when the moratorium expires.

The HWSETA entered into an agreement with the QCTO to manage the development of a new SAW qualification (NQF level 5) in cooperation with the SACSSP. By mid-2014 this qualification was in the final approval process by the QCTO. A new CHW qualification was developed in 2013/14 and submitted to the QCTO for registration with SAQA. The HWSETA applied to fulfil the role of Assessment Quality Partner (AQP) of this qualification as no professional body was ready to accept these functions. A new qualification for Pharmacy General Assistant (NQF level 4) is under development, with the HWSETA serving as a Qualification Development Partner (QDP) with the SAPC. The HWSETA has undertaken to register a learnership and support learners to attain this mid-level qualification. Good progress was made with the development of the CYCW qualification which will be concluded in 2014/15.

Curricula aligned to the new qualifications will be developed once the QCTO moratorium is lifted. The HWSETA also commissioned learning materials to support training under several FETC qualifications.

Over the period 2010 to 2013, a total of 14 999 learners entered HWSETA registered qualifications, of whom 7 766 (51.8%) were SETA-sponsored. The largest number of learners (3 692 or 24.6%) entered the Diploma in General Nursing: Bridging to qualify as a registered nurse and the Certificate in General Nursing: Enrolled (2 618 or 17.5%) to qualify as an enrolled

nurse[595]. The HWSETA will continue to support the development of new qualifications to replace those that reach their registration end dates and for which there is still a need. The HWSETA has also registered several learnerships for the sector with the DoL (the DHET now handle registrations) (Table 5 5).

595 Machava, R. and Miya, S. 2013. *"HWSETA Supported Programmes and Projects".*

Table 5 5 HWSETA learnerships

Learnership title	NQF level	DoL Registration Number
GETC Ancillary Healthcare	1	11 Q 110011 31 125 1
NC Theology and Ministry	2	11 Q 110017 30 120 2
Certificate Pharmacist Assistant (Basic)	3	11 Q 110002 13 120 3
Community Health Worker	3	11 Q 110016 27 120 3
Certificate in General Nursing (Auxiliary)	4	11 Q 110008 20 132 4
Certificate in General Nursing (Enrolled)	4	11 Q 110003 00 132 4
Certificate Pharmacist Assistant (Post Basic)	4	11 Q 110001 08 120 4
FETC Social Auxiliary Work	4	11 Q 110012 00 180 4
FETC Phlebotomy Techniques	4	11 Q 110006 28 134 4
FETC Child and Youth Care Work	4	11 Q 110014 35 155 4
FETC Counselling	4	11 Q 110018 69 140 4
FETC Community Development – HIV/AIDS Support	4	11 Q 110015 18 135 4
Diploma Medical Technology	5	11 Q 110005 00 120 5
Diploma in General Nursing (Bridging)	5	11 Q 110004 00 256 05
Post Basic Diploma in Medical / Surgical Nursing (Elective: Critical Care / Operating Theatre)	6	11 Q 110010 17 360 6
Diagnostic Radiography	6	11 Q 110031 00 360 6
Diploma in Primary Health Care (Post Basic)	6	11 Q 110009 23

Source: HWSETA, July 2014

5.6.3 Quality-assurance functions

The HWSETA accredits training providers to deliver learning programmes that lead to the qualifications and unit standards registered by the SETA. During 2013/14 the number of accredited providers increased to 274 up from 28 in the previous financial year. In that period 91 skills programmes were approved and a total of 257 learning programmes were evaluated. The HWSETA concluded contracts with the University of the Western Cape and Unisa to assist with the evaluations.

Only 31% of the sites visited for accreditation purposes during 2012/13 complied with HWSETA requirements. Workshops to build capacity for training providers and to promote quality were held in eight provinces. During 2013/14 a total of 35 workplaces were evaluated for the implementation of learnerships. Assessments conducted by 112 training providers were also verified.

A total of 691 assessors and 231 moderators were registered during 2013/14, which is a notable improvement compared to 2011/12 when only 403 assessors and 180 moderators were registered. Verification and monitoring activities were also stepped up in 2013/14. A total of 105 site visits and 105 monitoring visits took place. A total of 2 330 learner certificates were endorsed. Problems experienced in the previous two years pertaining to the verification of learners' achievements and the backlog in the certification of learners were addressed.

5.6.4 Learners who entered and qualified on learnerships

Learnerships remain the chief mechanism through which the HWSETA facilitates the disbursement of PIVOTAL and discretionary grants. Since learnerships enable learners to gain on-the-job competence and achieve a recognised qualification, the allocation of funding provides a tangible return on investment. In 2013/14 the HWSETA awarded learnership certificates to 1 664 workers in the sector, of whom 1 198 were black females. Another 3 777 unemployed persons were certificated after completing learnerships. Of those, 3 255 (86%) were black women and 484 (12.8%) were black men. The largest number of unemployed learners completed learnerships in social auxiliary work (1 528 or 40.5%), community health (928 or 24.6%) and child and youth care (551 or 14.6%).

Workers in the sector who entered learnerships in 2013/14 totalled 2 546, Preference was given to black women and youth. The number of unemployed learners entering learnerships increased by 62% between 2012/13 and 2013/14, or from 1 223 to 1 985.

Nursing learnerships are receiving particular support to boost the development of scarce and critical skills. Increased funding is provided to bridge enrolled nurses into the registered nurse category. In 2013/14 a total of 979 employed and 165 unemployed learners entered the nursing bridging learnership, notably higher than the previous year. The learnership for enrolled nurses attracted 419 employed and 375 unemployed learners. Nurses are also supported in learnerships for specialised fields where skills shortages exist, such as post-basic PHC, critical care and operating theatre and 286 employed learners registered in these areas during 2013/14. The learnerships for pharmacist assistants are also in demand. A total of 240 employed and 449 unemployed learners registered for the basic pharmacist assistant learnership; while the post basic pharmacist assistant learnership attracted 240 employed and 212 unemployed learners respectively.

The learnership in social auxiliary work (NQF level 4) is supported to increase the output of mid-level skills to the welfare sector.

During 2012/13 the HWSETA changed its policy on learnership funding to promote placement in employment upon completion of the learnerships. The aim is to ensure that learnerships have an impact which can be measured against actual employment of the learners.

Table 5 6 gives and overview of the learnerships completed in the sector over the period 2005/2006 to 2012/2013. A total of 10 845 learners had completed learnerships. The numbers varied from year to year with no definite trend discernible. The learnership with the highest number of learners is the GET Certificate in Ancillary Healthcare.

Table 5 6 Number of learners who completed learnerships in the health and social development sector by programme: 2005/06 to 2012/13

Programme	Financial year								Total
	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	
Certificate in General Nursing: Auxiliary	509	174	238	233	83	1			1 238
Certificate in General Nursing: Enrolled	178	734	566	264	94	2		113	1 951
Certificate in Social Auxiliary Work Level 4	84	53	1	49	382		308		877
Certificate Pharmacist Assistant: Basic	121	224	92	153	67	21			678
Commercial and Financial Accountant Public Practice		1							1
Community Health Worker					19		25	7	51
Diagnostic Radiography	13	37	6	6			23	13	98
Diploma in General Nursing: Bridging	244	252	251	71	2	2	163	176	1 161
Diploma in Primary Healthcare: Post Basic	18	32	1	18	36	1		5	111
FET Certificate: Child and Youth Care Work					526		6	4	536
FET Certificate: Phlebotomy Techniques	51	14	39	36	34		67	32	273
First Line Manager					16				16
GET Certificate in Ancillary Healthcare	499	166	18	56	20	606	78	725	2 168
National Certificate: Community Development -HIV/AIDS Support		1		5	29				35
Post Basic Diploma in Medical/Surgical Nursing (Elective: Operating Theatre Nursing)	8	22	14	12			1	4	61
Post Basic Diploma in Medical/Surgical Nursing: Elective (Critical Care)	20	55	37	10		1	42	5	170
Post-basic Pharmacist Assistant Learnership	57	158	56	79	47	18	52	138	605
Certificate in Pharmacist Assistance: Post Basic							70	122	192
Community Development HIV/AIDS support							11		11
Diploma in General Nursing : Auxiliary							147	35	182
Diploma in General Nursing : Enrolled							140	290	430
Total	**1 802**	**1 923**	**1 319**	**992**	**1 355**	**652**	**1 133**	**1 669**	**10 845**

Source: HWSETA, October 2013.

5.6.5 Workplace skills plans and implementation reports

Out of 18 967 organisations registered with the HWSETA, a total of 914 submitted workplace skills plans and implementation reports (WSPIRs) in 2013/14, down from 948 in 2011/12. Of the 914 submissions, 754 were from levy-paying and 160 from non-levy paying organisations. A total of 726 levy-paying organisations qualified for the mandatory skills grant as their WSPIRs were approved while 153 WSPIRs were approved from the levy-exempt sector. The number of rejected plans decreased from 88 in 2012 to 35 in 2013, due to concerted efforts by the HWSETA to enable compliance. However, submissions from the levy-exempt sector were notably lower than in 2012/13 when the SETA received 264 WSPIRs. Organisations who wish to register learners on learnerships with the HWSETA are required to submit WSPs.

5.6.6 Scholarships and bursaries

The HWSETA is contributing to the development of middle and high level skills required in sector. Through a partnership with the National Student Financial Aid Scheme (NSFAS) in 2012/13, the HWSETA made available bursaries to 562 unemployed learners studying towards health and social development related qualifications at universities, universities of technology and TVET colleges. Bursaries were awarded to undergraduates in the fields of nursing science, social work, biomedical technology, medicine, pharmacy, occupational therapy, physiotherapy, speech and language pathology, audiology, health promotion, demography and population studies and community development. The HWSETA also paid grants to employers for bursaries awarded to another 390 employed workers who pursued studies towards formal qualifications and skills programmes (unit standards) relevant for the sector.

Bursary funding was also approved for 47 postgraduate students (mostly at Masters Degree level) to conduct research into areas aligned to the HWSETA's research agenda. By March 2014 only 21 of the student researchers had signed the required memorandums of understanding. Constraints experienced during 2013/14 with the funding of research students at some universities will be addressed and the HWSETA will also explore alternative ways of funding via the National Research Foundation.

5.6.7 Support for work-based training

The HWSETA entered into a partnership with the Swiss South African Cooperation Initiative (SSACI) to train 300 unemployed learners on an accelerated artisan programme. Placements for 82 learners were found in the electrical-, millwright- and air conditioning and refrigeration trades. Recruitment for the balance of the learners is underway, but training providers have capacity constraints and the HWSETA is challenged to find employers to accommodate the apprentices. The National Artisan Moderation Body (NAMB) will assist the HWSETA to accredit workplaces in the sector.

Progress was made with the placement of graduates and learners from TVET colleges to gain work experience. The work experience grant supported the placement of 1 033 learners with employers during 2013/14. Over the same period the HWESTA provided work-based learning experience to 1 154 persons, 91% of whom were youth and 65.6% were black women. In terms of agreements between the HWSETA, training institutions and employers, graduates from TVET colleges were afforded work-based learning opportunities with the DSD. A total of 36 lecturers from TVET colleges received training on the NC(V) Community Health qualification.

HWSETA funding enabled 291 unemployed social work graduates to enter internships with the Department of Social Development in Limpopo for one year. Further funding for internships in the fields of social work, biomedical technology and medical technology will enable another 600 graduates to gain relevant work-based experience with employers in the Eastern Cape, Limpopo, Mpumalanga, the Free State, Gauteng and the Western Cape during 2014/15. Another 106 unemployed persons were certificated upon the successful completion of internships during 2013/14.

The HWSETA also supports the development of mid-level skills needed in the sector. During 2013/14 funding was approved for 1 985 learners in employment-linked programmes for mid-level skills. A total of 102 employers had signed contracts with the HWSETA to support this initiative.

Over the period 2010 to 2013, a total of 459 persons with disabilities entered learning programmes leading to HWSETA registered qualifications, comprising 3% of all entrants. The majority (282) were sponsored by the HWSETA[596]. Since 2012 the HWSETA has addressed the challenge of employment of persons with disabilities. During 2013/14 the work experience grant for persons with disabilities was used to place 155 disabled learners in administrative positions with the QuadPara Association of South Africa (QASA) across six provinces. It is hoped that the initiative will expand in 2014/15. A guide for persons with disabilities was compiled and distributed to employers in the sector.

During 2012/13 and 2013/14 a total of 170 and 61 employers respectively participated in work-based training by providing work experience or training for learners on learnerships. The work experience grant was made available for 34 postgraduate students to access work opportunities during 2013/14, while five benefitted in 2012/13.

5.6.8 Skills programmes

In 2013/14 the HWSETA certificated a total of 6 173 workers and 138 unemployed persons following the completion of skills programmes. The majority of certificated workers were women (5 566 or 90.2%) and of those workers, 63.2% were black. During the period 2012 to 2014, the HWSETA prepared a new set of skills programmes and worked to ensure that an adequate number of training providers were accredited against them. As a result, in 2013/14 a total of 7 322 workers in the health and welfare sector entered skills programmes based on registered unit standards. Of those, 5 030 (68.7%) were black women. Another 1 605 unemployed learners entered unit standards-based skills programmes. This represents a significant increase compared to 2012/13.

596 *Machava, R. and Miya, S. 2013. "HWSETA Supported Programmes and Projects".*

5.6.9 Partnerships for skills development

a) TVET colleges

By the end of the 2013/14 financial year, the HWSETA had entered into partnerships with 14 public TVET colleges[597] to offer training to unemployed learners in social auxiliary work and ECD, as well as in N-courses and pre-apprenticeships. The partnership with King Hintsa TVET College provides an extension of scope to offer the SAW qualification that enabled a public TVET College to offer the accredited learning programme. Previously learners had to register with private providers. Partnerships exist with four TVET colleges to train learners from rural areas in ECD (NQF level 4) and 8 TVET colleges to train learners on ECD (NQF level 5). At the time of writing, negotiations to conclude two further partnerships with public TVET colleges were at an advanced stage.

The HWSETA's pre-apprenticeship grant enables learners who wish to train as artisans but do not meet the minimum requirements to enter apprenticeships, to qualify. The National Artisan Moderating Body requires that a learner holds a trade-related N1 certificate to register as an apprentice. During 2013/14 the HWSETA formed eight partnerships with TVET colleges to offer preparatory courses in mathematics and science that train learners to enter apprenticeships. Provision has been made to support 889 learners. By 2014, a total of 511 unemployed learners entered the pre-apprenticeship training in trades such as electrical engineering, motor mechanic, boiler maker, diesel mechanic, fitter and welder.

The NC (Vocational) Health (i.e. a qualification for CHWs) was developed and curriculum books were compiled. A planning workshop was held for TVET colleges to help them prepare for the delivery of the vocational programme in accordance with the qualification requirements.

597 *These are Ingwe TVET College, Umfolozi TVET College, Gert Sibande TVET College, Lephalale TVET College, Letaba TVET College, Northern Cape Rural TVET College, Northern Cape Urban TVET College, King Hintsa TVET College, Taletso TVET College, King Sabatha Dalindyebo TVET College, College of Cape Town, West Coast College, Gold Fields TVET College and Mnambithi TVET College.*

b) Universities and Universities of Technology

During 2013/14 the HWSETA entered into partnerships with three universities (Walter Sisulu, Free State and Nelson Mandela Metropolitan University). SETA-funded bursaries for undergraduate students in nursing, social work and population studies were arranged. Another partnership agreement with the Durban University of Technology provides for the development of learning materials for three HWSETA qualifications in the field of occupational hygiene and safety.

Four universities were approached in 2012/13 to accept NCV qualifications to enable learners to access higher education in the health and social development fields. However, none of the universities were willing to enter into a memorandum of understanding.

c) Professional bodies

Following the introduction of the new mid-level pharmacy technician and pharmacy technical assistant qualifications, the SAPC approached the HWSETA to support training under these qualifications. Both entities are cooperating to develop a new qualification for Pharmacy General Assistant (NQF level 4). The HWSETA serves as a Qualification Development Partner (QDP) with the SAPC and is supporting the SAPC to develop capacity as a Qualification Assurance Partner (QAP). Once the learnership is registered, the HWSETA will also support learners to obtain this qualification.

Recently the HWSETA and SACSSP cooperated to develop the new SAW (NQF level 5) qualification.

d) Government and public sector employers

The need to develop a NC (Vocational) Social Development qualification was discussed with the DSD and TVET Directorate of the DBE during 2012/13. Plans for this qualification were outlined but its design was hampered by the moratorium on the development of further qualifications imposed by the QCTO. During 2013/14 the HWSETA reviewed the programmes already developed and evaluated whether they may be aligned to meet DSD requirements. Two workshops were held with the DSD to discuss skills development needs and a joint implementation plan to build capacity in the Department was agreed upon. Funding opportunities for the Western Cape DSD and Eastern Cape DSD were identified, and bursaries were provided to undergraduates in population studies at two universities. Further, the HWSETA will support the training of employed social workers on the facilitator course in all nine provinces and provide funding to develop cooperatives in the nutritional field.

The HWSETA is a member of a task team chaired by the DSD and CoGTA, which aims to establish the community development profession. As the DQP the HWSETA is contributing to the development of three new qualifications in the community development arena[598]. During 2014, norms and standards for community development practitioners and mid-level workers in the field were being drafted. The HWSETA engaged with the DoH on the qualification adjustment of the Health Promotion Officer (Community Health Worker, NQF level 3) as a DQP and an AQP.

5.6.10 Contribution to rural development

As part of its rural development strategy the HWSETA supported 291 unemployed learners from disadvantaged communities in the Eastern Cape, Northern Cape, Mpumalanga and the Free State to enter the ECD level 4 qualification. Partnerships were formed with TVET colleges already accredited on the qualification and by 31 March 2014, a total of 428 learners received financial support. By 2013, a total of 318 learners were ready to progress to the ECD (NQF level 5) programme[599], but the HWSETA encountered challenges with the implementation thereof.

Provincial offices have been established in four provinces (KwaZulu-Natal, Limpopo, Eastern Cape and Western Cape) as well as two satellite offices at TVET Colleges in the Northern- and Eastern Cape. The SETA is investigating the most cost effective way to increase its presence across the country, and also into rural areas.

598 *These qualifications are the FETC: Community Development (NQF level 4); NC: Community Development (NQF level 5) and Bachelor of Community Development (NQF level 8), a professional qualification for community development practitioners.*

599 *Machava, R. and Miya, S. 2013. "HWSETA Supported Programmes and Projects".*

5.6.11 Adult Education and Training

In the past the HWSETA supported Adult Education and Training (AET) through discretionary grants to increase literacy in the sector. It was found that more unemployed people needed access to AET than employed workers in the sector. Workers who need AET are generally employed in outsourced functions such as cleaning, catering and general work, or as volunteers with NPOs and their employers are not registered with the HWSETA. Since the DBE now carries the responsibility for AET, the HWSETA gave priority to other elements of the NSDS III strategy during 2013/14. Most recently the HWSETA cooperated with the Deaf Federation of South Africa to fund sign language training at NQF level 4 for 60 employees and volunteers. In future the HWSETA will continue to contribute AET through its programme for special projects. In 2011/12 a total of 541 learners achieved ABET levels.

5.6.12 Skills development support to small enterprises

During 2013/14 a total of 83 small-micro enterprises accessed funding (limited to R 20,000) for skills development priority areas as identified in the SSP. Industry-specific training and CDP were offered, as well as courses in management; finance, accounting and corporate governance; project management; occupational health and safety; presentation and communication skills; information technology; HIV/AIDS and SDF training. This intervention followed upon the HWSETA's pilot project of 2011/12 to support levy-paying small and micro enterprises (SMEs) to access funding for training via a voucher system. In this way a total of R2.8 million was distributed to 147 SMEs and 2 199 learners. The SME grant was paid to 250 organisations in 2012/13 to train employed workers in priority skills areas.

5.6.13 Skills development support to NGOs, CBOs and NPOs

Provision is also made for training in scarce and critical skills needed by levy exempt organisations. In 2013/14 funding was provided to 108 levy-exempt organisations including NGOs and NPOs to train employees in learning areas identified in their WSPIRs. At least 147 potential cooperatives, 80 from the social sector and

67 from the health sector, were identified for skills training from the Department of Trade and Industry (DTI) database for cooperatives. A survey of small firms listed on the MedPages database was conducted to identify their skills needs. Preliminary findings were completed early in 2013 and the final report will be ready for dissemination later in 2013/14.

5.6.14 Skills development support to trade- and labour unions

The HWSETA Board approved financing for 300 labour representatives to attend training courses for skills development facilitators (SDFs). Due to the need for standardisation of the training and the scope of the project, the HWSETA embarked on a tender process in 2013. A total of 125 trade union representatives were trained in 2013/14 and further training is scheduled for 2014/15.

5.6.15 Strengthening capacity for skills development

The HWSETA embarked on a number of strategies to strengthen the capacity for skills development in the sector. Between 2012 and 2014 positive steps were taken to strengthen the SETA's institutional capacity, improve internal operations, enhance service delivery, speed up response times and reduce business risks. To improve the quality of training, the HWSETA provided capacity-building workshops for training providers during the past three financial years. A total of 135 providers attended training during 2013/14 to enable them to gain accreditation to offer HWSETA accredited qualifications. Another 176 providers were trained to upload learner achievement information onto the HWSETA SETA Management System in accordance with SAQA requirements. The correct uploading of data onto the SMS resulted in the HWSETA obtaining green status on the National Learner Record Database (NLRD) performance chart.

Medium term plans for the HWSETA include the implementation of the Investors in People Standard which is an internationally recognised business improvement framework and quality standard.

5.6.16 Measures to support a green environment

A paperless process of applications for registration of assessors and moderators was introduced as part of the HWSETA's strategy to support a green environment. With further refinement of the facility, the HWSETA hopes that all future applications will be done electronically.

5.6.17 Career guidance and career paths

A new version of the HWSETA career guide with updated career information on scarce skills was prepared in 2012/13. During 2013/14 the updated career guide was made available to learners in presidential/ poverty nodal zone schools in partnership with relevant NGOs. Comprehensive career development (which includes aptitude assessment) was provided to 7 266 learners in 2013/14 and a total of 10 663 learners were reached through career awareness programmes.

5.6.18 Research, monitoring and evaluation activities of the HWSETA

Research activities of the HWSETA focus on gathering and interpreting information from experts with sectoral knowledge; key stakeholders; databases; from specific SETA-initiated research projects; and from the work of researchers in fields relevant to the sector. The HWSETA also conducts impact studies of learning programmes and tracks learners' progress. Providers' training activities are also monitored against training objectives and quality provisions of the learning programmes.

Research was undertaken in 2013/14 to assess the impact of the HWSETA's skills development activities. Five research reports were prepared that focused on the employment and learning pathways of learnership participants; the impact of skills programmes and short courses; the evaluation of strategic grants and their contribution to skills development; and the evaluation of the return on investment on skills development initiatives. A research study to identify the skills needs and current skills gaps of NPOs operating in the sector will be completed during 2014/15.

The HWSETA also needs to understand how skills programmes affect the occupational development of learners. A consortium comprised of Program for Appropriate Technologies in Health (PATH), Health Development Africa (HAD) and the International HIV/AIDS Alliance (IHAA) approached the HWSETA for a collaborative research partnership to assess the impact of training provided to community caregivers in the Thogomelo Project. This project provides accredited training for community caregivers (CCGs) employed in extended public works programmes in the social sector[600]. The CCGs are skilled to improve the wellbeing of vulnerable children, with training offered in three skills programmes: psychosocial support, child protection and supportive supervision. A track and trace study of learners who completed these skills programmes will determine whether those learners accumulated additional credits towards a qualification above those earned from the Thogomelo training, and identify factors which may enable or hinder the uptake of further training towards a recognised qualification. Results from this study are expected during 2014/15.

Research projects in 2012/13 included a study of the feasibility of distance learning for the social auxiliary work qualification and advice on the best model for a distance learning programme; a tracer study on the training and learnership outcomes of HWSETA funded graduates; and primary research for the annual update of the SSP. Another focus area was the feasibility study on the decentralisation of HWSETA functions to enhance service delivery.

During 2012/13 and 2013/14 the HWSETA adopted measures to ensure that its research strategy is in place to support a credible institutional mechanism for skills analysis and planning across the health and social development sector. The research strategy was reviewed, and research standards were defined with reference to acceptable academic standards. A research agenda addressing partnerships with universities was also drafted. Considerable progress was also made to engage universities in partnerships for research and the development of innovation capacity relevant to the sector.

5.7 Professional Registration

As stated in Chapter 2, healthcare professionals have to register with their respective professional councils in order to have the right to practise or work in the health sector. Ideally, the professional registers should provide a fair reflection of

600 Interview with DSD, Directorate HIV/AIDS Community Caregivers, July 2014. Health Development Africa. 2014. http://www.hda.co.za/Home/Our-projects/Projectdatabase/ProjectThogomelo.aspx. (Accessed 16 Jul 2014).

the stock of professional skills available in the country. However, the registers don't keep track of professionals' movement out of the country and it is possible that people who are registered no longer offer their services to the South African health sector, or only work part-time. Some of the registered professionals may also be employed elsewhere in the economy or may be economically inactive[601]. Nevertheless, the professional registers do provide an indication of growth in the number of health professionals available.

5.7.1 Registrations with the Health Professions Council of South Africa (HPCSA)

The HPCSA offers registration in 89 registration categories and is by far the registration body with the largest number of categories of health professionals. At the end of December 2012 there were 167 842 people registered with the 12 Professional registration boards of the HPCSA. This figure has more than doubled since 2000, when there were 84 682 people on the registers. This increase was, however, mainly the result of the registration of new health workers who were not regulated in the past – e.g. basic ambulance assistants.

Table 5 7 shows the registration figures for a number of key professions as on 31 December of each year from 2003 and 2013. The table also shows the average annual growth in the number of professionals registered. The total number of registered dentists grew by 2.5% per year, medical interns by 4.6%, and medical practitioners by 2.8%. Clearly, this slow growth is the most important reason why the dire employment figures are not improving.

As many as 9 117 healthcare practitioners were suspended from the HPCSA register in November 2012 for failure to pay annual fees. Among those struck from the register were 1 360 medical and dental practitioners, 6 207 emergency care practitioners and 323 psychologists. These practitioners no longer enjoyed statutory recognition to practise their professions[602]. According to the Health Professions Act, it is a criminal offence to practise any of the health professions under the ambit of the Council when one has been suspended or erased from the register.

5.7.2 Registrations with the South African Nursing Council (SANC)

The number of nurses registered with the SANC over the period 2003 to 2013 can be seen in Table. In 2013 there were 260 698 nurses registered with the Council. The number of registered nurses grew steadily from 2003 to 2013 at an average annual rate of 2.8%. The average annual growth rate for all nurses was 3.8% over the period 2003 to 2013. Registration figures for pupil and student nurses grew from a low base (16 419 in 2002) to 36 293 in 2013 at an average annual rate of 7.5%.

In May 2012 about 9 300 nurse practitioners were removed from the SANC register for non-payment of their annual registration fees[603].

There is a gap in numbers between nurses who complete their training in one year and those who register in the following year, and this attrition rate is estimated at 40%. Throughput of nurses (i.e. the number that enters training and actually qualify) is estimated at 50%, while about 18% of nurses on the SANC register may not be actively working[604].

The proportion of registered nurses is decreasing and is estimated to decline from 50% in 2009 to 37% in 2020. Registered nurses are older than the other categories, with 44% being over 50 years old and retiring at a rate of 3 000 per year for the decade and beyond[605].

According to the DoH, the numbers of professional nurses with specialist qualifications registering with the SANC in intensive care, operating theatre care, advanced midwifery and psychiatry declined gradually between 1996 and 2010[606]. Representatives of private hospitals raised the need to recruit specialist nurses internationally and train operating theatre assistants[607].

601 Day, C. and Gray, A. 2013."Health and Related Indicators" in South African Health Review 2012/13.

602 HPCSA, 10 October, 2013.

603 South African Nursing Council. 2012. News. Published athttp://www.sanc.co.za.(Accessed 24 August 2012).

604 DoH. 2012. Strategic Plan for Nursing Education, Training and Practice 2012/13 -2016/17.

605 DoH. 2012. Strategic Plan for Nursing Education, Training and Practice 2012/13 -2016/17

606 DoH. 2012. Strategic Plan for Nursing Education, Training and Practice 2012/13 -2016/17.

607 Interview with HASA, October 2012.

Table 5 7 Number of professionals registered with the HPCSA as at 31 December of 2003 to 2013 (selected professions) with average annual growth

Registration category	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Growth %
Dentist	4 500	4 644	4 761	4 836	5 047	4 890	5 015	5 296	5 423	5 652	5 787	2.5
Medical Intern	2 157	2 479	2 899	3 275	3 760	3 645	3 006	3 619	3 862	3 338	3 396	4.6
Medical Practitioner	30 578	31 330	32 443	33 507	34 449	33 534	33 800	36 633	37 289	38 652	40 258	2.8
Medical Technologist	4 713	4 869	4 877	4 954	5 048	5 151	5 311	5 383	5 552	4 948	5 045	0.7
Occupational Therapist	2 511	2 819	2 808	2 922	3 159	2 946	3 156	3 490	3 668	3 945	4 238	5.4
Optometrist	2 218	2 401	2 516	2 633	2 733	2 915	3 023	3 083	3 168	3 342	3 458	4.5
Physiotherapist	4 400	4 785	4 760	4 915	5 240	5 081	5 261	5 773	5 954	6 328	6 585	4.1
Psychologist	5 401	5 774	5 878	6 130	6 391	6 532	6 684	6 914	7 073	7 245	7 433	3.2
Radiographer	4 789	5 221	5 237	5 433	5 624	5 562	5 800	6 208	6 500	6 225	6 645	3.3
Speech Therapist and Audiologist	1 345	1 397	1 391	1 396	1 441	1 222	1 296	1 388	1 426	1 448	1 448	0.7

Source: HPCSA, 2014.

Table 5 8 Number of nurses registered with the SANC: 2002 to 2013 (with average annual growth)

Registration category	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Growth %
Registered	94 948	96 715	98 490	99 534	101 295	103 792	107 978	111 299	115 244	118 262	124 045	129 015	2.8
Enrolled	32 495	33 575	35 266	37 085	39 305	40 582	43 686	48 078	52 370	55 408	58 722	63 788	6.3
Auxiliaries	45 426	47 431	50 703	54 650	56 314	59 574	61 142	62 440	63 472	64 526	65 969	67 895	3.7
Total	172 869	177 721	184 459	191 269	196 914	203 948	212 806	221 817	231 086	238 196	248 736	260 698	3.8
Student	10 338	11 478	12 280	13 096	13 272	15 258	16 457	17 167	19 778	20 581	20 920	20 956	6.6
Pupil	6 081	7 245	8 300	8 096	8 483	9 528	11 179	13 052	16 836	16 428	16 424	15 337	8.8
Pupil Nursing Auxiliaries	4 685	4 938	6 577	6 289	6 169	4 812	5 058	37 53	6 711	5 744	5 910	6 747	3.4
Total	21 104	23 661	27 157	27 481	27 924	29 598	32 694	30 219	43 325	42 753	43 254	43 040	7.5

Source: SANC, 2013. Published at http://www.sanc.co.za/stats.htm. (Accessed June 2014).

5.7.3 Registrations with the South African Pharmacy Council (SAPC)

From 2006 to 2014 the number of registered pharmacists grew by 2.3% per annum from 11 167 to 13 589 and pharmacist interns by 6.4% per annum from 474 to 808 (Table 5 9). The registration figures in the support staff categories showed higher growth, but from a low base. From 2006, basic pharmacist assistants (NQF Level 3) annually grew by 39.7% from 114 in 2006 to 1 774 in 2014 and post-basic pharmacist assistants (NQF Level 4) by 17% from 1 792 in 2006 to 6 086 in 2014.

In 2011 South Africa had 12 346 registered pharmacists or 25.5 pharmacists per 100 000 population, which was significantly lower than the WHO recommended ratio of 45 per 100 000 population. Rural provinces fell short – in Limpopo the ratio was only 10.23, the Northern Cape 13.77, Mpumalanga 14.53 and the Eastern Cape had 15.94 pharmacists per 100 000 population[608]. According to the SAPC, approximately 96% of registered pharmacists were practising actively in 2011.

The proportion of pharmacists working in the public sector increased from 12% in 2004 to 29% in 2010, mainly as the result of the implementation of the public sector scarce skill and rural allowances, the OSD, as well as the creation of new posts to support the ARV programmes[609].

608 South African Pharmacy Council. 2011. Pharmacy Human Resources in South Africa 2011. Published at http://www.e2.co.za/emgs/phrsa/pageflip.html. (Accessed 24 Aug 2012).

609 South African Pharmacy Council. 2011. Pharmacy Human Resources in South Africa 2011.

Table 5 9 Number of registrations with the SAPC: 2006 to 2014 (with average annual growth)

Registration category	2006	2007	2008	2009	2010	2011	2012	2013	2014	AAG %
Basic Pharmacist Assistant	114	140	178	284	437	622	867	1 184	1 774	39.7
Learner Basic Pharmacist Assistant	2 191	2 657	2 766	3 146	3 637	3 858	3 807	4 372	3 500	10.4
Post-basic Pharmacist Assistant	1 792	2 257	2 443	2 768	3 457	4 159	4 533	5 371	6 086	17.0
Learner Post-basic Pharmacist Assistant	944	1 269	1 328	1 381	1 507	1 757	1 693	1 956	1 849	11.0
Pharmacist	11 167	11 365	11 905	12 109	11 939	12 346	12 805	13 119	13 589	2.3
Pharmacist Intern	474	480	489	372	566	625	619	732	808	6.4
Specialist pharmacist								13	13	-

Source: SAPC, 2014. Published at http://www.pharmcouncil.co.za/B_Statistics.asp. (Accessed 4 June 2014).

5.7.4 Registrations with the Allied Health Professions Council of South Africa (AHPCA)

By June 2014 a total of 2 703 people were registered with the AHPCSA (Table 5 10). Of these, 635 were registered as reflexologists, 667 as chiropractors, and 557 as homeopaths. From 2010 to 2014, the total number of registrations annually dropped by 3.8% from 3 160 in 2010 to the current 2 703. Generally, allied health professionals and complementary practitioners are not employed in the public sector, but they do hope to provide healing services in the NHI service delivery framework currently under development[610].

610 DoH. 2012. *Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.*

Table 5 10 Total registrations with the AHPCSA: 2010 to 2014 (with average annual growth)

	Number of persons registered					AAG
Registration category	**2010**	**2011**	**2012**	**2013**	**2014**	**%**
Acupuncture	130	118	113	99	66	-15.6
Ayurveda doctor	14	12	14	15	15	1.7
Chinese medicine	160	153	156	152	155	-0.8
Chiropractic	578	603	628	647	667	3.6
Homoeopathy	541	546	565	559	557	0.7
Naturopathy	92	91	95	89	91	-0.3
Osteopathy	46	48	49	47	46	0.0
Phytotherapy	32	39	40	38	40	5.7
Therapeutic aromatherapy	396	342	306	242	222	-13.5
Therapeutic massage therapy	194	174	163	146	138	-8.2
Therapeutic reflexology	900	783	735	662	635	-8.3
Unani-Tibb	77	81	79	70	71	-2.0
Total	**3 160**	**2 990**	**2 943**	**2 766**	**2 703**	**-3.8**

Source: AHPCSA, June 2014.

5.7.5 Registrations with the South African Veterinary Council (SAVC)

The number of veterinarians registered with the SAVC grew by 2.9% from 2 769 in 2010 to 3 102 in 2014 (Table 5 11.) Of the para-professionals registered, 1 034 were registered as animal health technicians, 602 as veterinary nurses, and 287as veterinary technologists.

Table 5 11 Number of registrations with the SAVC: 2010 to 2014 (with average annual growth)

	Number of persons registered					AAG
Registration categories	**2010**	**2011**	**2012**	**2013**	**2014**	**%**
Veterinarians	2 769	2 842	2 902	3 006	3 102	2.9
Veterinary specialists	135	139	147	157	164	5.0
Animal Health Technicians		1 008	1 043	1 039	1 034	0.9
Laboratory Animal Technologists		21	21	21	20	
Veterinary Nurses		542	573	589	602	
Veterinary Technologists		210	246	260	287	
Professionals in training	650	1 693	1 926	2 077	2 221	36.0
Total	3 554	4 762	6 858	7 149	7 430	20.2

Source: SAVC, June 2014.

5.7.6 Registration with the South African Council for Social Service Professions

The registration figures of social workers and SAWs can be seen in Table 5 12. The total number of registered social workers increased on average by 5.5% annually from 10 645 in 2004 to 18 213 in 2014.

The majority (87%) of currently registered social workers are women. Registered social auxiliary workers (NQF Level 4) increased from 1 455 in 2004 to 5 239 in 2014, or on average by 13.7% per annum.

The SACSSP also registers student social workers who are registered with HEIs in their 2nd, 3rd and final years of undergraduate study. The number of candidate professionals in training increased from 1 195 in 2004 to 2 189 in 2014, or on average by 6.2% per annum. In 2009, 2010 and 2011, the numbers of student social workers expanded notably to 3 100, 4 225 and 5 742 respectively but decreased in subsequent years.

Table 5 12 Social workers and social auxiliary workers registered with the SACSSP: 2004 to 2014

Occupation	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Social Workers	10 645	11 111	11 762	12 252	14 072	14 266	14 904	15 866	16 164	16 682	18 213
Social Auxiliary Workers	1 455	1 591	2 065	2 132	2 577	2 323	2 729	2 980	3 243	4 489	5 239

Source: SACSSP, June 2014.

5.8 Factors Influencing the Supply of Skills in the Health Sector

Apart from the institutional strengths and constraints described earlier in this chapter, a number of other factors also impact, or are set to impact, on the supply of skills in the future. These include poor workforce planning and the absence of an occupational framework for key health professions, government strategies and policy interventions, the management of public sector health facilities, the migration of South African health professionals, the recruitment of foreign professionals, and the socio-economic realities faced by many potential professionals.

5.8.1 Health workforce planning

Health workforce planning is very challenging because of the time required to train health professionals, especially doctors and medical specialists (i.e. 9 years and 14 to 15 years respectively). While the aim is to align supply, demand and need, this is not necessarily achievable; e.g. health professionals may be trained but not accommodated in the health system as a result of budget constraints or frozen posts.

According to the DoH, education and training for the health sector has not kept pace with health needs and requirements of the health system, and the supply of health professionals has not been adequately managed. This is attributed to the lack of planning between the health- and education sectors, as well as inadequate financing to develop and deploy health professionals[611]. A lack of clarity on the roles, responsibilities and scopes of practice in several occupational categories has also continued to affect supply – e.g. clinical associates, several nursing categories and CHWs – while the sector lacks data and information needed for planning of the professional health workforce[612].

The DoH proposes to introduce a range of measures to improve health workforce planning. It intends to develop databases to support planning and monitoring of the health workforce. Staffing norms, standards and training requirements for clinical health professionals in the fields of physiotherapy, occupational therapy, clinical psychology, dietetics, environmental health, oral hygiene, medical technology, radiography, optometry and pharmacy will also be determined[613].

Concerns were raised about the lack of coordination among different government departments tasked with health workforce planning. While Government continues to promote skills development for the NHI, budget constraints limit further employment. HEIs receive subsidies to train health professionals (and some learners also receive state-funded bursaries), yet the posts to deploy graduates are not created or filled[614]. This situation has an adverse impact on skills provision.

5.8.2 Government strategies and policy interventions

Over the last few years government has introduced a number of strategies and plans to improve the supply of health workers. A few of these interventions are discussed below:

a) Nursing

Healthcare provision in South Africa is affected by the global shortage of nurses. Both the public and private sectors have suffered losses of experienced nursing professionals who are regarded as essential components in the overall healthcare delivery system. Cuts in provincial health budgets for training, the rationalisation of public nursing colleges (and the subsequent closure and merger of many), and reduced output of specialist nurses have had an adverse effect on their supply[615]. The DoH and SANC raised concerns about clinical education and training of nurses while many nurses apparently lack competence in PHC and midwifery. Clinical training departments are no longer in existence in health service institutions, while the supervision and management of learners is also inadequate.

In response to these challenges the SANC and the DoH developed The National Strategic Plan for Nurse Education, Training and Practice 2012/13-2016/17[616]. The document outlines plans to augment the nursing profession to manage the country's healthcare needs. Important elements of this strategy are to re-position nursing education in higher education; develop nurse educators and nurse managers; run programmes to restore the professional ethos of nursing; and address governance, leadership, legislation and policy for the nursing profession. Other interventions will aim to develop positive practice

611 *DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.*

612 *DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.*

613 *DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.*

614 *Interviews with HPCSA in July 2014.*

615 *Breier, M., Wildschut, A. et al. 2009.Nursing in a New Era – The Professional Education of Nurses in South Africa; DoH. 2013. The National Strategic Plan for Nurse Education, Training and Practice 2012/13-2016/17.*

616 *DoH. 2013. The National Strategic Plan for Nurse Education, Training and Practice 2012/13-2016/17.*

environments [617], improve conditions of service and human resources planning, and set staffing norms[618]. Nursing colleges will be re-positioned as nursing education institutions (NEIs) on a higher education platform. NEIs, their programmes and clinical training facilities will be required to meet accreditation criteria set by the SANC and CHE. As outlined in Chapter 3, new nursing categories aligned to revised scopes of practice for nurses and a new nursing qualifications framework were developed. The DoH has set a goal for the accreditation of 220 public nursing colleges that offer the new qualifications by 2018/19[619].

According to the SANC, training under the new qualifications will commence in 2016 and a teach-out period for the legacy qualifications will be provided until 2020 or 2022[620]. Entry requirements for all the new nursing categories differ from those for older qualifications. This may restrict the pool of potential entrants, especially at the level of professional nurse, where a solid pass in Grade 12 mathematics is required[621]. Education and training requirements will be set to meet the new scope of practice and competency requirements for each category of nurse, and curriculum guidelines will be given. Nurse educators will need to have core competencies in clinical specialities and teaching, and training of nurse educators will be accelerated. Clinical teaching units will be established at NEIs and hospitals to improve clinical training for nurses[622].

Older-cadre nurses will require skills development interventions to upgrade their skills and develop the necessary competencies aligned to the revised scopes of practice[623]. The SANC has identified the need for a bridging course to transition enrolled nurses to the new registered staff nurse category. Nurse educators will require bursaries to pursue postgraduate studies and to develop the requisite teaching and mentoring capabilities to register as nurse educators with the SANC[624]. The ranks and skills base of nurse managers will also be developed to enable them to manage and implement complex healthcare reforms. Long-term planning by the SANC includes the introduction of a professional licensing examination for all categories of nurses as a registration requirement to enter practice[625].

617 According to the DoH "positive practice environments "are healthcare settings that support nursing excellence and decent work, enable quality patient care and improve patient satisfaction, outcomes, and staff retention.

618 DoH. 2013. The National Strategic Plan for Nurse Education, Training and Practice 2012/13-2016/17.

619 DoH. 2014. Strategic Plan 2014/15-2018/19.

620 Interview SANC, October 2012; Interviews with academics in nursing field in July 2014.

621 Democratic Nursing Organisation of South Africa. 2010. "Skills development input". Written submission dated 14 December 2010 made to the HWSETA on the draft SSP for the health sector for the period 2011 to 2015.

622 DoH. 2013. The National Strategic Plan for Nurse Education, Training and Practice 2012/13-2016/17.

623 Democratic Nursing Organisation of South Africa. 2010. "Skills development input". Written submission dated 14 December 2010 made to the HWSETA on the draft SSP for the health sector for the period 2011 to 2015.

b) Community service for health professionals

Compulsory community service in the public sector was introduced for 11 health professions between 1998 and 2007. Newly qualified health professionals serve one year of community service in under-resourced areas to enhance access to healthcare and also to develop their own clinical skills independently from their institutions of training[626]. Each year a number of these health professionals are allocated positions in the SA Military Health Services and the Department of Correctional Services. The creation of academic community service posts in faculties of health sciences are under consideration, while similar proposals have been made for pharmacy schools[627]. While community service alleviates some skills shortages, public health services are still challenged to retain professionals, especially in rural areas. The attrition rate among community service professionals remains relatively high at around 23.1%. This constitutes a notable loss of trained professionals to the health system, as it is equivalent to the annual output of one medical school[628].

Veterinarians will be required to perform mandatory community service in the public sector from 2015 or 2016, and para-professionals will also do so within the next few years. These measures will address acute skills shortages in the animal health sector[629].

624 DoH. 2013. The National Strategic Plan for Nurse Education, Training and Practice 2012/13-2016/17.

625 Interview with the SANC in October 2012.

626 DoH. 2006. "Community service to improve access to quality health care to all South Africans". Published at http://www.doh.gov.za. (Accessed Aug 2010).

627 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17; SAPC. 2011. Pharmacy Human Resources in South Africa 2011.

628 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.

629 SAVC. 2012. Interview in October 2012.

c) Salary adjustments

A few years ago the DoH introduced rural and scarce skills allowances to attract and retain healthcare professionals in areas of greatest need[630]. The introduction of the occupational-specific dispensation (OSD) for health professionals in the public sector was aimed at eliminating salary differentials between the private and public sectors and retaining scarce skills. However the arrangements have been hampered by incapacity in provincial health departments[631]. Inadequate financial planning for OSD resulted in problems: the scheme was under-funded and funds allocated to health services and goods were used to cover the shortfall, thus reducing service delivery[632]. Over-spending on budgets resulted in the non-filling of vacant posts. In nursing, OCD benefits are only paid for some, but not all areas of post-basic training and this incentive has diverted skills development away from other much needed specialist areas[633]. The DoH will review current OSD arrangements to ensure that appropriate incentives are in place to attract and retain health professionals[634].

d) The introduction of mid-level skills

Supply constraints are hampering the provision of mid-level skills. According to the HPCSA, the training of clinical associates is viewed as a medium-term solution to overcome the acute shortage of doctors and to strengthen access to healthcare at district hospitals. In theory, their presence in the health system will make task-sharing possible and enable better utilisation of high-level medical skills. However, challenges in the health system have hampered the deployment of clinical associates. At the time of writing, clinical associates were not regulated by a scope of practice and were required to work under supervision of medical practitioners. The implication

630 Lehmann, U. 2008. "Strengthening Human Resources for Primary Health Care". South African Health Review 2008. Health Systems Trust. Published at www.hst.org.za/publications/841. (Accessed Aug 2010).

631 Bateman, C. 2010. "Occupation-specific dispensation – a hapless tale". South African Medical Journal. May 2010. 100 (5).Published at http://www.scielo.org.za/pdf/samj/V100n5. (Accessed Aug 2010).

632 Engelbrecht, B. and Crisp, N. 2010. "Improving the performance of the health system". South African Health Review 2010; DoH. 2011. Human Resources for Health for South Africa 2030 – Draft HR Strategy for the Health Sector: 2012/13 – 2016/17.

633 Interviews with academics in the nursing field in July 2014.

634 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.

is that doctors have to accept professional responsibility (and liability) for the work of clinical associates. Their role relative to other health professionals has not been finalised and they are not trained to prescribe medication[635]. Many have been unable to work, as public sector posts were not created or funded. It is not yet clear whether they will work in the private sector. Uncertainties remain about how the roles of doctors and nurses (especially in rural areas) may change when clinical associates are introduced. The current corps of health professionals will require re-orientation to practise task-sharing, while responsibility for supervision and areas of accountability will have to be delineated. Thus, as these mid-level skills are supplied to the health system, the need for further training and re-orientation across health professions will increase.

Several professions are planning to introduce more proficient MLWs at semi-professional level to better serve the health needs of the population. However, training of MLWs is hampered by sub-optimal planning as this has not been integrated into the higher education platform[636].

e) Community health workers

In the re-engineered PHC system, health promotion and prevention services will be delivered by CHWs who assist with alleviating the quadruple burden of disease. Their main roles will be to promote maternal- and child health, and to identify at-risk individuals and families who require further interventions, and to improve population health[637]. As outlined in Chapter 3, the ranks of CHWs are disorganised and their skills levels vary. It will be necessary to transition this diverse informal workforce into formal positions (and employment) as part of PHC outreach teams. This will require clarity on the scope of their work, their roles and responsibilities, job descriptions, qualification requirements, employment mechanisms and conditions of service. The DoH has proposed that CHWs be regulated, accredited and trained to meet requirements of the health system[638].

At the time of writing, a new Level 3 qualification for CHWs was under development by the DoH, with the HWSETA as the development partner. It is structured as an occupational qualification with theoretical- and practical- and workplace learning components. The DoH has developed curricula and the HWSETA will serve as assessment quality partner of the qualification. Training will commence at the regional training centres of the DoH in 2015. The DoH recommended that the qualification be structured as a learnership and replace the current HWSETA learnerships in ancillary healthcare (NQF level 1) and community health work (NQF level 3)[639]. During the period 2013-2019 an estimated 45 000 CHWs must be trained to serve in the community-based PHC outreach teams[640].

However, skills provision for CHWs may be hampered by the continuing uncertainty amongst important role-players in the health sector. According to the HPCSA, the occupation has not been registered and confusion remains about their roles and responsibilities. In particular, the range of services to be delivered by CHWs has neither been finalised and nor has their scope of practice. Potentially, the tasks of CHWs may overlap with the scopes of practice of almost all healthcare professions, and so the HPCSA has declined requests to regulate the occupation. It appears that CHWs will need a spectrum of skills to monitor the use of complex medication regimes; provide psycho-social support; assist with rehabilitation of victims of abuse and crime; provide advice on nutrition and infant care; and offer counselling for a range of conditions and interventions. To the HPCSA it seems that the CHW may have to be trained as “a jack-of-all-trades”. Consequently the HPCSA has reservations about the level of the proposed new occupational qualification (i.e. NQF level 3) and suggests that a higher-level qualification (i.e. above NQF 4) may be more appropriate[641].

The nursing profession is particularly concerned about role confusion and role conflict between CHWs and nurses. The profession maintains that CHWs are neither nurses, nor trained in a nursing environment and, in the future, nurses may be required to supervise CHWs in the PHC teams. However, nurses have not been trained to supervise such workers[642]. Public health experts contend that PHC workers will only be effective if the health system attracts them into rewarding jobs[643].

Another concern relates to the lack of career paths for CHWs. Stakeholders indicated the need to create clear and structured career pathways linked to qualifications and exit points from training for CHWs and caregivers[644]. It was suggested that CHWs could be trained while gaining work experience in the PHC system, and be enabled to enter the lower steps of the nursing profession, from where they could permeate to higher qualification levels[645].

f) Special grants

Government has made available a number of grants to support the development of healthcare skills. The health professions training and development grant will amount to R7.3 billion from 2014/15 to 2016/17[646], and is paid to provinces to fund operational costs associated with the training of health professionals while also strengthening undergraduate and postgraduate teaching and training processes in health facilities. Specific targets are set to train 38 149 undergraduate students and deploy 1 599 registrars (i.e. medical doctors receiving advanced training in a specialist field) and at least 125 specialists[647]. This grant also provides for the recruitment of medical specialists in under-served areas. A dedicated nursing college/school grant is allocated to maintain and re-open these training institutions[648]. Through the national health grant more general practitioners are contracted to work in public sector health facilities[649].

g) Licensing of health professional practices

Provisions of the National Health Act, 2003 (NHA) have been enacted that require private hospitals and practices of health professionals

635 Doherty, J., Couper, I. and Fonn, S. 2012. “Will clinical associates be effective for South Africa?” South African Medical Journal. November 2012. 102 (11). Published at http://www.scielo.org.za/scielo... (Accessed 20 July 2013).

636 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.

637 Interviews with DoH in October 2012; DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.

638 DoH .2013.The National Strategic Plan for Nurse Education, Training and Practice 2012/13-2016/17.

639 Interviews with the DoH in October and November 2012 and July 2014.

640 Matsotso, M.P., Fryatt, R. 2013 “National Health Insurance: The first 18 months”. South African Health Review 2012/13.

641 Interviews with HPCSA during Oct 2012 and July 2014.

642 Interview with the SANC in October 2012.

643 Frenk, J., Chen, L. et al. 2010. Health Professionals for a New Century: transforming education to strengthen health systems in an interdependent world.

644 Interviews with HWSETA stakeholders held in October 2012 in preparation of this SSP.

645 Lehmann, U. 2008. “Strengthening Human Resources for Primary Health Care”. South African Health Review 2008.

646 National Treasury. 2014 Budget Review.

647 Department of Health 2012. Annual Performance Plan 2012/13 – 2014/15.

648 Department of Health 2012. Annual Performance Plan 2012/13 – 2014/15.

649 DoH. 2014 Strategic Plan 2014/15-2018/19.

to hold a "certificate of need". Effectively, health professionals themselves and the physical facility of their practice will require a license for the professional and the service functions to be performed at the site[650]. The deadline for compliance is April 2016. The NHA empowers the Director-General of Health to consider, amongst other factors, "the need to promote an equitable distribution and rationalisation of health services and healthcare resources", as well as "the need to correct inequities based on racial, gender, economic and geographical factors" before the certificate of need is issued or renewed[651]. Such an intervention will enable the state to manipulate the supply of skills while also controlling the location where health professionals may render their services. It is anticipated that the provisions will have significant implications for the distribution of skills in the sector. In addition, Government intends to develop regulatory strategies to improve access to health professionals in rural and remote areas[652]. The SAPC also called for a moratorium to be placed on the issuing of pharmacy licences to allow the Council and the DoH to map needs across all provinces, sectors and pharmacy categories[653].

5.8.3 Education and training of health professionals

Education output of most health professions, and specifically of medical doctors, has remained stagnant over the past 15 years. As highlighted in paragraph 5.3.1, posts for academic clinicians have reduced as a result of budget cuts, and hence academic capacity for clinical training and clinical research has been reduced. In addition, registrar and sub-specialist training posts remain at 30% and 75% unfilled respectively, largely because of a lack of funding. This restricts the number of medical specialists that are trained. Similarly, budget cuts and the lack of public sector posts have limited the development of specialists in the therapeutic sciences.

Another factor affecting supply is the cost and time to train health professionals who are trained on an academic-, clinical-, and workplace platform. The cost to the public sector of training health professionals is notably higher than for other education and training programmes. This is mainly due to the nature of clinical training, which requires a low academic clinician to student ratio, the time required in such training and availability of equipment, technology and clinical infrastructure[654]. Government has pressurised all medical schools to increase their student intake, but has not provided the considerable resources needed to expand clinical training platforms[655]. It is also a slow process to increase the supply of health professionals. For example, to produce 1 053 extra MBChB graduates annually (in addition to the current 1 300) by 2025, requires increasing the enrolment of medical students from 8 589 to 15 549 (a doubling of the current medical training platform)[656]. Training of South African medical students also takes place abroad by arrangement with the Cuban government.

According to the SAPC, pharmacy training is also hampered by limited resources. Since access to work-based training and tutors to train pharmacist interns is limited, it may be necessary to develop a revised training model for pharmacists[657]. In the nursing field, nurse educators face several challenges. Their numbers have declined due to improved public sector remuneration while many have reached retirement age. Insufficient numbers of educators are required to train a growing student corps and to absorb a greater workload. Provision of CPD is inadequate and this impacts negatively on the quality of teaching, supervision of clinical training, and the skills needed to apply new technologies[658].

The DoH has recognised the formative and essential role of health educators and academic clinicians. Measures will be introduced to strengthen the health education sector[659]. Short-term strategies include an assessment of HEI programmes at undergraduate and postgraduate levels in the clinical and non-clinical professions; the development of various databases to plan and monitor the employment of health academics and registrars[660]; the identification of additional financing for the education and training of health professionals; and the development of a national framework for academic clinicians who also provide clinical services at provincial hospitals[661]. Specific interventions will aim to strengthen academic health complexes, through additional financing for teaching, research and service. Local and foreign recruitment of academic clinicians will be stepped up and faculties of health sciences will be required to actively plan the development of academic clinicians. New campuses and service sites in rural and peri-urban areas will also be developed. Steps will be taken to standardise the quality of clinical training offered by HEIs and to set minimum requirements for output.

5.8.4 Migration of professionals

Emigration of professionals and their migration from the public sector to the private sector directly impact on healthcare delivery and outcomes. Research has identified a number of factors that contribute to increased emigration in the healthcare sector – including remuneration, working conditions, job satisfaction, medical infrastructure, safety and risk of disease, along with more general concerns about political instability, crime, and standards of service delivery[662].

Lack of posts in the public sector as well as budget constraints to fill vacant public sector posts contribute to attrition and migration. Although the numbers of health professionals in the public sector have grown since 2002, both newly qualified and postgraduate health professionals have difficulty finding jobs in the sector[663]. When graduate output is compared with the increase in public sector posts for the period 2002 to 2010, it is evident that graduates from faculties of health sciences are not absorbed into the public health sector, as is illustrated in Table 5 13 below:

650 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17; Child, K. 2014. "Docs to be told where to work". The Times. 23 May 2014.
651 Sec 36 of the National Health Act, 2003; Child, K. 2014. "Docs to be told where to work". The Times. 24 May 2014.
652 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.
653 SAPC. 2011. Pharmacy Human Resources in South Africa 2011.
654 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.
655 Interviews with HPCSA and academics in the health-care sector in October 2012.
656 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.
657 South African Pharmacy Council. 2011. Pharmacy Human Resources in South Africa 2011.
658 Interviews with stakeholders in October 2012; DoH. 2012. Strategic Plan for Nursing Education, Training and Practice 2012/13 -2016/17.
659 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.
660 Registrars are medical doctors who are undergoing advanced training in a specialist field.
661 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.
662 Ramjee, S. and McLeod, H. 2010. "Private sector perspectives on National Health Insurance". South African Health Review 2010.
663 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.

Table 5 13 Retention gap for professional graduates, 2002-2010

	Graduate output	Public sector post increase	Retention gap	Retention gap
Profession	N	N	N	%
Medical doctors	11 700	4 403	7 ,297	62.4
Dentistry	2 140	248	1 892	88.4
Pharmacy	3 645	1 960	1 685	46.2
Physiotherapy	2 934	497	2 437	83.1
Occupational therapy	1 827	410	1 417	77.6
Speech-language pathology and audiology	1 413	265	1 148	81.2
Dietetics	657	502	155	23.6

Source: Department of Health. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.

The analysis shows that while 11 700 doctors graduated between 2002 and 2012, the number of doctors employed in the public sector only increased by 4 403. Low absorption rates are noted for dentistry and the therapeutic sciences (physiotherapy, occupational therapy and speech-language pathology) because of the lack of public sector posts.

Burnout due to a combination of workload, under-staffing, lack of resources, high-risk working conditions, poor local hospital management, and dysfunctional administration is another factor contributing to public-private sector migration[664]. Doctors and nurses are often ill-prepared to work in PHC facilities and complain of poor support while they work there[665]. In an attempt to address the difficult working conditions, two trade unions – DENOSA and Solidarity – are calling for the introduction of legally enforceable nurse/patient ratios to bring nurses back to practice and to boost training outputs. The implications are that if the nurse/patient ratio is reached, patients will either wait to be admitted, or be refused treatment, or wards in under-staffed hospitals and facilities will have to close in order to reach the prescribed nurse/patient ratios[666].

South African health professionals are a sought-after resource[667]. Foreign commercial recruitment agencies are working locally to recruit and place South African health professionals overseas[668]. As part of a broader strategy to address skills supply challenges, the DoH plans to establish a national recruitment and retention unit to ensure and oversee recruitment, retention and equitable distribution of professionals for the health sector[669].

5.8.5 The impact of HIV/AIDS

Workers in the health sector are required to treat, counsel and care for patients infected with HIV/AIDS. Unlike workers in other sectors who risk HIV infection due to human and social behaviour, health workers are exposed to additional infection risks in the workplace daily. The nature of their work makes them more vulnerable to infection risks from HIV and tuberculosis. Surveys have found that as many as 46% of in-hospital patients in the public sector may be HIV positive, while more than 36% of private sector patients are infected. Exposure to these conditions increases the risks of illness and premature death among staff and adversely affects worker morale[670]. In turn, service delivery in the health system is affected by absenteeism, loss of skills due to preventable deaths, and the risk of neglect as a result of increased patient load[671]. During interviews with NGOs serving the health and social development sector, respondents confirmed that large numbers of volunteers take ill, and that the organisations have to constantly train more people to replace those who leave.

By 2002 an estimated 15.7% of health workers employed in the public and private sectors were living with HIV/AIDS. Among younger health workers in the age group 18 to 35 years, the risk of infection was higher and the estimated HIV prevalence was 20%. Of the total number of health workers who died between 1997 and 2001, it was estimated that 13% died from HIV/AIDS-related illnesses[672].

5.8.6 Recruitment of foreign health workers

Since 1994 the DoH has entered into bilateral agreements with foreign governments (including Cuba, Iran, Tunisia, Germany and the United Kingdom) to recruit and employ foreign doctors in the public health sector. Priority has been given to doctors from Cuba and by mid-2011 the agreements with the other countries had not been fully activated[673]. According to the DoH, the longer-term policy was to limit the recruitment of foreign doctors to 6% of the medical workforce, but that they comprised 10% of the medical workforce by 2011[674]. However, from 2012 foreign recruitment of health professionals was stepped up in the short term, especially for rural areas. Priority will be given to academic health professionals who will train, transfer skills and develop innovative care interventions, and to clinicians who are willing to work

664 Bateman, C. 2007. "Slim Pickings as 2008 Health Staff Crisis Looms". South African Medical Journal. Nov 2007. 97(11).

665 Coovadia, H., Jewkes, R., et al. 2009. "The health and health system of South Africa: historical roots of current public health challenges". Lancet. Sept 2009; Day, C. and Gray, A. 2008. "Health and Related Indicators". South African Health Review.

666 Bateman, C. 2009. "Legislating for nurse/patient ratios 'clumsy and costly' – experts". South African Medical Journal. Aug 2009. 99 (8).Published at http://www.scielo.org.za/pdf/samj/V2009n8. (Accessed Aug 2009).

667 Macheke, C. 2010. HWSETA Health Sector Baseline Study.

668 Bateman, C. 2007. "Slim Pickings as 2008 Health Staff Crisis Looms". South African Medical Journal. Nov 2007. 97 (11).

669 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.

670 Lehmann, U. 2008. "Strengthening Human Resources for Primary Health Care". South African Health Review 2008.

671 Shisana, O., Hall, E., Maluleke, J. et al. 2004. The Impact of HIV/AIDS on the Health Sector – National Survey of Health Personnel, Ambulatory Patients and Health Facilities, 2002.

672 Shisana, O., Hall, E., Maluleke, K.R. et al. 2004. The Impact of HIV/AIDS on the Health Sector – National Survey of Health Personnel, Ambulatory Patients and Health Facilities, 2002; Shisana, O. Hall, E., Maluleke R. et al. 2004. "HIV/AIDS prevalence among South African health workers. South African Medical Journal October 2004. Vol. 94 (10); Coovadia, H., Jewkes, R., Barron,P. et al. 2009. "The health and health system of South Africa: historical roots of current public health challenges". Lancet. Sept 2009. Vol. 374.

673 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.

674 DoH.2011. Human Resources for Health for South Africa 2030 – HR Strategy for the Health Sector: 2012/13 – 2016/17.

in rural areas[675]. During 2013, a further 95 medical specialists were recruited from Cuba to serve public sector needs[676].

The recent HRH Strategy for the Health Sector 2012/13-2016/17 recommends that the DoH should review foreign recruitment policies to draw more health professionals, and also attract locally trained persons back from abroad. Other potential policy interventions include staff exchanges between health facilities (i.e. structured temporary development opportunities); twinning (i.e. establishing links with foreign hospitals to support resources locally) and educational support (foreign educators or educational resources move temporarily to hospitals and training facilities in South Africa); as well as bi-lateral agreements between a local and foreign health facility to train and develop staff[677].

The SAPC also requested the DoH to recruit foreign qualified pharmacists for the public sector, especially from SADC countries[678].

5.8.7 Management of the public sector health facilities and health workforce

The DBSA Road Map process found that many of the human resource problems in the public sector arise from institutional problems in the public sector itself[679]. Health sector analysts believe that the most effective short-term response to the crisis of human resources is to use existing resources better, and this means improving the management of health systems[680]. Better outcomes achieved by poorly resourced districts compared with those of well-resourced districts are attributed to effective management[681].

Institutional factors such as poor planning, sub-standard clinical care, poor governance, inadequate management systems, lack of effective controls, low levels of organisational responsibility for actions and failures, and inadequate devolution of authority to make effective operational decisions about patient care all have an impact on how effective skills are deployed[682]. The effectiveness of skills development and training programmes for middle- and senior managers is compromised, as working environments are not conducive to change and innovation[683]. National-level attempts to develop effective management-training programmes for managers have not achieved the desired success and it is suggested that HEIs should deliver appropriate courses at local level[684]. Government established the Leadership and Health Management Academy in October 2012 to develop leadership and management capacity in the public health sector[685]. Draft regulations issued in 2012 require that every hospital CEO must be a graduate in a health-related field and preferably also hold a management qualification[686].

Other research has found that poor treatment of doctors and other health professionals in the public sector was the major reason for them leaving the public sector and the country[687]. If this situation does not improve quite significantly, interventions to retain staff and to increase the supply of skills may prove to be ineffective.

In recognition of these challenges, Government will adopt measures to improve the working environment of the health workforce. Management and leadership in the health sector are viewed as primary priorities to improve the motivation and abilities of healthcare professionals. The DoH and provincial health departments will address a series of interdependent matters, such as job design, performance management, remuneration, employment relationships, the physical work environment and equipment, workplace cultures and practices, facility workforce planning and career pathways[688].

In addition, measures will be introduced to actively manage the health workforce. Specific strategies are under development to secure supply; meet the demand for services; enable access; and to attract and retain graduates in the public and private sectors. In the short-term enhanced support will be given to community service professionals while their retention in the public sector will be encouraged. Minimum staffing norms and workload analysis will be used to guide planning and the freezing of critical posts will be re-visited. Over the medium term the DoH will link the growth in posts to service, staff planning and budgets. Efforts will be made to align education strategies (supply of health workers) and employment (demand) in both public and private sectors. A rural health strategy to attract and retain health professionals in rural areas will also be developed[689].

5.8.8 Socio-economic realities of potential learners

Lastly, prevailing socio-economic realities and the lack of equal educational opportunities for differing population groups continue to impact on the number of black African learners who enter the health professions. Long training periods mean that aspiring health professionals forego earning an income for many years and this deters people, especially persons from lower socio-economic positions, from entering the professions. The relatively high costs of education in the health sciences, compared with other tertiary programmes, may also affect the supply of skills.

675 DoH. 2010. "Health Sector Strategic Framework: The 10 Point Plan" in the Strategic Plan 2010/11-2012/13.; National Treasury. 2010. "Vote 15: Health". Estimates of National Expenditure 2010.

676 Matsotso, M.P., Fryatt, R. 2013 "National Health Insurance: The first 18 months". South African Health Review 2012/13.

677 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.

678 SAPC.2011. Pharmacy Human Resources in South Africa 2011.

679 DBSA. 2008. A Roadmap for the Reform of the South African Health System.

680 Quotation from Rajat Gupta, Board Chair of the Global Fund to fight AIDS, Tuberculosis and Malaria in Rispel, L. 2011. "Understanding demand and supply of health services: managing the health workforce". ERSA Symposium on health reform.

681 Engelbrecht, B. and Crisp, N. 2010. "Improving the performance of the health system". South African Health Review 2010.

682 Harrison, D. 2009. An Overview of Health and Health Care in South Africa 1994-2010: Priorities, Progress and Prospects for New Gains. DBSA. 2008. A Roadmap for the Reform of the South African Health System.

683 Lehmann, U. 2008. "Strengthening Human Resources for Primary Health Care". South African Health Review 2008.

684 Engelbrecht, B. and Crisp, N. 2010. "Improving the performance of the health system". South African Health Review 2010.

685 Matsotso M.P., Fryatt, R. 2013 "National Health Insurance: The first 18 months". South African Health Review 2012/13.

686 Gray, A., Vawda, Y. and Jack, C. 2013. "Health Policy and Legislation". South African Health Review 2012/13.

687 Wolvaardt, G., Van Niftnik, J. et al. 2008. "The Role of Private and Other Non-Governmental Organisations in Primary Health Care". South African Health Review 2008.

688 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.

689 DoH. 2012. Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.

5.9 Factors Influencing the Supply of Skills in the Social Development Sector

Several factors influence the supply of skills to the social development sector, including gaps in policy development, the absence of an occupational framework for social services, the capacity of HEIs, government policies and the availability of workplace training. These factors are considered below.

5.9.1 Policy gaps

The new statutory framework for social services demands services from occupational groups that are not yet formally organised, recognised or regulated[690]. According to the Children's Act, 2005 a "social service professional" includes a probation officer, development worker, child and youth care worker, youth worker, and a registered social auxiliary- and social security worker who are registered as such in terms of the Social Service Professions Act, 110 of 1978[691]. Social workers are excluded from the definition but are defined separately. Although new categories of workers have been identified in legislation and policy documents, Government and key role-players have been slow to identify which cadres of workers should be developed and deployed[692].

At present the statutory framework for social service occupations only recognises two professions: social workers and CYCWs, and two mid-level occupations: SAWs and assistant CYCW. The Professional Board for Child and Youth Care at the SACSSP was established but, as a result of challenges in the sector, it was not operational for several years. Renewed efforts were underway to revive this Board during 2013 and 2014. The PBCYC aims to start with the registration of professionals by 2014/15, or as soon as regulations are promulgated[693].

Further, at the time of writing, there was uncertainty as to whether certain service areas fall within the scope of social development, e.g. there is support for the notion that community caregivers should resort with the health sector and that ECD practitioners should operate in the education sector[694].

5.9.2 Absence of a broader occupational framework

Academics in the social work field have alluded to tensions between the various social work professions and that their scopes of practice remain contested[695]. Although the SACSSP has taken steps to categorise more social service professions and occupational groups, progress has been slow and proposals are still under development[696]. Government accepts the need to diversify the social services occupational groups and to recognise them formally. A task team of the DSD is working on a draft policy for social services practitioners to guide the development of new legislation and an institutional framework for human resources in the sector. The intention is to develop an HR model that provides for different social services occupations, as well as their roles and responsibilities, scopes of practice, competencies, qualifications and registration requirements[697]. The future model will also define delivery units for social welfare services, including teams of practitioners, administrative support, supervision and management. It is also necessary to develop an occupation-specific dispensation for care workers, to recognise their status, and improve the skills base[698].

During interviews held to prepare this SSP, several stakeholders expressed their concerns about role conflicts between social workers and SAWs, and that this affects services delivery. It is hoped that an occupational framework and revised scopes of practice will bring more clarity about the respective roles and responsibilities.

By mid-2014 three specialisation areas in social work had been developed, namely adoptions, occupational- and probation social work. Forensic- and clinical social work are under development as other specialisation areas, while victim support and trauma counselling was identified as emerging areas. Work was underway by the SACSSP to possibly develop further areas of specialisation – social work in education, social work in healthcare, school social work, and social policy and planning, as well as management and supervision[699]. It has been mooted that a postgraduate qualification will be required in future before social workers will be permitted to specialise in a field of social work.

5.9.3 Extended Public Works Programme

In the social sector, the EPWP creates work opportunities for unemployed and unskilled persons in to deliver services in ECD, home community based care, school nutrition, crime prevention and literacy promotion. Most of the CCGs provide their services as part of the EPWP for the social sector.

The Sector Skills Plan (SSP) for the EPWP 2011 to 2014 outlines a major scaling up of the programme, with a target of 4.5 million job opportunities by 2014. A range of training opportunities will be offered in the community care- and personal care occupational categories. These include learnerships, skills programmes, non-accredited courses, and bursaries. Training will be provided to 125 000 unemployed people in areas relevant to the health and social development sector[700]:

a) **Learnerships up to levels 4 and 5:** AET and ECD practitioner training, nursing, pharmacy, child and youth care, ancillary healthcare, psychosocial support, community healthcare, assistant probation service, social auxiliary work, assistant pharmacy work, youth development work, and community development work;

b) **Skills programmes:** child and youth care, emergency care, reflexology, human physical development and sexuality, project management, care for people with disabilities, child care, counselling, and bookkeeping; and

c) **Non-accredited courses:** toy making, needlework, knitting, cooking, first aid, candle making, bead making, basic health promotion, principles of hygiene, frail care, life skills, HIV counselling, personal

690 Loffel, J., Allsopp, M., Atmore, E. and Monson, J. 2008. "Human resources needed to give effect to children's right to social services". South African Child Gauge 2007/08.

691 The Children's Act appears to include more occupational categories than those currently controlled by the SACSSP in terms of the Social Service Professions Act, 110 of 1978.

692 Schmid, J. 2012. "Trends in South African Child Welfare Reform". Centre for Social Development in Africa.

693 South African Council for Social Service Professions. 2013. SACSSP E-News. April 2013. Vol 2(2).

694 DSD. 2013. Policy for Social Service Practitioners, 5th Draft.

695 Ross, E. 2012. "Social Work in South Africa". Social Dialogue 3 2013; Interviews with academics in social work field in 2012.

696 Patel, L. 2009. The gendered character of social care in the non-profit sector in South Africa; South African Council for Social Service Professions. 2012. SACSSP Newsletter. May 2012. Vol.1 (1).

697 DSD. 2011. DSD Norms and Standards: Draft Norms and Standards for Social Welfare Services.

698 Patel, L. 2009. The gendered character of social care in the non-profit sector in South Africa.

699 SACSSP. 2012. SACSSP Newsletter. May 2012. Vol.1 (1); SACSSP. 2012. Mapping of Specialities; Interview with SACSSP in July 2014.

700 http://www.epwp.gov.za/sector_social.html; Interview with DSD, July 2014.

finance management, and team work.

The Strategic Plan of the Department of Public Works 2014-2019 provides for training and enterprise development of NGOs that serve communities and provide EPWP work opportunities[701].

There are several challenges pertaining to skills development for community caregivers. Most of the CCGs are semi-schooled or illiterate women from local communities, although unemployed youth and graduates also work in the EPWPs. According to the DSD, skills development should be pitched at NQF levels 2 and 3 which are above the basic literacy level, but below the level of qualifications held by unemployed youth and graduates. This area of work also falls outside the proposed occupational framework for the social services professions and there are no accredited qualifications[702]. The DSD believes that a multi-sectoral approach is required to address these challenges. Recent research has found that the skills developed as part of the EPWP are often not retained in the social development sector. This is attributed to structural issues, as unskilled, unemployed workers are given new competencies and leave once the sector cannot retain them as salaried workers[703].

5.9.4 Capacity of higher education institutions

Although the number of social work graduates increased over the last five years, the supply to the sector is still insufficient to meet service demands. The increased enrolment of social work students has put pressure on student-lecturer ratios at HEIs. Currently, universities and institutions of higher learning have the capacity to accommodate 3 040 social work graduates per annum[704]. The DHET also caps student intake based on the available infrastructure, training facilities and teaching posts.

According to the DSD a number of factors continue to impact on the capacity of academic institutions and so too on the output of social services professionals. Government subsidies to tertiary institutions for social work are lower than for certain other fields of study (which require similar academic inputs). To produce quality graduates capable of dealing with the challenge of social work practice in South Africa, there is a need to train students in small groups and to provide individual supervision for them in fieldwork placements. Academic departments struggle to cope with training demands and the growing student numbers against the present subsidy formulae. Many difficulties arise to place and maintain students in fieldwork placements that provide them with practical training required for graduation. Despite the compulsory practical training for undergraduates, the DSD is concerned that many new social work graduates still require occupational-specific and work-readiness training[705], and this need raises concerns about the quality of the formal education programmes.

Another concern relates to inadequate selection processes at HEIs. According to the DSD, candidates apply for admission to social work programmes for the wrong reasons. Many candidates access bursaries for social work, although they are not committed to study and work in the field. One respondent feared that some candidates viewed the bursaries as “their tickets out of poverty”. Academic criteria for admission to social work programmes are generally in the lower ranges – typically a 50% pass in Grade 12, and so candidates expect to enter a “lighter” academic programme[706]. The dropout rate of undergraduates in social work remains high, especially among distance learners. Further, learners from disadvantaged communities are often under-prepared for tertiary level studies and grapple with language- and cultural barriers. Institutions and educators often lack resources to provide individual and interactive learning support[707].

5.9.5 Limited access to workplace training

Academic institutions are increasingly challenged in placing final-year social work students in the field. Workplace training providers often lack the resources to take in students and to provide adequate supervision. High staff turnover in organisations depletes skills and the remaining social workers are often too inexperienced to supervise social work students. Some social workers in the field have not kept abreast with developments in the profession and are not sensitive to students’ learning needs and are thus unable to provide students with the required support. Many NPOs also lack the funds, capacity and infrastructure to accommodate learners in formal learnerships[708]. While some NGOs do provide training to social development workers, most lack the capacity to seek accreditation, and training provision is often hampered by resource constraints and administrative problems[709].

Challenges pertaining to the availability and quality of work-based training in the field of child and youth care will also impact on the number of professionals and mid-level skills produced. The PBCYC called for cooperation with the HWSETA to accredit more workplace training providers and for assistance with quality assurance problems[710].

5.9.6 Government initiatives to improve supply

Government has several initiatives to improve the supply of skills in the social welfare sector[711]. As part of an active recruitment and retention strategy, the DSD is working to improve the remuneration and working conditions of social workers. Over the period 2008/09 to 2013/14 the National Treasury disbursed almost R1.3 billion[712] to offer full scholarships to social work students, and by 2016/17, a total of 11 050 students will benefit[713]. These interventions helped to boost professional registrations with the SACSSP by almost 4 000 between 2009 and 2014. However, the absorption in the public sector of the newly trained social workers has been slow because of budget constraints and the non-availability of public sector posts. Government approached NGOs to deploy unemployed social work graduates, but given the vast differences in

701 Department of Public Works. 2014. Strategic Plan 2014-19.
702 Interview with DSD in July 2014; DSD.2013. Policy for Social Service Practitioners, 5th Draft
703 Schmid, J. 2012. “Trends in South African Child Welfare Reform”. Centre for Social Development in Africa.
704 HWSETA. 2011. Sector Skills Plan for the Social Development Sector in South Africa.

705 Interviews with DSD in October 2012.
706 Interview with Prof. Antoinette Lombard, Head of Department of Social Work, University of Pretoria in October 2012.
707 Ross, E. 2012. “Social Work in South Africa”. Social Dialogue 3 2013; Interviews with academics in social work field in 2012.

708 Earle-Malleson, N. 2008. “Social workers”. Human Resources Development Review 2008: Education, Employment and Skills in South Africa: Interviews with NGOs in October 2012 and July 2014.
709 Patel, L. 2009. The gendered character of social care in the non-profit sector in South Africa.
710 Interview with PBCYC of the SACSSP in July 2014.
711 Loffel, J., Allsopp, M., Atmore, E. and Monson, J. 2008. “Human resources needed to give effect to children’s right to social services” in South African Child Gauge 2007/08.
712 Calculated from 2012 Estimates of National Expenditure and 2014 Estimates of National Expenditure.
713 National Treasury. 2014. “Vote 19: Social Development”. 2014 Estimates of National Expenditure; DSD. 2014. Strategic Plan 2014-2019.

remuneration structures, many candidates have been reluctant to work for NGOs[714].

The DSD is driving the training of community development workers to facilitate effective community development processes. A skills audit in 2009/10 identified the need for training in research and analysis, project management, conflict management, human resources management, budgeting, effective writing skills, and computer literacy. Plans are underway to establish community development as a profession and to introduce an occupational framework for community development. The DSD worked with HEIs to align curricula to the community development qualifications at NQF levels 5 and 8 and to implement these by 2014/15[715]. Norms and standards for community development will be implemented by 2015[716].

To facilitate formal recognition of skills, the DSD will support the development and implementation of a RPL model for community development. Targeted training programmes in community development practice will also be offered to 1 400 CBOs over the period 2013/14 to 2015/16. The DSD has introduced measures to improve the delivery- and governance skills of CSOs, and by 2014 a total of 25 000 persons will be trained in the provisions of the Non-Profit Organisations Act, 71 of 1997 and governance practices[717]. Governance training will be made available to 2 500 NPOs during 2014/15 and increase to 3 000 per annum in the following two years[718].

The public sector has embarked on a huge drive to bring back retired social workers to mentor young social services professionals. This is proving challenging, as the older cadres were trained under different curricula for different roles while the young professionals are required to provide developmental social services in a rights-based context[719]. In response to the shortage of professional skills in rural and poor communities, the DSD has mooted the introduction of compulsory community service for graduates in the social services field[720].

714 Interviews with DSD ,NGOs and academics in October 2012; Interviews with NGOs in July 2014.
715 DSD. 2014 Annual Performance Plan 2014-2015.
716 DSD. 2014 Annual Performance Plan 2014-2015
717 DSD. 2011. Strategic Plan 2011/12 – 2013/14.
718 DSD. 2014. Annual Performance Plan 2014-2015; National Treasury. 2014 “Vote 19: Social Development”. 2014 Estimates of National Expenditure.
719 Interviews with DSD, October 2012.
720 DSD. 2013. Policy for Social Service Practitioners, 5th Draft.

5.9.7 Socio-economic realities of new entrants

Many newly graduated social workers hail from deprived backgrounds and lack the resources to obtain a driver’s licence, which typically is required to enter employment. Social work students require a driver’s licence to access practical training and newly qualified professionals have to reach communities and families in areas not serviced by public transport. According to the SACSSP, many social work graduates lack the resources to obtain a driver’s licence, and in the absence of a licence, their employability is affected[721].

5.9.8 Measures to enhance professionalism

The recently published norms and standards for social services practitioners promote professionalism and set benchmarks for practice. These include requirements for basic qualifications, professional registration, compliance with codes of conduct, adherence to work scope, and participation in CPD[722]. These developments aim to improve the skills base and quality of services in the sector. By enforcing a new CPD policy, the SACSSP seeks to ensure that professionals keep pace with developments and advances in their disciplines and fields of practice.

The DSD has also devised norms and standards for the structured supervision of social welfare practitioners and students, including norms for the qualifications, practical experience, skills levels and duties of supervisors[723]. Implementation of these generic norms and standards is expected from 2013/14 onwards, with full implementation by 2016[724]. New legislation on the professionalisation and regulation of social service practitioners is expected by 2016/17[725].

The SACSSP and HWSETA have taken steps to improve the skills sets and service delivery capacity of SAWs, and will work with training providers to apply more stringent quality assurance processes. The Professional Board for Social Work of the SACSSP intends to administer a Board Examination as a pre-condition to registration of SAWs[726].

The DSD has also commenced a process to improve HR management in the welfare sector. Providers of social welfare services will be required to set policies for recruitment and retention of staff, training and development, conduct, performance, and working conditions[727]. In addition, providers will also be obliged to offer professional support and development to social welfare practitioners in the form of structured training, personal development plans and debriefing sessions to advance their health and mental well-being[728].

721 Interviews with SACSSP in July 2014.
722 DSD. 2011. DSD Norms and Standards: Draft Norms and Standards for Social Welfare Services.
723 DSD. 2011. DSD Norms and Standards: Draft Norms and Standards for Social Welfare Services.
724 SACSSP. 2013. Newsletter February-March 2013. Vol 2(2). DSD. 2014. Strategic Plan 2014-2019
725 National Treasury. 2014. “Vote 19: Social Development”. 2014 Estimates of National Expenditure.

5.10 Conclusions

A combination of complex factors influences the supply of skills to the health sector. At the heart of the problem are the number and quality of learners who complete high school. The secondary school system is producing fewer candidates with the combination of mathematics, physical sciences and/or life sciences required to enter tertiary-level studies in the health sciences. Quality standards of education in mathematics, physical sciences and life sciences are major supply-side constraints impacting on the skills of the health sector. Sub-standard levels of literacy and numeracy skills of school leavers and their poor level of readiness for tertiary studies further reduce the supply pool.

Long lead times required for developing health professionals and the lack of coordinated planning for health professional training between the health sector and education sector impact on the supply of skills. Existing institutional arrangements and regulatory provisions regarding the training of health professionals restrict the supply of skills to the sector. Most of the health professionals who are required to register with the HPCSA, the SANC, the SACP and the SAVC are trained by universities and universities of technology, and undergo practical training in state-owned academic health complexes. Production levels at these institutions are limited due to constraints in clinical training platforms; the numbers of health educators and health academics; infrastructure and equipment; and budgets. However,

726 Interviews with SACSSP in July 2014.
727 DSD. 2011. DSD Norms and Standards: Draft Norms and Standards for Social Welfare Services.
728 DSD. 2011. DSD Norms and Standards: Draft Norms and Standards for Social Welfare Services.

the strengthening of academic medicine and health training platforms is a key strategic area for the DoH. Measures will be introduced to improve the management of academic resources. Opportunities to train healthcare professionals in the private sector are also limited, as private HEIs appear to be challenged in meeting the extensive accreditation requirements for the training of health professionals set by the professional councils and the HEQC, or are restricted by government policy.

Owing to recent changes made to the manner in which the number of graduates in various higher education programmes are grouped and recorded, it is difficult to compare the supply of graduates from HEIs in health-related fields over the medium- to longer term. Between 2010 and 2011 the total output from the HET sector in the health-related fields of study grew on average by 0.7% at first three-year B Degree level and at 5.7% at first four-year B Degree level. However, comparative analysis reported in the previous HWSETA SSP for the period 2012-2017 showed that, with the exception of basic healthcare sciences, the growth in supply of new graduates from the higher education system has been moderate, and even low, over the last decade. Total output from nursing colleges reached 20 764 in 2013, and has increased on average by 7.1% per annum since 2003, while the number of pupil nurses has risen sharply since 2007.

Growth in the registration of health professionals with their respective statutory councils has been slow since 2000 and in some instances lower than the growth rates in graduates produced for the particular professional category. For example, from 2003 to 2013 the annual average growth rates of nursing graduates in the four-year- and bridging programme were 9% and 6% respectively, while from 2002 to 2013 the annual growth in SANC registrations in the category of registered nurses was only 2.8%.

The supply of skills to the health sector is not only determined by capacity at training institutions and the scope of training activities on clinical platforms. Structural barriers in the public sector also impact the supply of skills. Newly qualified health professionals are often not absorbed in the public sector due to the non-availability of posts and budget constraints.

Public health policies and skills planning by various role-players have lagged behind demand for mid-level skills. Considerable uncertainty prevails about the scopes of practice of MLWs, their roles in healthcare teams and responsibility for their supervision. The production of MLWs may remain low until these issues are addressed and provision is made for their training and career progression.

In order to provide the sector with better skilled practitioners, several of the health professions are elevating healthcare qualifications and training requirements to higher education platforms. The direct implications are that current training providers such as TVET- and nursing colleges will have to meet different (and perhaps more stringent) accreditation requirements and be declared HEIs. Delays in authorising and accrediting the new training platforms will limit graduate output and hamper the supply of more competent, better-skilled health practitioners.

Skills formation for the social development sector takes place via direct entry from school, after school via learnerships, and after completion of higher education. Volunteer workers may also enter the sector via EPWPs and via NPOs through informal training and work experience. Although “academic-stream” subjects such as mathematics and science at Grade 12 level do not present barriers to entry into the social development sector, the personal characteristics of learners in respect of well-developed communication skills, personal trustworthiness, and a desire to serve others are important.

The number of social work graduates has grown substantially over the last ten years, as did the number of registered social workers. However, the educational infrastructure is under great pressure and it is unlikely that the growth required to supply social workers for the country’s needs is sustainable. The main constraining factors are practical placements for final-year social work students and supervision capacity of practice supervisors. Placing undergraduate students in suitable workplace training is becoming increasingly challenging, mainly because of limited resources in social services organisations. Access to learnerships in the social development sector is also hampered because NPOs, the main delivery channel for social services, lack the infrastructure, funds, and human resources to accommodate learners. While the availability of bursaries has boosted the numbers of social work graduates, screening or selection processes to identify candidates with the desired attributes for social services appear inadequate. As a result, the retention rate of new professionals in the sector is too low. More recently, the absorption of new social work professionals in the public sector has been impeded by budget restrictions and the absence of positions.

The quality of formal education and training for the social services workforce may also limit the provision of adequate skills. Discussions in Chapter 4 highlighted concerns about the quality of training for SAWs, while the DSD is calling for the training of social work graduates in occupational-specific fields and in work-readiness.

It is anticipated that the introduction of new generic norms and standards for social welfare services and a higher education qualification for SAWs will impact directly on training and skills development needs of thousands of workers in the social development sector.

The HWSETA also contributes to skills formation in the health and social development sector. Since 2002 more than 25 000 learners have enrolled on health-related learnerships. Over the period 2005/06 to 2012/13 more than 10 800 learners had completed learnerships, and were recorded on the HWSETA’s electronic system. Many more completed learnerships that are quality-assured by professional councils and their achievements are recorded by the councils and not by the HWSETA. The SETA also supports skills development through internships and workplace training programmes, skills programmes, scholarships, AET, partnerships with training institutions and other role-players, and small-enterprise development.

Measures to increase the number of health and social work professionals are only part of the challenge to increase the supply of skills. Other challenges relate to up-skilling and re-skilling the existing workforce to adopt new roles and scopes of practice, and to implement practices such as task shifting and task sharing to improve the basis for service delivery.

Health workers and community caregivers risk exposure to HIV/AIDS in the workplace

and face increased risks of contracting the disease compared with workers in other sectors. By 2002 the prevalence rate of HIV/AIDS among health workers was 15.7%, much higher than the national prevalence rate at the height of the pandemic in 2010. As a result of AIDS, skilled health workers and community caregivers leave the sector prematurely – either because they fear infection, become ill themselves, or need to care for others who fall ill.

Delays in establishing effective regulatory frameworks for several professions and evolving occupational categories have also impacted on skills formation for the sector, especially in nursing and social services fields such as ECD, and child and youth care. Skills development of CHWs is required on an extensive scale to incorporate them into PHC teams. However the supply of skilled CHWs is hampered by uncertainty about their roles and scope of work, the training and supervision framework required, and their current employment status as volunteers or partially paid helpers.

Many of the government's positive strategies to improve the supply and retention of skills in the sector may be compromised by budget constraints and various institutional problems such as weak management systems, sub-functional working environments and poor human resources practices. The information presented in this chapter shows that unless major improvements in leadership and management of the health system at all levels are made, migration of health professionals out of the public sector and emigration to other countries are likely to drain the supply of skills for the considerable future.

Responsible regulatory bodies in the sector also need to speed up processes to recognise emerging occupational categories and professions and institute the required regulatory frameworks for such professions and occupations. For as long as those arrangements are not in place, efforts to supply critical skills for healthcare and social development will be hamstrung.

6 Skills Development Priorities of the HWSETA

6.1 Introduction

Throughout this SSP the health and social development sector has been portrayed as a sector faced with enormous challenges. Evidently skills problems are at the heart of many of these challenges. The nature and magnitude of the challenges are such that they can only be addressed through a very concerted and, as far as possible, integrated effort of a host of role-players. These role-players include the provincial and national departments of health and social development, the public higher education and training sector, private education and training providers, public and private health facilities, NPOs, and the HWSETA.

As the HWSETA is only one of a number of institutions tasked with the funding and provision of skills development for the sector, it is important to outline the specific role that the SETA will play in terms of skills development. At the same time the SETA forms part of the institutions that are required to deliver on the NSDS III and to support various government initiatives, including the National Development Plan, to stimulate employment growth and to expand the skills base of the country.

This chapter starts with a discussion of the main priority areas that the HWSETA will focus on in the coming five years. The programmes according to which the SETA's activities are structured are then outlined. The rest of the chapter discusses the various policy imperatives that are driving skills development initiatives and indicates how the HWSETA will contribute to and support the various national policies, plans and other government initiatives. Attention is given to the President's outcomes approach to planning government's work and how the HWSETA will assist in attaining the high-level performance targets agreed with the DHET. The SETA's contribution to the development and economic growth objectives of the National Development Plan are discussed. Reference is made to: the contribution to government's MTSF objectives; the contribution to the strategic areas of focus for the NSDS III; the contribution to the Human Resource Development Strategy for South Africa; the contribution to the green economy and the contribution to the Presidential Infrastructure Coordinating Commission.

The chapter also looks at government's New Growth Path (NGP) and the National Skills Accord, which is a broad-based agreement to adopt the NGP.

6.2 The HWSETA's Skills Development Priorities

This section outlines the broad skills development priorities that the HWSETA will address in the five-year period covered by this SSP. The skills development priorities were informed by the analysis of the skills situation in the sector, needs identified by stakeholders, the NSDS III and key Government policies including the NDP, NHI Green Paper, Human Resources for Health Strategy and White Paper for post-school education and training.

The HWSETA's skills development priorities are contained in a comprehensive agenda of economic and social infrastructure development that seeks to deliver skilled persons who are ready to enter and advance in careers in the health and social development sector. The main goal of the HWSETA skills development programmes and projects is to provide skills to learners in the workplace in scarce and critical areas within the sector. In doing so, the HWSETA will strengthen the skills pipeline for occupations in demand and contribute to the provision of essential and specialised skills for the health and social development sector. For HWSETA stakeholders it is vital to nurture persons who are employable, competent, and work-ready and equipped with "day one" skills when they enter the scarce occupations and critical skills areas.

In order to create the workforce desired, partnerships will be formed with professional bodies, tertiary training institutions, government entities, non-profit organisations and public and private employers to develop and register appropriate learning programmes, and to facilitate their effective implementation.

Outcomes of the skills development interventions will be evaluated at three levels. Firstly, qualifications conferred and work experience gained will be assessed as low-level outcomes. Secondly, intermediate-level outcomes are linked to whether learners secure employment on a permanent basis. Thirdly, high-level outcomes of the interventions will be assessed in terms of sustainable livelihoods, healthy communities, and alleviation of poverty. Provider accreditation policy and procedure has been reviewed by the HWSETA to ensure that each accredited training provider has the necessary capacity to conduct RPL in specific areas such as Primary Health Care, Community Health Work and Ancillary Health Care. This is another initiative that complements the HWSETA's skills development interventions.

The HWSETA's skills development programmes and projects will be implemented across four sub-programmes and the special programme described below, and within the ambit of the financial resources available through the skills development levy. The HWSETA will allocate mandatory grants and discretionary grants to finance skills development projects and programmes that are aligned with the Annual Performance Plan. Budget provision for grant funding for the period 2014/15 to 2016/17 has been adjusted to R 743 296 000.

6.2.1 Occupationally directed programmes

The HWSETA will facilitate and increase access to occupationally directed programmes so that learners may achieve credits in such programmes. Specific interventions will focus on the six areas discussed in sub-paragraphs a) to f) below:

a) The development of mid-level skills

In view of the acute shortages of key higher-level skills in health sciences and the social services professions, there is a pressing need to equip MLWs to share and take over tasks usually performed by higher-level professionals. Research by the HWSETA reported in this SSP clearly identified the need for mid-level skills in the health and welfare sector.

The introduction and expansion of MLWs is one of the seven foundations of the HRH SA model for the period 2012/12 to 2016/17[729]. As discussed in Chapter 3, mid-level skills are also needed to support healthcare services in the NHI scheme. While the HWSETA recognises that policy makers and the organised health professions still need to develop the categories of MLWs required, it is already evident that the ranks of clinical associates, pharmacy technicians and pharmacy technical assistants must be increased, and the ranks of mid-level nurses be boosted[730].

Over the planning period the HWSETA will work with stakeholders, statutory and professional bodies, training institutions and national- and provincial government departments to support the development of mid-level skills for the health and social development sector. Apart from the development of appropriate qualifications and learning programmes, the HWSETA will enable unemployed graduates of mid-level qualifications to gain relevant workplace experience.

b) Development of artisans

During interviews with stakeholders in preparation of this SSP, it was confirmed that the national shortage of artisans is affecting service delivery and quality of care, especially in the health sector. To address the need for mid-level technical skills outlined in Chapter 4, the HWSETA will design projects and implement partnerships to assist learners to enter training programmes for artisans which will enable them to qualify, and to become work ready.

729 DoH. 2012. *Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.*

730 DoH. 2012. *Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17.*

c) Development of high-level national scarce skills

Discussions in chapters 3, 4 and 5 underscore the necessity to expand development of high-level skills in many priority areas in health sciences as well as the social development field. Technical skills and professional competences are required to improve the health profile of South Africans and to steer many critical programmes and policies aimed at enhancing human- and social development. Stakeholders with whom the HWSETA engaged to prepare this SSP emphasised the need for work-ready professionals, especially in the social development sector.

The HWSETA will address the shortage of high-level national scarce skills through projects aimed at producing work-ready graduates from HEIs. The HWSETA entered into partnerships with two universities to provide bursaries to undergraduates in Demography and Population Studies, as this interdisciplinary field of study supports community development. Another partnership agreement enabled undergraduates in the fields of nursing and social development to access bursary funding.

The HWSETA will support interventions that enable students to enter work experience and experiential learning programmes and postgraduate students will be aided to access work opportunities.

d) Research, development and innovation capacity

It is also necessary to develop the research and development and innovation capacity of the sector and to establish innovative research projects. The HWSETA will put programmes in place that focus on the skills needed to produce sector-relevant research, and that will have an impact on the achievement of the economic- and skills development goals of the sector. Flagship research projects will be established in cooperation with universities and other stakeholders and researchers will be supported.

At the time of writing, the HWSETA had developed research themes to attract masters ‘and doctoral students to participate in the HWSETA Research Postgraduate Bursary Programme. The programme was announced to the general public and to HE institutions. A total of 41 applicants were approved for this programme in 2013.

The following themes are covered in the Research Bursary Programmes:

- Labour market related research for the health and welfare sectors;
- Traditional healing related research in SA;
- Education and training in the health and welfare sectors;
- Medical research: Burden of diseases; and
- Health and welfare sectoral skills development policy research.

Further calls for participation will be made in 2014. The programme is aimed at supporting 250 research postgraduates in order to contribute to the research and development and innovation capacity in the health and social development sector. By May 2014 the HWSETA signed agreements with eight universities to implement this bursary programme, including the Universities of the Free State, South Africa, Fort Hare, KwaZulu-Natal, Limpopo, Zululand, the Witwatersrand and Cape Town.

e) N-courses and pre-apprenticeships

The Minister of Higher Education and Training initiated a process to bring back the National Technical Education (NATED) programmes- or ‘N’ courses, which had historically formed an integral part of the apprenticeship system[731]. Government and HWSETA stakeholders recognise the need for learners in trades to undergo solid theoretical training and have relevant work experience so that they may enter the labour market with marketable skills and obtain employment. The National Certificate (Vocational) and N-courses are recognised by employers as important base qualifications through which young people are obtaining additional vocational skills and work experience that prepare them to successfully enter the labour market. The HWSETA will allocate funding to support learners on pre-apprenticeship training and N-courses for technical trades required in the sector, and for this purpose partnerships have been established with eight TVET colleges.

731 DHET. 2010. *Media Briefing on Performance Monitoring and Evaluation for Minister of Higher Education and Training.*

f) Partnerships

The HWSETA will enter into partnerships with universities and universities of technology, public TVET colleges, employers and private providers to increase the skills base to meet the needs of the health and social development sector. Work experience grants will be made available to learners attending public TVET colleges and work experience for graduates of middle-level qualifications will be supported. The HWSETA is cooperating with the Durban University of Technology to develop learning materials for one lower level and two mid-level qualifications needed in the health sector, while current arrangements with TVET colleges will continue for the purpose of offering HWSETA programmes.

6.2.2 Workplace based skills development

The HWSETA will encourage the better use of workplace-based skills development and engage with stakeholders in the health and social development sector to provide substantial quality programmes for employed workers.

6.2.3 Training initiatives for cooperatives, small enterprises, workers, NGOs and the community

Research by the HWSETA clearly identifies the need to develop the capacity of NGOs, CBOs, cooperatives and small enterprises to be more self-sustaining. The HWSETA will encourage and support training initiatives to help achieve this goal.

a) Cooperatives

Projects will be established based on research conducted on the skills needs of emerging cooperatives. Funding will be made available for skills development and training of cooperatives working in the health and social development sector. These measures will aim to contribute to employment and economic growth in the sector.

b) Small businesses

The HWSETA will provide funding for training and development support to small businesses in both the health and social development sectors.

c) Workers

Education programmes for workers, NGOs and communities will be supported. Training projects for skills development facilitators or labour representatives of trade unions will continue, their impact measured and reported on by the HWSETA.

d) Levy-exempt organisations

Skills-development programmes will be established for levy-exempt organisations and the HWSETA will encourage stakeholders to expand successful projects with support from the NSF.

6.2.4 Capacity building for the public sector

The HWSETA will contribute to capacity building in the public sector to improve service delivery. Interventions will support the building of a developmental state and increased efficiency. Education and training plans for the public sector will be revised and programmes will be implemented to strengthen the capacity of the DoH and the DSD.

6.2.5 Post school education and training priority areas

The HWSETA will support programmes to advance the objectives of the 2013 White Paper for Post-school Education and Training, referred to in Chapter 3 of this SSP. A special programme will be introduced in 2014/15 to strengthen training infrastructure in the post school education and training system. The HWSETA will set targets and allocate resources to address five post school education and training priority areas, including:

a) Operationalisation of new FET college campuses;
b) Student funding for technical and vocational education;
c) Bursary provision through National Students Financial Aid Scheme (NSFAS);
d) Implementation of the National Senior Certificate for Adults (NSCA); and
e) Turnaround interventions for Walter Sisulu University.

6.3 The HWSETA Strategic Business Plan

The Strategic Business Plan is structured according three programmes, each with sub-programmes. The programmes and sub-programmes are:

a) Programme 1 – Administration, with sub-programmes:
   - Research, Innovation, Monitoring and Evaluation; and
   - Corporate Services.
b) Programme 2 – Skills development programme implementation and projects, with sub-programmes:
   - Projects; and
   - Learning programmes.
c) Programme 3 – Quality assurance and qualification development.

The three programmes coincide with the structural and operational arrangement of the HWSETA and cut across all the skills development priority areas outlined in paragraph 6.2 above. Each of the programmes has a programme objective and a set of strategic objectives. Targets, performance indicators and budgets are set for each of the strategic objectives.

The programmes, sub-programmes, indicators, targets and the budgets allocated for the 2015/16 financial year are indicated in Table 6-1.

The way in which the HWSETA will contribute to various government imperatives are outlined in the sections that follow.

Table 6 1 HWSETA performance indicators and budget: 2015/16

Indicator Title	Sub-programme	No	Indicator Title	Precise Definition	Five-year target	2015/2016 target	NSDS III Objectives	2015/2016 budget
ADMINISTRATION	Research, Information Monitoring and Evaluation	5	Percentage artisans and unemployed learners funded by HWSETA find employment within 6 months of completion	This is an enumerator indicator to indicator 4 and 1 for unemployed learners. It measures the number of artisans and unemployed learners, after going through training, who obtains employment. It seeks to establish the needs for artisans and other critical skills in South Africa based on the principle of supply and demand. A qualified artisan is a person who has been awarded a certificate of competency. The ILO defines 'decent work' as productive work which generates an adequate income, in which workers' rights are protected, and where there is adequate social protection providing opportunities for men and women to obtain productive work in conditions of freedom, equality, security, and human dignity[732]. This indicator also measures the number of months an unemployed learner takes to obtain a decent job. Obtaining employment will be measured from the day an employment offer is made.	80% (11365)	80% (1380)	Admin budget	1
		12	Number of applied research reports completed and signed off that inform planning	A research activity is defined as any perusal of materials related to skills development and HWSETA, such as desk review, surveys, etc. Applied research is a form of systematic inquiry involving the practical application of science. It accesses and uses some part of the research communities' (the academia's) accumulated theories, knowledge, methods, and techniques, for a specific, often state-, business-, or client-driven purpose. Applied research is compared to pure research (basic research) in discussion about research ideals, methodologies, programs, and projects. Evaluation of training includes research reports on areas such as dropout rate and analysis and impact analysis.	31	5	R 563 000	1
		13	Number of post graduate research students funded in the health and welfare field	This indicator measures the number of post graduate research students funded by HWSETA. This indicator also measures the number of support programmes funded to support develop and expansion of research in the sector. Counting from this indicator will commence upon the implementation of the programme. Lastly this indicator will also measure the number of post graduate students with access to employment opportunities after graduation. New post graduate research students refer to registered students in higher education institutions for higher degrees that have a research component in the curriculum and have registered for the first time. Funded refers to issuing of funding approval letter and signing of Memorandum of Agreement and where applicable release of tranche payments as per the Memorandum of Agreement.	540	75	R 4.770 mil	1, 2
	Corporate Services	15	Number of learners reached through HWSETA career development awareness programmes	This indicator measures the number of career awareness drives and documents created and distributed with information on the labour market to guide learners on career opportunities in specified areas of work. This indicator also measures the number of learners who are undergoing the career development/guidance programme. Career guides will be mapped to qualifications for all sectors. Reached in this context refers to learners recorded in the register of career fairs or career exhibitions.	79 000	11 500	R 500 000 Admin. budget	8
		18	Percentage of filled positions in the HWSETA	This indicator measures the fraction of jobs in the HWSETA that are open but have not been filled. Vacancy rate is defined as the number of job vacancies to the sum total of employment and job vacancies.	94% (84)	94% (81)	R 850 000 Admin budget	
		20	Percentage of HWSETA processes automated and integrated	This indicator measures the fraction of work processes that are automated and integrated. It includes the efficiencies derived from the use of the document management system and the creation of a paperless environment. Automation and integration refers to the development and deployment of the ERP system as approved by the HWSETA board	95% (111)	70% (36)	R 2 mil	

732 *http://pstalker.com/ilo/d-decent.html*

Indicator Title	Sub-programme	No	Indicator Title	Precise Definition	Five-year target	2015/2016 target	NSDS III Objectives	2015/2016 budget
SKILLS DEVELOPMENT PRPOGRAMMES AND PROJECTS	Projects	2	Number of employers participating in work-based training	This indicator measures the number of employers (all organisations working with HWSETA to implement skills development programmes) who are implementing employee development programmes. This includes private and public entities. Evaluation and participation means workplace has been validated and the learners allocated as per the approval schedule and the Memorandum of Agreement signed.	755	140	Included in learnerships and skills projects budgets	2
		4	Number of apprentices funded and enrolled to become artisans through HWSETA funding	This indicator measures the number of artisans trained with HWSETA funding. (The artisan is a technically skilled person. Whilst he/she will mainly do manual work, these skills require a fairly high degree of scientific and engineering knowledge and a considerable amount of experience in the electrical trade). The tasks of the artisan in the workplace could entail: installation, maintenance, repairs, and servicing and operating of, for example, control systems, generators, transformers, power lines, etc. Funded refers to issuing of funding approval letter and signing of Memorandum of Agreement and where applicable release of tranche payments as per the Memorandum of Agreement. Enrolled refers to registration with both the training institution and HWSETA Seta Management System	1000	100	R 6.500 mil	2
		6	Number of HWSETA funded students in higher education institutions funded for high-level scarce skills	This indicator measures the number of learners who graduate in courses listed as scarce skills. Scarce Skills refers to those occupations in which there is a scarcity of qualified and experienced people, currently or anticipated in the future, either because (a) such skilled people are not available or (b) they are available but do not meet employment criteria. Funded refers to issuing of funding approval letter and signing of Memorandum of Agreement and where applicable release of tranche payments as per the Memorandum of Agreement.	1735	280	R 11.4 mil	2
		7	Number of students enrolled for work-experience and experiential learning programmes funded by the HWSETA	Experiential learning refers to a spectrum of meanings, practices, and ideologies which emerge out of the work and commitments of policy makers, educators, trainers, change agents, and 'ordinary' people all over the world. This indicator seeks to collect data on a number of learners who are practicing the theory learnt in class or at an organisation to which they are attached as a partial fulfilment of the requirements of their course. Enrolled refers to registration with both the training institution and HWSETA Seta Management System Workplace experience and experiential learning refers a course, or a portion of a course, requiring students to participate in a supervised workplace experiential learning, directed field study, internship, cooperative, or cooperative work term course that is related to their program of study or training. It is also viewed as having four basic elements of learning in the workplace: experience, practice, conversations and reflection where at least 70% of workplace learning is through on-job experiences and practice 20% of workplace learning is through others (coaching, feedback and personal networks) 10% of workplace learning is through formal off-job training (Jennings, C: 2009).	4084	400	R 9.6 mil	2, 3
		9	Number of cooperatives in the health and social development sector whose skills needs are funded by the HWSETA	This indicator measures the number of co-operatives whose skills development needs are assessed for the purposes of closing the gaps. It also measures the number of co-operatives linked with trainings programmes meant to benefit their members for its development and growth. Lastly this indicator measures the number of projects supported by the NSF for the benefit of the co-operatives and small businesses. The National Skills Framework provides the basis for high quality, flexible, nationally consistent vocational education and training which meets industry needs and which employers can trust. Co-operatives are defined as an autonomous association of persons united voluntarily to meet their common economic, social, and cultural needs and aspirations through a jointly owned and democratically controlled enterprise. Co-operatives are those organizations established in terms of the co-operatives Act, 2005 (Act 14 of 2005). Funding in respect of these organizations includes start-up funding and skills development funding linked to worker initiated training.	145	20	R 1 mil	6
		10	Number of small and emerging businesses funded	This indicator measures the number of small and emerging businesses that have undergone skills needs inventory for the purposes of expanding developmental support. The indicator also measures the number of projects identified and designed to help small and emerging businesses to develop and grow. A small or emerging business is a business that is privately owned and operated, with a small number of employees and relatively low volume of sales. Small businesses are normally privately owned corporations, partnerships, or sole proprietorships. Funded refers to issuing of funding approval letter and signing of Memorandum of Agreement and where applicable release of tranche payments as per the Memorandum of Agreement.	685	100	R 1.3 mil	6

Indicator Title	Sub-programme	No	Indicator Title	Precise Definition	Five-year target	2015/2016 target	NSDS III Objectives	2015/2016 budget
SKILLS DEVELOPMENT PRPOGRAMMES AND PROJECTS		11	Number of skills development projects funded to support NGOs, Cobs and trade unions	This indicator measures the number of skills development projects meant to benefit NGOs, CBOs, and Trade Unions. The scope will be limited by the number of users who can access the projects, the people affected, the partners involved, or other restrictions as appropriate. Pilot projects could be initiated in new areas whose purpose is to test whether the projects are working as they were designed.	1145	175	R 4. 725 mil	6
		22	Number levy-exempt organisations funded by the HWSETA	This indicator measures the number of workers who benefit from funding earmarked to non-levy paying organisations. Levy paying employers who submit Workplace Skills Plans and Annual Training reports qualify to receive mandatory grants based on their submission having been made by the 30 April 2014. This submission must be compliant in all respects as determined by the HWSETA.	760	120	R 5. 042 mil	
		17	Number of learners in TVET colleges and other public colleges (and the number of associated learners) enrolled for vocational training courses funded by the HWSETA	This indicator measures the number of TVET colleges and other public colleges offering vocational training. TVET colleges include the former Technical Colleges although Colleges of Education, Manpower and Skills centres, and some former community colleges were also merged during the restructuring process with Technical Colleges to form the new TVET colleges. Vocational training will be defined as an organised educational programme that is directly related to the preparation of individuals for employment. The system prepares learners for careers or professions that are traditionally non-academic and directly related to a trade, occupation, or 'vocation' in which the learner participates. Public colleges include pubic nursing colleges and other colleges reporting to a Government Department or State Institutions. Enrolled refers to registration with both the training institution and HWSETA Seta Management System. Funded refers to issuing of funding approval letter and signing of Memorandum of Agreement and where applicable release of tranche payments as per the Memorandum of Agreement.	9450	1 000	R 9 mil	3
		14	Number of projects funded through discretionary grant aimed at the public sector education and training	This indicator measures the number of funded projects focused on improving the institutional framework for public education and training so as to improve delivery of services in those areas. Funded refers to issuing of funding approval letter and signing of Memorandum of Agreement and where applicable release of tranche payments as per the Memorandum of Agreement.	29	5	R4.1 mil	7
	Learning programmes	1	Number of programmes funded through grants to develop and address middle level skills	Programmes will be defined to mean strategies and combination of activities to meet identified needs. Middle level skills are those above routine skills but below professional skills. This includes, but is not limited to Pharmacist assistants, Medical assistants, and Auxiliary Social Workers etc.	32	4	R 4.4 mil	2
		3	Number of learners registered in learnership training programmes	This indicator measures the number of learners enrolled in learnership training programmes funded by the HWSETA. This indicator includes employed and unemployed learners. Registered means learner, employer and training provider details captured in the Seta Management System. Funded refers to issuing of funding approval letter and signing of Memorandum of Agreement and where applicable release of tranche payments as per the Memorandum of Agreement. Funded refers to issuing of funding approval letter and signing of Memorandum of Agreement and where applicable release of tranche payments as per the Memorandum of Agreement.	21500	2450	R 64.679 mil	2, 5
		8	Number of employed and unemployed learners in skills programmes funded by the HWSETA	This indicator measures learners on skills programmes or projects developed to benefit employed workers and unemployed by developing their work skills. HWSETA will only count when programmes are being implemented. Unemployed and employed workers undergoing training on skills programmes will be counted when an employer selects and registers them with the HWSETA in order to improve their skills. Skills programmes are defined as per SAQA definition and include short courses for the employed workers	19150	6100	R 3.2 mil from discretionary grant, Balance funded from mandatory grants	2, 3, 8
		21	Number of learners registered for AET programmes funded by the HWSETA	This indicator measures the number of learners registered for Adult Education and Training that is funded by the HWSETA. This indicator includes those learners funded through partnerships with employers or partnerships with training institutions who are registered examination centres. Registered means learner, employer and training provider details captured in the Seta Management System.	5954	1440	R 5.76 mil	4
		16	Number of TVET College lectures placed in work experience with employers in the reporting period	This indicator measures the number of public TVET college lecturers exposed to the workplace in the health and welfare sector. The objective of the exposure is to ensure that these lecturers are updated on the latest developments and innovations by employers so that they impact this practical knowledge to their students. Placement refers to temporal visitation to employer premises to gain work related experience in the aspect of work that relates to the training programme the lecturer is engaged in.	190	30	R 75 000	

Indicator Title	Sub-programme	No	Indicator Title	Precise Definition	Five-year target	2015/2016 target	NSDS III Objectives	2015/2016 budget
QUALITY ASSURANCE AND QUALIFICATION DEVELOPMENT		23		This indicator measures the number of collaborating partners who have signed a Memorandum of Understanding or a service level agreement to collaborate with HWSETA. A collaborating partner is a person, institution, or association that has signed a service level agreement with HWSETA. Partnerships herein include Universities, TVET Colleges, Councils, Statutory bodies, employer bodies, communities of practice, etc.	79	10	R 5 mil	2, 3
		19	The number of skills development training providers accredited to offer full qualifications	This indicator measures the number of new training providers accredited and current training providers re-accredited by the HWSETA in the reporting period. This includes the process of approving learning programmes, evaluating the QMS and conducting site visits. For re-accreditation we would also have conducted successful verification of the learners' achievements. Assessors and moderators will have to be currently registered against the qualifications against which the training providers are accredited or re-accredited. Skills Development Training Providers refers those as defined by the SAQA Act and the HWSETA policy. Accreditation refers to meeting the criteria as set in the SAQA Act and the QCTO Act and policies/regulations and the HWSETA accreditation policies.	280	40		

6.4 The National Development Plan and HWSETA Strategies

Two of the central priorities of the National Development Plan are to improve the quality of education, skills development and innovation, and to build the capability of the state to play a developmental role. These themes also underpin the strategic outcomes for the NSDS III. The HWSETA's strategic objectives and operational interventions are aligned to the core priorities of the NDP as outlined in paragraph 3.10. The HWSETA will allocate funds in the health and social development sector to help build a capable public service that is skilled to deliver on the objectives of a developmental state.

6.5 Sectoral Contribution to Strategic Areas of Focus for NSDS III

6.5.1 Overview of NSDS III

The focus of training and skills development in the NSDS III is to enable learners to enter the formal workforce or create a livelihood for themselves. More particularly, the emphasis is on those who lack the relevant technical, reading, writing and numeracy skills to access employment. However, since the formulation of NSDS III, the responsibility for AET has moved away from the SETAs to the DBE. The key developmental and transformation priorities for the NSDS III are:

a) **Racial and economic inequality:** Preference in skills provision should be for previously and currently disadvantaged South Africans and specifically African blacks;

b) **Class:** Skills provision should reduce social and economic inequalities in society;

c) **Gender:** Women and black women in particular should benefit from skills development programmes to advance their employment and career development;

d) **Geography:** Skills provision should train rural people to deliver services in rural areas and to contribute to the economic development of rural areas;

e) **Age:** Skills provision must focus on training the unemployed youth;

f) **Disability:** Skills programmes must overcome labour market barriers for persons hampered by physical and intellectual disabilities by opening employment opportunities for them; and

g) **HIV and AIDS pandemic:** All skills development programmes must incorporate measures to fight and manage HIV/AIDS in the workplace.

The analysis of the health and social development sector presented in the previous chapters clearly shows that the current shortages of skills in the public sector lead to massive inequalities in terms of access to proper healthcare and social services. This leads to the perpetuation, and even the intensification, of inequalities in South African society. Therefore, the HWSETA's skills development interventions will be strongly focused on the alleviation of skills shortages and the development of new skills that can be applied in the poorest and most under serviced areas of the country and segments of the population. Skills development support and interventions will also give preference to historically disadvantaged individuals, and specifically African blacks and women, and people with disabilities.

The HWSTA makes every effort to ensure participation from the following groups in all of its projects and programmes:

- 85% Black,
- 60% women,
- 5% people with disabilities,
- 70% youth (35yrs and less), and
- 20% people from the rural areas.

By enabling participation of learners on the above basis, the HWSETA contributes to transformation and equity imperatives. This is evident in the HWSETA's skills development programmes (Table 6-1).

6.5.2 HWSETA contributions to the NSDS III goals

This section outlines the HWSETA's contribution to the goals of the NSDS III. The requirements of the NGP, National Skills Accord and other national policies are incorporated within reasonable, feasible skills development strategies and constrained resources. The section refers specifically to the HWSETA Annual Performance Plan for 2014/2015 (as adjusted), which forms part of the 2013-2017 Strategic Business Plan (as adjusted).

The main purpose of the discussion in this section is to link the HWSETA's

Strategic Business Plan and its Annual Performance Plan to NSDS III goals. The specific indicators in the Strategic Business Plan are referenced. It must be noted that the Strategic Business Plan covers all of the HWSETA's activities and although the total functioning of the SETA is in general supportive of the NSDS III, not every indicator in the Strategic Business Plan can be directly linked to the NSDS III. These indicators are also linked to other Government strategies such as the following:

a) National Skills Accord;
b) National Development Plan;
c) Green Paper on the NHI and Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17;
d) New Growth Path; and
e) White Paper for Post-School Education and Training.

1. Establishing a credible institutional mechanism for skills planning

Several strategies will be implemented to ensure that national needs in relation to skills development are researched, documented and communicated to enable effective planning across the health and social development sector. Resources will be allocated to ensure that the HWSETA conducts sound analysis of the health and welfare skills development needs that respond to Governmental and sectoral strategies. The HWSETA will conduct research and sectoral analysis in accordance with acceptable academic standards to produce SSPs which are supported by empirical evidence, provide sound analysis of the sector, and are confirmed by key stakeholders. Monitoring and evaluation of programmes and projects and impact assessments of skills development interventions will be undertaken by the HWSETA throughout the planning period – with a specific focus on the employability of learners and their absorption in the labour market after completion of HWSETA-funded training. Furthermore, the SETA will build research capacity in the sector through its support of post-graduate students – also in the field of labour market and skills development research (Programme 1, Indicators 5, 12 and 13). With regard to the quality of training provision, the HWSETA will increase the number of training providers accredited to offer full qualifications (Programme 3, Indicator 19).

2. Increasing access to occupationally directed programmes

The second NSDS III goal is to increase access to occupationally directed programmes, referring specifically to intermediate skills, higher-level professional qualifications and PIVOTAL grants[733]. The sub-goals under this broader goal also include the development of research and innovation capacity in the sector.

Intermediate skills

As indicated in Chapters 3 and 4, the need for mid-level skills in the sector emanates from the shortage of professionals as well as the vast range of needs faced by a large portion of South African society. The HWSETA Strategic Plan provides for several strategies and projects to address the need for intermediate-level skills in the sector. The HWSETA will provide grant funding to 15 priority projects between 2015 and 2017 to address mid-level skills needs in the sector (Programme 2, Indicator 1). Cooperation will be established with employers nationally to support the development of mid-level skills through work-based training opportunities. The number of employers evaluated annually to open up their workplaces as places of learning will grow substantially over the period 2015 – 2017 (Programme 2, Indicator 2). Students will be supported to qualify on learning programmes and to obtain the workplace training required through a workplace experience grant (Programme 2, Indicator 7). Targeted funding will be made available to register employed and unemployed learners on learnerships that develop mid-level skills (Programme 2, Indicator 3).

Vocational skills

Learners on pre-apprenticeships and N-courses will be supported to develop vocational skills and qualify for entry into vocational programmes at TVET colleges. New career paths will be developed for learners to access the sector. In this regard the HWSETA will continue with measures to support the review and development of the NCV Primary Healthcare (Programme 3, Indicator 17).

By 31 March 2014, the HWSETA formed partnerships with 14 TVET Colleges for pre-apprenticeship training and vocational courses for SAWs, CYCWs, ECD practitioners and artisans (See Table 6-2).

733 *DHET. 2011. National Skills Development Strategy III. Published at http://www.dhet.gov.za. (Accessed 9 Aug 2011).*

Table 6 2 TVET colleges in partnership with the HWSETA, 2014

TVET college	Province
Northern Cape Urban	Northern Cape
Northern Cape Rural	Northern Cape
King Hintsa	Eastern Cape
King Sabatha Dalindyebo	Eastern cape
Ingwe	Eastern Cape
Taletso	North West
Gert Sibanda	Mpumalanga
Mnambithi	Kwa-Zulu Natal
Umfolozi	Kwa-Zulu Natal
Lephalale	Limpopo
Letaba	Limpopo
Goldfields	Free State
West Coast	Western Cape
College of Cape Town	Western Cape

The number of learners in TVET colleges and other public colleges (and the number of associated learners) enrolled for vocational training courses supported by the HWSETA will reach 1 500 and 1 550 respectively in 2015/16 and 2016/17 (Programme 2, Indicator 17). Lecturers at TVET colleges will be placed in work experience programmes with employers (Programme 2, Indicator 16).

The development of vocational skills will also focus on the trades relevant to the sector. Apprentices will receive financial assistance to qualify as artisans (Programme 2, Indicator 4). The HWSETA will endeavour to achieve an 80% rate of employment for artisans and unemployed learners in their respective trades and occupations within six months of completing the SETA-funded programmes. (Programme 1, Indicator 5).

High-level professional skills

The HWSETA will ensure that appropriate interventions are in place to advance entry into priority programmes for high-level national scarce skills. The main vehicle for this is the provision of bursaries at tertiary institutions (Programme 2, Indicator 6).

PIVOTAL programmes

PIVOTAL programmes are "professional, vocational, technical and academic learning" programmes that meet the critical needs for economic growth and social development. PIVOTAL programmes generally combine course work at educational institutions with structured learning at work and culminate in an occupationally directed qualification. In the health sector most of the entry-level learning paths can be classified as PIVOTAL programmes. Learning paths for a number of occupations in the social development sector may also be categorised as such. The HWSETA learnership model is pivotal in nature as it is employer-driven with a high component of workplace experience. The learnerships are also occupationally directed and linked to employment.

During this planning period the HWSETA will support increased access of learners and students to occupationally directed programmes. Formal partnerships will be established with TVET colleges, universities of technology, universities, and other stakeholders to enable workplace-based training in mid-level skills and scarce high-level skills needed in the sector. The SETA will also support learners in learnerships and in skills programmes (Programme 2, Indicators 1, 3, 6, 7 and 8).

Research and innovation capacity

Measures will be taken to cultivate and strengthen relevant research and development and innovation capacity required for the sector. Evidence-based research will be conducted to inform skills planning and the impact of training will be assessed (Programme 1, Indicator 12). In the planning period the focus will be on partnerships with universities and universities of technology and on the cultivation of research and innovation capacity through post-graduate studies (Programme 1, Indicator 13).

3. Promoting the growth of a public TVET college system that is responsive to the sector, local, regional and national skills needs and priorities

According to the NSDS III, the NGP and the White Paper for Post-School Education and Training, the public TVET college system is central to the government's programme of skilling and re-skilling youth and adults. The NDP proposes that TVET colleges be strengthened and expanded and that the graduation rate be increased to 75%. Proposals in the White Paper for Post-school Education and Training are to re-position these institutions as Technical and Vocational Education and Training (TVET) colleges that meet the national vocational training needs. This will require pro-active measures to improve the quality and relevance of TVET courses. A number of HWSETA interventions will support these goals.

Partnerships will be established between the HWSETA, DHET, employers and public TVET colleges to offer vocational training and courses for social services needed in the sector. Where required, the HWSETA will share responsibility for the development of qualifications, learning programmes and learning materials (Programme 3 Indicator 23). The training of TVET college lecturers and their exposure to work experience is a direct contribution to building the capacity of TVET colleges and the quality of training provision (Programme 2 Indicator 16). Direct financial support will be offered to learners on vocational programmes at TVET colleges (Programme 2, Indicator 17). The TVET college system will also benefit from opportunities that will be created for learners to complete the workplace components of their qualifications (Programme 2, Indicator 7). These interventions will increase the throughput rates of the TVET colleges and aid the production of work-ready graduates.

4. Addressing the low level of youth and adult language and numeracy skills to enable additional training

Through its discretionary budget the HWSETA has in the past supported unemployed adults to undergo literacy training and AET (Programme 2, Indicator 21). Although the responsibility now lies with the DBE, special projects will be launched to promote and fund AET (Special project, Indicator 27).

5. Encouraging better use of workplace-based skills development

During the planning period the HWSETA will support the training of employed workers to address critical skills and enhance productivity. Programmes that stimulate economic growth and the ability of the workforce to adapt to change in the labour market will receive financial backing. In view of these objectives, the HWSETA will allocate funds for particular projects that address sector-specific health and social development skills gaps. Funding will be made available for learnerships and skills programmes for unemployed and employed learners (Programme 2, Indicators 3 and 8).

6. Encouraging and supporting cooperatives, small enterprises, worker initiated, NGO and community training initiatives

Chapters 3 and 4 of this SSP highlight the skills development challenges faced by NPOs that deploy workers and volunteers for community-based healthcare and social services. One of the "job drivers" in the NGP is to leverage the social economy and support NPOs and civil society organisations. During the planning period the HWSETA will engage with trade unions, NGOs and CBOs in the sector and identify skills needs, community-based education programmes and strategies to address them. Specific projects will be established to support and develop cooperative organisations (Programme 2, Indicator 9). Education programmes to support levy exempt organisations and trade unions will be funded (Programme 2, Indicator 11, 22) as well as small and emerging businesses (Programme 2, Indicator 10).

7. Increasing public sector capacity for improved service delivery and supporting the building of a developmental state

In Chapters 3 and 4 of this SSP reference was made to the significant challenges faced by the public sector to deliver quality services in healthcare and social development. Many of these challenges can be attributed to serious skills gaps and capacity constraints associated with sub-optimal skills levels of public service managers, officials and workers. Among the critical actions identified in the NDP involve steps by the state to professionalise the public service. The HWSETA will also contribute to this end.

The HWSETA will engage with national and provincial departments of health and social development to determine their capacity needs, especially in terms of critical skills. Education and development plans and funding arrangements will be agreed between the various departments, the HWSETA, the PSETA and other relevant SETAs. Specific projects aimed at education and training for the public sector to deliver on the objectives of a developmental state will be funded via discretionary grants (Programme 2, Indicator 14).

8. Building career and vocational guidance

The NSDS III underscores the need to provide career- and vocational guidance to young people in order to direct them to training areas needed in the economy and to identify programmes for which they have an aptitude. The HWSETA will adopt strategies to create awareness of the occupations in the health and social development sector at all levels. Special attention will be given to occupations in which skills shortages exist and new mid-level occupations that are being created to alleviate the shortages of professionals. More specifically, the HWSETA will update its career guides with relevant labour-market information for all the health and social development sub-sectors. Career paths will be mapped to qualifications. The SETA will participate in career awareness programmes and events and aims to reach at least 34 500 learners in the planning period 2014/2015 to 2016/17 (Programme 1, Indicator 15).

9. Strengthening the post school education and training system

Over the planning period 2014 to 2015, the HWSETA will contribute to the development and strengthening of the public post school education and training system. A special project with five specific strategic targets will be used to measure the impact of HWSETA-related interventions. Firstly, HWSETA funding will enable 40% of processes at new TVET colleges to be put into operation (Special project 1, Indicator 24). Secondly, financial assistance will be made available to 1 000 students in health and welfare related technical and vocational education fields (Special project 1, Indicator 25). Thirdly, unemployed students in the health and welfare field will receive funding from the HWSETA via NSFAS. Fourthly, a number of projects will be directed at adult education and training (Special project, Indicator 27). Finally, the HWSETA will fund projects in health and social development that support the turnaround strategy of the Walter Sisulu University (Special project, Indicator 28).

6.6 Sectoral Contribution to Government's MTSF Objectives

In government's MTSF ten priorities are set for attaining higher- and sustainable economic growth for the country and for improving the conditions of life of all South Africans[734]. Five of the strategic priorities are central to the work of the HWSETA:

a) Priority 2, which involves programmes to build economic and social infrastructure;
b) Priority 4, which is to strengthen the skills and human resource base of the country;
c) Priority 5, which is to improve the health profile of all South Africans;
d) Priority 7, which is to build cohesive, caring and sustainable communities; and
e) Priority 10, which is to build a developmental state and improve the delivery and quality of public services.

In previous chapters of this SSP various strategies and plans of government to improve the health and social development systems have been discussed. The HWSETA will continue to work closely with the DoH and the DSD, and will support these departments' public service strategies through skills development. It must, however, be noted that these initiatives may be hampered by a disjuncture between the different ministries involved in the planning of health and social development services. Within its own mandate and budgetary allocations the SETA will contribute to the supply of larger numbers of health and social services workers equipped with the skills necessary to improve healthcare and the quality of life of vulnerable persons in South Africa.

Learnerships in social auxiliary work, child and youth care work, community development, and ECD constitute significant investments in social capital and will contribute to social infrastructure development in communities. The HWSETA will encourage learning programmes that are accessible to people living in rural areas and will support innovation in the provision of these programmes. In addition, the development of skills in community-based interventions and multi-disciplinary team work will be promoted and supported.

A developmental social welfare response requires a range of social service occupational groups who are able to work cooperatively in multi-disciplinary teams. The HWSETA will promote skills development for all occupational groups in the social development sector, and will support development of the "emerging" professions – including child and youth care work, ECD and community development.

6.7 The New Growth Path and National Skills Accord

South Africa's New Growth Path (NGP) is essentially a policy package that strives to create employment on a large scale to reduce poverty and inequality[735]. The main objectives are to reduce unemployment from 25% to 15% over a ten-year period and to prioritise employment creation in all policies. All economic role players are required to create decent work (i.e. more and better jobs), enhance skills, and develop small enterprises. Among government's key priorities are investment in health and education to improve service delivery, access to employment, and competitiveness. Five "job-drivers" are identified to create employment on a large scale, four of which are relevant for HWSETA. These are: targeting labour-absorbing activities in the services field; utilising opportunities

734 *The Presidency. 2009. Together doing more and better: Medium Term Strategic Framework.*

735 *DGCIS. 2010. The New Growth Path: The Framework. Published at http://www.info.gov.za/....(Accessed 12 Sept 2011).*

in the knowledge- and green economies; leveraging social capital in the social economy and public services by supporting CBOs and cooperatives; and fostering rural development.

Key strategies in the NGP focus on measures to step up education and skills development. Higher education must meet the needs of broad-based development and shortfalls in technical and artisanal skills must be addressed. Extensive workplace-based skills interventions are envisaged, with SETAs encouraged to improve the skills in every job and to co-finance training of 10% of the workforce annually. TVET colleges must be strengthened, as they are major providers of mid-level skills.

The National Skills Accord is an agreement between business, organised labour, constituent communities at the National Economic Development and Labour Council (NEDLAC)[736] and government to establish partnerships to achieve the broad goals of the NGP. In July 2011 the parties made commitments to training and skills development in eight areas and a commitment specifically to[737]:

a) Expand the level of training by using existing facilities more fully by training more artisans, technicians and technical skills than are needed by employers;

b) Make internship and placement opportunities available in workplaces;

c) Set guidelines of ratios of artisans and trainees in technical vocations;

d) Improve the funding of training and the use of funds available for training and incentives for companies to train – including the effective use of the NSF and allocating part of the mandatory grant to fund workplace training for TVET college students, university of technology students, and middle-level skills;

e) Set annual targets for training in state-owned enterprises;

f) Improve SETA governance and financial management and stakeholder involvement;

g) Improve the role and performance of TVET colleges by positioning them as preferred providers of skills training and steering the SDL towards programmes provided by TVET colleges.

The HWSETA's skills development strategies for the health and social development sector as discussed in the previous sections clearly address the key objectives of the NGP and National Skills Accord. In particular, the HWSETA will contribute to the national commitment to increase the number of artisans that enter training, qualify and enter the labour market with the required skills. The HWSETA will also support workplace experience for learners from public TVET colleges and internships for third-year students of universities of technology. The SETA is also making a commitment to provide training exposure in a work environment for lecturers at TVET colleges.

6.8 HWSETA Contribution to the Human Resources Development Strategy

The Human Resources Development Strategy South Africa 2010-2030 sets out strategic objectives to develop priority skills, such as artisans needed to accelerate economic growth. A further objective is to improve the employment outcomes of post-school education. The need for unemployed adults, especially women, to have access to skills development programmes that will enable employment and income-generation is also stated. In order to improve the foundation of human development in the country, access to literacy training, adult education and ECD must be expanded[738]. These strategic priorities are covered in the HWSETA's Strategic Business Plan. A new HWSETA Special project to strengthen the post school education and training system will enable unemployed adults to access training opportunities in AET.

6.9 HWSETA's Performance Agreement with DHET

In previous updates of the SSP, the HWSETA indicated how it aligned its skills planning and skills development with reference to performance outputs assigned to the Minister of Higher Education and Training for the period 2010 to 2014. At the time of this SSP update, new performance outputs required of the Minister were not available. Hence, reference is made to the Service Level Agreement with the DHET for the period 2014 to 2015. The HWSETA's high-level obligations are to:

a) Carry out its statutory mandate and adhere to requirements for good governance;

b) Assess skills needed in sector, identity scarce skills and conduct skills planning for the sector;

c) Establish partnerships with public TVET colleges, universities, training providers and industry which provide for specific training programmes, learner targets, funding arrangements and placement of lecturers in industry;

d) Strengthen work-integrated learning by setting plans to use the public sector as a training platform and placing N3, N6 and NC(V) TVET graduates and university students in workplace training;

e) Contribute to improving levels of education in the sector by:
   - awarding bursaries to deserving citizens at universities and TVET colleges;
   - providing access to learning programmes for workers and unemployed learners;
   - enabling artisans to enter apprenticeships and register in their trades;
   - supporting RPL arrangements;
   - supporting cooperatives, small businesses, NGOs and CBOs.

f) Promote rural development through targeted learning programmes and interventions.

The skills development priorities and programmes set by the HWSETA will address these high-level performance outputs required by the Executive Authority. In particular, the HWSETA contributes to the achievement of a) and b) above through extensive research in the sector, stakeholder engagement to identify skills needs, and the allocation of resources to support skills planning. Focussed efforts to strengthen internal management - and service capacity and to improve quality

736 The community constituents at NEDLAC include organisations of civic structures, women, youth, people with disabilities and co-operatives.

737 Department of Economic Development. 2011. New Growth Path: Accord 1 – National Skills Accord. Published at http://www.info.gov.za/view/DownloadFileAction?id=149083. (Accessed 12 Sept 2011).

738 Department of Education. 2010. Human Resources Development Strategy South Africa – draft strategy for discussion 2010-2030. Published at http://www.info.gov.za/view/DownloadFileAction?id=117580. (Accessed Aug 2010).

controls and response time will continue. As discussed earlier in this Chapter, the SETA has put measures in place to achieve the outcomes referred to in c) to f) above. Several interventions will support partnerships with public TVET colleges and HEIs, and expand access to work-integrated learning.

6.10 Contribution to the Green Economy

The HWSETA will work to refine facilities and systems to accommodate paperless processes in its internal operations and services to stakeholders so that information may be exchanged and stored electronically.

Aspirations to advance the green economy are closely linked to some of the environmental focus areas that deal with the management of waste, pollution, hazardous substances and abattoirs, as well as surveillance measures needed for food safety. Environmental health interventions aim to prevent the outbreak of diseases when humans interact with their surroundings and with animals. As discussed in Chapter 3, environmental health officers will be key members of PHC teams to monitor the environmental conditions in which people live and work. The HWSETA will work with the DoH and provincial health departments to design programmes to train environmental health practitioners.

6.11 Presidential Infrastructure Coordinating Commission

In 2012 Government adopted the infrastructure plan proposed by the Presidential Infrastructure Coordinating Committee to support economic development and improve service delivery, especially in the poorest provinces. Seventeen strategic integrated projects (SIPs) have been developed, which aim to transform the economic landscape, create jobs and strengthen public services. The SIPs cover a range of economic and social infrastructure[739]. The work in these SIPs is being aligned with human settlement planning and with skills development, which are seen as key cross-cutting areas. The following SIPs are relevant for the health and social development sector:

- SIP 12 – Revitalisation of public hospitals and other health facilities: Work has commenced to build and refurbish hospitals and to revamp 122 nursing colleges, while extensive capital expenditure is needed to prepare the public health system for the NHI system.
- SIP 14 – Higher education infrastructure will be developed to expand lecture rooms, laboratories, libraries, student accommodation and ICT connectivity.

Specific opportunities are identified as “enablers” for further economic development. In the health sector, Government will work to support the establishment of a pharmaceutical manufacturing plant to complement the expansion of clinic and hospital infrastructure. Industrial pharmacists, i.e. highly skilled specialist pharmacy professionals with postgraduate qualifications, will be needed for all phases of the manufacturing process. In Chapter 3 the HWSETA reported on the need to train pharmacists in specialist areas, including public health management and industrial pharmacy.

The intention is to support the implementation of the SIPs with skills development programmes, and role-players such as SETAs are required to align their skills planning accordingly. Chapters 3 and 4 of this SSP describe the demand for additional healthcare workers in public hospitals and skilled practitioners to deliver services under the NHI. The HWSETA recognises the pressing skills development needs across all the occupational categories in the public health sector and will continue to support learnerships, training courses and occupationally-directed programmes to alleviate scarce skills. Expansion of the higher education platform will grow the training capacity of institutions but more lecturers and educators will be needed and more students will require bursaries. The HWSETA has taken note of these further opportunities to contribute to skills development for the health and social development sector.

739 Presidential Infrastructure Coordinating Commission. 2012. A summary of the Infrastructure Plan.

Table 6 3 Summary of HWSETA contributions to government strategies

Sector	Learning programmes, projects an partnership	Linked to government strategy (NDP, NSDSIII, NSA,NHI,HRHSA 2010-2030, NGP, White paper on PSET,MTSF)
Health	**Learnerships**	
	Certificate in General Nursing: Auxiliary	NSDS III and HRHSA 2010-2030
	Certificate in General Nursing: Enrolled	NSDS III and HRHSA 2010-2030
	Certificate Pharmacist Assistant: Basic	NSDS III and HRHSA 2010-2030
	Diploma in General Nursing: Bridging	NSDS III and HRHSA 2010-2030
	Diagnostic Radiography	NSDS III
	Diploma in Primary Health Care: Post Basic	NSDS III
	Further Education and Training Certificate: Public Awareness	NSDS III White paper on PSET
	Promotion of Dread Disease and HIV\AIDS	NSDS III
	General Education and Training Certificate : Hygiene and Cleaning	NSDS III
	GET Certificate in Ancillary Health Care	NSDS III
	Post Basic Diploma in Medical/Surgical Nursing (Elective: Operating Theater Nursing)	NSDS III, White paper on PSET, HRHSA 2010-2030
	Post Basic Diploma in Medical/Surgical Nursing: Elective (Critical Care)	NSDS III, White paper on PSET, HRHSA 2010-2030
	Post Basic Pharmacist Assistant Learnership	NSDS III, White paper on PSET, HRHSA 2010-2030
	Projects	
	Skills programmes for the employed and unemployed (for unemployed and employed earners)	NSDS III, NDP and White paper on PSET
	Levy exempt (for organisations that are exempt from paying levies and those that have identified interventions)	HRHSA 2010-2030 and NSDS III
	BEE (Improve quality by training personnel on patients' rights and dignity; advance BEE through increased levels of black ownership of companies and creating more equity)	White paper on PSET and NSDS III
	Bursaries	
	Bursaries (Masters and PHD funding for health and welfare research)	NDP, NSDS III
	Employer initiated-Nelson Mandela University (Bursaries for B cur students) in partnership with the Eastern Cape Department of Health	NDP, HRHSA 2010-2030
	Workplace Experience for persons with disabilities (Placement of unemployed persons with disabilities into workplace experience) in partnership with employer and QASA	NDP, NGP, NSA
Welfare	**Learnerships**	
	Certificate in Social Auxiliary Work Level 4 Community worker	NSDS III,MTSF
	Early childhood development	NDP,MTSF
	FET Certificate: Child and Youth Care Work	MTSF,NDP, Department of Social Development Ministerial Project
	FET Certificate: Phlebotomy Techniques	NSDSIII
	National Certificate: Community Development -HIV/AIDS Support	NSDS III, NDP, MTSF
	Bachelor of social work	NSDS III
	Projects	
	Skills programmes for the employed and unemployed	NSDS III, NDP,NGP
	Levy exempt (for organisations that are exempt from paying levies and those that have identified interventions)	NDP,NGP
	AET (Workers who need AET are generally employed in outsourced functions such as cleaning, catering and general work, or as volunteers with NPOs and their employers are not registered with the HWSETA)	NSDS III
	ECD (This project offered learners in rural areas access to the qualification in Early Childhood Development (ECD) Level 4 qualifications in partnership with FET colleges)	NDP, HRHSA 2010-2030, MTSF
	SME Support (Research skills, HIV/AIDS Awareness; Management and Life Skills)	NSA
	Bursaries	
	ECD level 5 (2012-13) Progression of learners who were funded on NQF level 4 to Level 5	NDP,MTSF,HRHSA2010-2030
	Employer initiated-Deafsa (Training of learners on Sign Language 1 and 2 , Social Auxiliary Work and Professional Development qualifications)	NDP,MTSF
	Partnerships	
	Partnership with universities	NSDS III
	Nelson Mandela Metropolitan University (Bursaries for learners studying towards Baccalaureus Curationis (Social Workers and Medical Nursers)	White paper on PSET, NSDS III

Sector	Learning programmes, projects an partnership	Linked to government strategy (NDP, NSDSIII, NSA,NHI,HRHSA 2010-2030, NGP, White paper on PSET,MTSF)
	University of North West (Bursaries for learners studying towards the Barchelors Degree in Demography and Population Studies)	NAS,NSDS III
	Water Sisulu University (Bursaries for learners studying towards the Barchelors Degree in Demography and Population Studies)	NSDS III, White paper on PSET
	Partnerships with UKZN, WITS, University of Zululand, University of Fortare and UFS for Postgraduate Research Bursary Programme	NSDS III
	Partnership with TVET colleges	
	College of Cape Town (ECD NQF LEVEL 5)	NDP, NSA
	Learning for Sustainability (ECD NQF LEVEL 5)	NDP, NSA
	Compass Academy of Learning (ECD NQF LEVEL 5)	NDP, NSA
	Northern Cape Rural TVET College (ECD NQF LEVEL 5)	NDP, NSA
	Boland College (ECD NQF LEVEL 5)	NDP, NSA
	Worldwide Education (ECD NQF LEVEL 5)	NDP, NSA
	Khululeka Community Education Development Centre (ECD NQF LEVEL 5)	NDP, NSA
	Tshepang (ECD NQF LEVEL 5)	NDP, NSA
	Mnambithi TVET College (ECD NQF Level 4)	NDP, NSA
	Ingwe TVET College (ECD NQF Level 4)	NDP, NSA
	Goldfelds TVET College (ECD NQF Level 4)	NDP, NSA
	Northern Cape Rural (ECD NQF Level 4)	NDP, NSA
	Ekurhuleni East College (Partners on the training of NCV: Primary Health Care Qualification)	NDP and NSDS III
	South West Gauteng (Partners on the training of NCV: Primary Health Care Qualification)	NDP and NSDS III, White paper on PSET
	Gert Sibande (Partners on the training of NCV: Primary Health Care Qualification)	NDP and NSDS III, White paper on PSET
	West Coast (Partners on the training of NCV: Primary Health Care Qualification)	NDP and NSDS III, White paper on PSET
	College of Cape Town (Partners on the training of NCV: Primary Health Care Qualification)	NDP and NSDS III, White paper on PSET
	Northlink TVET College (Partners on the training of NCV: Primary Health Care Qualification)	NDP and NSDS III, White paper on PSET
	Maluti TVET College (Partners on the training of NCV: Primary Health Care Qualification)	NDP and NSDS III, White paper on PSET
	Northern Cape Urban TVET (Partners on the training of NCV: Primary Health Care Qualification)	NDP and NSDS III, White paper on PSET
	Waterberg TVET College(Partners on the training of NCV: Primary Health Care Qualification)	NDP and NSDS III, White paper on PSET
	East Cape Midlands(Partners on the training of NCV: Primary Health Care Qualification)	NDP and NSDS III, White paper on PSET
	Umfolozi TVET College(Partners on the training of NCV: Primary Health Care Qualification)	NDP and NSDS III, White paper on PSET
	Taletso TVET College (Partners on the training of NCV: Primary Health Care Qualification)	NDP and NSDS III, White paper on PSET
	King Hintsa TVET (Partners on the training of NCV: Primary Health Care Qualification)	NDP and NSDS III, White paper on PSET
	Universities with strategic institutions	NSDS III, National Skills Accord and NDP
	South African Pharmacy Council (SAPC) : Support and increase the number of accredited training providers that offer MLW training as determined by the SAPC Identify and capacitate TVET Colleges in partnership with the SAPC to offer level 4 learnerships. They conclude an MoU with SAPC as a Qualification Development Partner (QDP); support the SAPC to build and increase its capacity as a Qualification Assurance Partner (QAP); foster strong relationships with employers and fund Workplace Experience Grant (WEG) and provide career and vocational guidance in partnership with the SAPC and employers in the sector	NSDS III, NSA, NDP

NB: HRHSA (Human Resources for Health South Africa), NSA (National Skill Accord), NDP (National Development Plan), NGP (National Growth Plan), NHI (National Health Insurance), NSDSIII (National Skills Development Strategy III), PSET (Post-School Education and Training), MTSF (Midterm Strategic Framework)

Table 6 4 2015-2016 HWSETA projects and programmes

Subsector	Projects and programmes	Linked to government strategy (NDP, NSDSIII, NSA,NHI,HRHSA 2010-2010, NGP, White paper on PSET,MTSF)
Allied health	Partnerships and funding linked to the following: • Internships • Bursaries • Curriculum Development • Learning/teaching /simulation Aids • Relevant equipment	• NSDS III • NSDS III and White paper on PSET • HRHSA 2010-2030 • HRH 2010-2030
Veterinary	Partnerships and funding linked to the following: • Bursaries • Internships • Curriculum Development • Skills Programmes • Short courses for veterinary and para veterinary • Support CPD training	• NSDS III and White paper on PSET • NDP • NSA
NGOs and CBOs	Partnerships and funding linked to the following: • Learnerships • Hosting of learners • Generic Skills programmes for coordinators and managers • CPD training • Training of care givers/home based care workers • Gerontology related training of caregivers and home based care givers • Curriculum development for Older persons Act and Children's Act • Training on the Older Person's Act and Children's Act • Placement/ work experience for unemployed Social Workers and Social Auxiliary Workers	• NDP • NSDS III • NDP • NDP and HRHSA 2010-2030 • HRHSA 2010-2030 • NDP
General	Partnerships and funding linked to the following: • Training of caregivers • Training of beneficiaries of Road Accident Fund	• NDP And NSA
Traditional healing services	Partnerships and funding linked to the following: • Primary health care • Prevention of communicable diseases • Curriculum development	• HRHSA 2010-2030
Manufacture of medical precision and surgical equipment and orthopedic appliances	Partnerships and funding linked to the following: • Partnerships with UoT and TVET Colleges • Cross sectoral partnership with MerSETA • Partnership with Departments of Health and Social Development • Partnerships with employers	• HRHSA 2010-2030 • NSDSIII
Optical and optometric services	Partnerships and funding linked to the following: • Partnerships with industry employers and NGOs in the subsector • Partnerships with UoT and TVET Colleges • Partnership with DBE to open up schools for screening	• NDP • NSA • NSDS III
Psychological and Psychometric services	Partnerships and funding linked to the following: • Bursaries • Internships • Stipend for students	• NSDS III • NDP
Social Work	Partnerships and funding linked to the following: • Curriculum development for Day 1 skills/ Common induction standard for newly qualified Social Workers and Social Auxiliary Workers	• White paper on PSET
Technician development support	Partnerships and funding linked to the following: • Partner with DoH to train personnel that repair medical and diagnostic equipment	• HRHSA 2010-2030

NB: HRHSA (Human Resources for Health South Africa), NSA (National Skill Accord), NDP (National Development Plan), NGP (National Growth Plan), NHI (National Health Insurance), NSDSIII (National Skills Development Strategy III), PSET (Post-School Education and Training), MTSF (Midterm Strategic Framework)

6.12 Conclusions

The skills development priorities and interventions set out in this Chapter will be further developed and implemented within the available funding of the SETA. The success and impact of these strategies and interventions will be assessed on a continuous basis and the overall strategy and Strategic Business Plan will be revised annually. On-going performance management and progress reviews will be reflected in quarterly reports to the DHET. Focussed efforts to improve service delivery and governance of the HWSETA will continue. Specific attention will be given to provide the resources, processes and capacity required to deliver on the HWSETA mandate. During this planning period the HWSETA will continue to engage with stakeholders in the sector on an on-going basis regarding the skills development strategies and outcomes of the skills development interventions.

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ANNEXURE A
HWSETA Budget 2011/12 to 2016/17

Health and Welfare Sector Education and Training Authority 5 year Budgets

Statement of Financial Performance

	Audited 2013-2014 R'000	Approved adjusted Budget 2014-2015 R'000	Approved Budget 2015-2016 R'000	Proposed Budget 2016-2017 R'000	Proposed Budget 2017-2018 R'000	5 Year Budget R'000
REVENUE						
Non - Exchange Revenue	**384,423**	**385,350**	**406,105**	**427,575**	**448,905**	**2,052,358**
Skills Development Levy: income	381,440	384,350	405,105	426,575	447,905	2,045,375
Skills Development Levy: penalties and interest	2,983	1,000	1,000	1,000	1,000	6,983
Exchange Revenue	**27,981**	**25,007**	**26,358**	**27,755**	**29,143**	**136,244**
Interest income	27,981	25,007	26,358	27,755	29,143	136,244
Other income						0
Total revenue	**412,404**	**410,357**	**432,462**	**455,330**	**478,048**	**2,188,602**
EXPENSES						
Total expenses	**265,915**	**285,799**	**301,357**	**451,619**	**476,581**	**1,781,271**
Employer grant and project expenses	201,848	193,493	202,250	347,553	364,930	1,310,074
Administration expenses	64,067	91,409	97,894	102,427	109,438	465,234
QCTO funding	-	897	1,214	1,639	2,213	5,962
TVET Infrastructure Grant		-	0	0		0
Finance costs		-	0	0		0
Net surplus for the Period before capex	**146,489**	**123,979**	**131,105**	**3,711**	**1,467**	**406,752**
Capital expenditure	**1,571**	**4,900**	**3,295**	**3,711**	**1,466**	**14,943**
Net surplus for the Period after capex	**144,918**		**127,810**	**0**		**272,728**
		290,699	*304,652*			*595,351*
Ceiling Expenditure		*290,699*	*304,652*	*no ceiling*	*no ceiling*	
SKILLS DEVELOPMENT INCOME						
Levy income: Administration	**92,089**	**97,207**	**102,457**	**107,887**	**113,282**	**512,922**
Levies received from SARS	38,949	43,381	45,723	48,146	50,554	226,753
Government levies received	53,185	53,827	56,734	59,740	62,728	286,214
Interseta transfers in	(18)	-	-	-		-18
Interseta transfers out	(27)	-	-	-		-27
Percentage of admin expense/ admin income		95	95.55	95.90		287
Levy income: Employer Grants	92,241	82,630	87,092	91,708	96,294	449,966
Levies received from SARS	92,318	82,630	87,092	91,708	96,294	450,043
Interseta transfers in	(91)	-	-	-		-91
Interseta transfers out	(86)	-	-	-		-86
Levy income: Discretionary Grants	197,110	204,512	215,555	226,980	238,329	1,082,486
Levies received from SARS	178,360	204,512	215,555	226,980	238,329	1,063,736
Levies received from GOVERNMENT DEPARTMENTS	18,867					18,867
Interseta transfers in	(35)	-	-	-		-35
Interseta transfers out	(82)	-	-	-		-82
		384,350	**405,105**	**426,575**	**447,905**	**1,663,935**
EMPLOYER GRANT AND PROJECT EXPENDITURE						
Mandatory grants	57,847	58,668	61,836	65,113	68,369	311,832
Discretionary grants	144,001	134,825	140,414	282,440	296,561	998,242
	201,848	**193,493**	**202,250**	**347,553**	**364,930**	**1,310,074**
Particpation Rate	*63%*	*71%*	*71%*	*71%*	*71%*	
ADMINISTRATIVE EXPENDITURE						
Depreciation	1,234	1,581	1,900	2,000	2,100	8,815
Amortization of Intangible assets						

	Audited 2013-2014 R'000	Approved adjusted Budget 2014-2015 R'000	Approved Budget 2015-2016 R'000	Proposed Budget 2016-2017 R'000	Proposed Budget 2017-2018 R'000	5 Year Budget R'000
Operating and finance lease	6,006	8,234	9,049	9,945	10,940	44,175
Buildings	5,929	8,050	8,855	9,741		32,575
Plant, machinery and equipment	77	184	194	205		661
Maintenance, repairs and running costs	208	321	339	357	376	1,601
Property and buildings	208	321	339	357		1,225
Machinery and equipment	-	-	0	0		0
Advertising, marketing and promotions, communication	1,484	1,954	2,071	2,181	2,299	9,989
Consultancy and service provider fees	257	295	311	328	345	1,536
Legal fees	192	527	555	585	616	2,476
Cost of employment	34,107	50,829	53,878	56,734	59,571	255,119
Travel and subsistence and accommodation	4,865	6,000	6,350	6,687	7,048	30,949
Staff training and development	516	854	911	959	1,011	4,251
Remuneration to members of the accounting authority	1,443	1,587	1,687	1,776	1,872	8,366
Remuneration to members of the audit committee	171	232	244	257	271	1,174
External auditor's remuneration	1,699	2,126	2,241	2,359	2,487	10,911
Audit fees	1,699	2,126	2,241	2,359	2,487	10,911
Other	11,428	16,869	18,357	19,298	20,502	86,453
Workshops	1,239	2,000	2,128	2,209	2,328	9,904
Internal audit fees - Audit fees	1,360	1,212	1,278	1,345	1,418	6,613
Special assignments	269	527	555	585	616	2,553
Courier and postage	208	300	350	369	388	1,615
Telephone	722	843	889	936	986	4,376
Programme evaluations - ETQA	639	1,054	1,111	1,170	1,233	5,207
Printing and stationery	1,500	1,952	2,057	2,166	2,283	9,959
Staff welfare	156	500	600	632	666	2,554
SDF Contractors	-	246	259	273	288	1,066
Office cleaning	330	422	444	468	515	2,179
Insurance	335	348	367	386	425	1,860
Motor vehicle expenses	90	92	97	103	108	490
Software support	1,242	2,000	2,400	2,527	2,714	10,883
Storage	39	150	160	168	178	695
Subscriptions	216	315	332	350	368	1,581
Staff bursaries	236	262	277	291	307	1,373
Security	4	553	600	632	666	2,455
Water and electricity, rates and taxes	1,170	1,404	1,500	1,580	1,737	7,391
Recruitment costs	429	700	850	895	943	3,817
Bank charges	56	89	94	99	105	443
IT systems	249	541	570	600	633	2,593
Branding	316	500	527	555	585	2,483
Other consumables	62	-	0	0		62
Office move	29	60	70	74	78	310
Catering and refreshments	291	258	272	286	302	1,409
General expenses	149	6	6	7	7	175
Bad debts written off	-	-	0	0		0
Research costs	92	534	563	593	625	2,406
Loss on scrapping of assets		-	0	0		0
	63,610	**91,409**	**97,894**	**103,466**	**109,438**	**465,816**
Total cost of employment	34,107	50,829	53,878	56,734	59,571	255,119
No of employees	87	111	111	111	111	
Salary costs as a % of administration exp	*54%*	*56%*	*55%*	*55%*	*54%*	

ANNEXURE B
The Process of Updating 2013 Employment Data

For the 2013 update, data from three databases were used. WSPs submitted by private sector employers to the HWSETA were combined with data extracted from such plans submitted by public sector employers to the PSETA. This information was augmented with data extracted from the MEDpages database.

Public service

Data for the public health and social development sectors was obtained from the PSETA. All nine provinces' departments of health and of social development as well as the two national departments submitted employment data to the PSETA in 2013.

Information on scarce skills was not submitted by the Northern Cape Department of Health and the Department of Social Development in Mpumalanga.

Private sector

The information that employers submit to the HWSETA in their annual mandatory grant applications is the only information that deals specifically with the private health sector. However, not all the organisations in the sector submit mandatory grant applications. In order to compensate for organisations belonging to the HWSETA that did not submit WSP-ATR information, the data received in 2013 was weighted to a sectoral total. This was done by using the levy amount paid as a proxy for employment. Weighting was done separately for each Standard Industrial Classification (SIC) code.

In each of the industries the weights applied were calculated as follows:

Weight = Levy amount paid (all organisations)/levy amount paid (organisations – WSPs approved).

Estimated employment = (Weight * WSP employment)

The exact calculations are shown in the tables below.

Weights by SIC code (industry)

SIC code	SIC description (industry)	Total Levy amount	Levy amount WSPs	Weight
0	Unknown	R 318 046.10	R 311 470.69	1.021110847
33531	Traditional healing services	R 662 139.96	R 27 238.97	24.30855352
37410	Manufacture of medical and surgical equipment and orthopaedic appliances	R 1 720 069.01	R 762 497.83	2.25583463
37411	Orthopaedic appliances	R 619 765.97	R 233 291.61	2.656614912
62312	Retail of prescribed medicines and pharmaceutical products by registered/licensed pharmacy	R 12 440 518.95	R 9 180 991.16	1.355030054
82132	Medical aid schemes	R 496 318.81	R 141 713.95	3.502257964
87000	Research and development	R 921 696.95	R 547 035.21	1.684895109
87130	Medical and veterinary research	R 651 878.02	R 111 205.41	5.861927221
87131	SA medical research council	R 16 352.67	R 10 117.67	1.616248603
87200	Research and experimental development on social sciences and humanities	R 954 761.43	R 717 719.85	1.330270342
88221	Biomedical engineering	R 54 059.03		0
88915	Health professionals employment agencies	R 2 467 015.41	R 2 207 468.73	1.117576605
93101	Universities; specialist pharmaceutical and drug information services	R 177 112.17	R 141 569.30	1.251063401
93102	Public and private rehabilitation	R 147 231.17	R 72 956.20	2.018076188
93103	Other services including local government; mines and industry	R 309 524.22	R 164 402.82	1.882718435
93104	Ancillary health care services	R 797 567.92	R 616 046.36	1.294655681
93105	Residential care facilities	R 932 983.75	R 315 537.90	2.95680408
93106	Rehabilitation services	R 304 933.13	R 135 077.01	2.257476161
93107	Environmental and occupational health and safety services	R 386 513.12	R 232 992.78	1.658905997
93108	Health maintenance organisations	R 163 214.74	R 30 588.24	5.335865679
93110	Hospital activities	R 1 536 380.29	R 1 118 623.42	1.373456216
9311B	Private hospitals	R 27 974 109.32	R 27 556 090.21	1.015169754
9311C	Mine hospitals	R 33 757.75		0
9311E	Hospice care facilities	R 25 633.25		0
9312A	Public sector doctors	R 382 328.07	R 7 717.32	49.54155976
9312B	Private sector doctors	R 3 166 643.59	R 489 188.65	6.473256463
9312C	General and specialist practice	R 12 640 574.65	R 5 033 897.96	2.511090759
9312D	Industry based doctors	R 40 218.68	R 9 049.77	4.444165984

SIC code	SIC description (industry)	Total Levy amount	Levy amount WSPs	Weight
9312E	Doctors in charitable organisations	R 19 555.35		0
9312F	Paediatrics	R 149 385.64	R 32 264.21	4.630072765
9312G	Public service dentists	R 116 330.25	R 11 147.99	10.4350874
9312H	Private sector dentists	R 688 346.24	R 10 339.14	66.57674043
9312I	Oral hygienists	R 54 222.09	R 6 702.49	8.08984273
9312J	Dental therapists	R 519 499.99	R 23 815.65	21.813387
9312K	Dental laboratories	R 367 333.81	R 62 402.00	5.886571103
93190	Other human health activities	R 2 140 558.24	R 1 211 071.98	1.767490517
93192	Clinics and related health care services	R 1 672 391.44	R 484 239.50	3.453645231
93193	Nursing services	R 2 101 450.93	R 1 473 681.26	1.425987415
93199	Other health services	R 14 078 220.52	R 11 279 230.64	1.248154326
9319A	Public sector emergency services	R 70 440.87		0
9319C	State services	R 3 272.51		0
9319D	Public hospitals and clinics	R 323 160.65	R 127 300.68	2.538561852
9319E	Community services	R 280 822.26	R 94 350.25	2.976380667
9319F	Private hospitals and clinics	R 10 284 569.68	R 10 007 959.40	1.027639029
9319M	Optical and optometric services	R 2 580 601.57	R 710 513.04	3.632025628
9319N	Dietetics and nutritional services	R 46 665.73		0
9319O	Hearing and audiometric services	R 8 242.85		0
9319P	Complementary health services	R 125 741.88	R 18 570.27	6.77113903
9319Q	Laboratory services	R 15 232 691.89	R 14 790 590.45	1.029890723
9319S	Ambulance services	R 695 208.85	R 613 730.76	1.132758687
9319T	Blood transfusion	R 2 425 565.84	R 324 846.99	7.466794875
9319U	Psychological and psychometric testing	R 78 193.19	R 5 008.93	15.61075719
9319W	NGOs involved in health work	R 104 344.56		0
93200	Veterinary activities	R 1 321 016.72	R 159 999.06	8.256403006
93300	Social work activities	R 43 561.23		0
93301	Public sector	R 54 495.37		0
93302	Hospices	R 2 457.58		0
93303	Development and social services	R 59 519.45	R 3 731.75	15.94947411
94000	Other community; social and personal service activities	R 2 066 359.61	R 560 480.86	3.686762131

Total employment (weighted) by occupational category

Occupational category	N
Managers	11 652
Professionals	101 190
Technicians and Associate Professionals	64 515
Clerical Support Workers	41 017
Service and Sales Workers	26 914
Skilled Agricultural, Forestry, Fishery, Craft and Related Trades Workers	1 975
Plant and Machine Operators and Assemblers	4 702
Elementary Occupations	10 538
Total	262 503

Submission rates for small professional practices in the health sector are very low. However, MEDpages, a private company, collects information on private health professionals and practices on an on-going basis and at this stage their data is one of the most comprehensive sources of information on private practitioners in the sector. For these reasons the MEDpages data was used to calculate employment of certain professionals. The table below shows the professions for which MEDpages data was used and the employment figures obtained from this source.

Data for professionals obtained from MEDpages

OFO code	Occupation	N
221101	General Medical Practitioner	10 328
221201	Anaesthetist	935
221202	Cardiologist	148
221204	Obstetrician and Gynaecologist	652
221205	Ophthalmologist	283
221206	Paediatrician	428
221208	Psychiatrist	414
221210	Specialist Physician (General Medicine)	325
221211	Surgeon	1 656
223101	Acupuncturist	139
223103	Homoeopath	461
225101	Veterinarian	1 294
226101	Dental Specialist	289
226102	Dentist	3 238
226401	Physiotherapist	3 423
226501	Dietician	1 063
226602	Speech Pathologist	1 333
226701	Optometrist	2 406
226902	Occupational Therapist	1 975
226905	Biokineticist	765
226906	Rheumatologist	30
226907	Dermatologist	151
263401	Clinical Psychologist	1 978
263402	Educational Psychologist	1 112
263403	Organisational Psychologist	266
263405	Research Psychologist	14
263407	Counselling Psychologist	1 751
263409	Psychometrician	218
263507	Social Worker	1 516

ANNEXURE C
Scarce Skills in the Health and Welfare Sector

The table includes only occupations in which 10 or more people are needed.

		Scarce skills					
		2014			2013		
OFO Code	OFO description	Public service	Private sector	Total	Public service	Private sector	Total
263507	Social Worker	6 121	82	6 203	5 518	95	5 613
222112	Registered Nurse (Surgical)	3 687	69	3 756	107	7	114
222101	Clinical Nurse Practitioner	980	1 146	2 126	1 390	183	1 573
221101	General Medical Practitioner	1 964	32	1 996	2 334	21	2 355
222108	Registered Nurse (Medical and Surgical)	847	320	1 167	3 637	1 216	4 853
226201	Hospital Pharmacist	966	178	1 144	923	77	1 000
322101	Enrolled Nurse	868	124	992	143	51	194
134402	Community Development Manager	812		812			
222105	Registered Nurse (Critical Care and Emergency)	58	751	809	540	238	778
222111	Registered Nurse (Preoperative)	41	724	765	1 229	304	1 533
222109	Registered Nurse (Medical Practice)	277	302	579	431	289	720
222201	Midwife	132	410	542	204	11	215
222102	Registered Nurse (Aged Care)	422	95	517		113	113
311502	Boilers and Pressure Vessels Inspector		500	500			
226203	Retail Pharmacist	114	325	439	74	672	746
811202	Healthcare Cleaner	431		431			
341201	Community Worker	410	2	412	1 337	13	1 350
222104	Registered Nurse (Community Health)	300	77	377	71	59	130
134201	Medical Superintendent	351	2	353	85	5	90
325801	Ambulance Officer	275	31	306		56	56
541902	Emergency Service and Rescue Official	280		280			
321301	Pharmaceutical Technician	5	249	254		15	15
441601	Human Resources Clerk	242		242			
341203	Social Auxiliary Worker	210	20	230	250	18	268
222116	Nurse Manager	30	197	227	116	41	157
321101	Medical Diagnostic Radiographer	176	39	215	322	55	377
732101	Delivery Driver	17	185	202	1	14	15
221207	Pathologist	147	35	182	27	20	47
226401	Physiotherapist	158	15	173	184	1	185
325802	Intensive Care Ambulance Paramedic / Ambulance Paramedic	134	30	164	130	10	140
226501	Dietician	156	1	157	126		126
226102	Dentist	131	1	132	92	2	94
263508	Child and Youth Care Worker	100	29	129		12	12
642601	Plumber	125		125	58		58
532902	Hospital Orderly	125		125			
221210	Specialist Physician (General Medicine)	115	2	117	258	3	261
812101	Laundry Worker (General)	105	3	108			
226902	Occupational Therapist	96	12	108	155	22	177
222113	Paediatrics Nurse	47	44	91	152		152
263506	Parole or Probation Officer	90		90	90		90
532903	Nursing Support Worker	85	3	88		13	13

		Scarce skills					
		2014			2013		
OFO Code	OFO description	Public service	Private sector	Total	Public service	Private sector	Total
524601	Food Service Counter Attendant	87		87			
221204	Obstetrician and Gynaecologist	81		81	34		34
263401	Clinical Psychologist	66	8	74	48	8	56
213110	Medical Scientist		70	70	3	41	44
221211	Surgeon	68	1	69	32		32
325102	Dental Hygienist	66		66			
321201	Medical Laboratory Technician	17	48	65		46	46
242401	Training and Development Professional	50	11	61		11	11
321104	Sonographer	17	39	56	102	21	123
323102	Ancillary Health Care Worker		56	56	11	164	175
332208	Pharmacy Sales Assistant	21	33	54		112	112
321102	Medical Radiation Therapist	50	1	51	20	10	30
411101	General Clerk	47	3	50			
441604	Labour Relations Case Administrator	50		50			
833401	Shelf Filler		50	50			
431101	Accounts Clerk	50		50			
226701	Optometrist	38	6	44	23	6	29
263501	Social Counselling Worker		41	41		52	52
121101	Finance Manager	30	10	40	20	9	29
222110	Registered Nurse (Mental Health)	15	25	40	87	61	148
311901	Forensic Technician (Biology, Toxicology)	33		33	47		47
226602	Speech Pathologist	26	6	32	50	2	52
671101	Electrician	28	4	32	23	1	24
222103	Registered Nurse (Child and Family Health)	18	14	32	97	112	209
221209	Radiologist	16	13	29	9	14	23
241107	Financial Accountant	25	4	29			
224101	Paramedical Practitioner	25	3	28	12	2	14
226101	Dental Specialist	25		25			
321103	Nuclear Medicine Technologist	25		25	15	1	16
243302	Sales Representative (Medical and Pharmaceutical Products)		25	25		16	16
222107	Registered Nurse (Disability and Rehabilitation)	21	2	23	58	1	59
331503	Insurance Loss Adjuster		23	23			
422602	Medical Receptionist		23	23			
121206	Health and Safety Manager		23	23			
133105	Information Technology Manager	20	2	22			
341204	Auxiliary Child and Youth Care Worker		22	22			
321402	Dental Technician	20	1	21			
122301	Research and Development Manager	20		20			
222114	Nurse Educator		20	20		18	18
215101	Electrical Engineer	19		19			
325501	Massage Therapist	2	16	18			
221201	Anaesthetist	15	3	18	27	3	30
121301	Policy and Planning Manager	16	1	17			
321403	Dental Therapist	17		17	11		11
531105	Child or Youth Residential Care Assistant		16	16		16	16
263407	Counselling Psychologist	13	2	15			
226301	Environmental Health Officer	12	3	15	40	1	41
226601	Audiologist	15		15	19	1	20

		Scarce skills					
		2014			2013		
OFO Code	**OFO description**	**Public service**	**Private sector**	**Total**	**Public service**	**Private sector**	**Total**
325301	Health Promotion Officer		15	15			
111204	Senior Government Official	15		15			
321114	Health Technical Support Officer		15	15		36	36
213104	Biochemist	14		14	14		14
242101	Management Consultant		13	13			
121901	Corporate General Manager		12	12			
221205	Ophthalmologist	9	3	12	28		28
532202	Aged or Disabled Carer		12	12		40	40
214402	Mechanical Engineering Technologist	1	10	11	39	10	49
221208	Psychiatrist	11		11	28	2	30
321118	Orthotist or Prosthetist	10	1	11	50	1	51
321116	Electroencephalographic Technician	10		10			
325601	Medical Assistant	10		10			
226302	Safety, Health, Environment and Quality (SHEQ) Practitioner		10	10	20	5	25

ANNEXURE D
Education and Training Needs Requested by HWSETA Stakeholders and Institutions of Higher Learning

Stakeholder/Institution	Training or education need	Target group	Duration	Estimated budget
Carl Zeiss Vision	Any skill and training programme	81 employees facing retrenchment	August 2014- July 2015	Any amount
Wits School of Education	Training of learners to parent advisor or deaf mentor	Learners from both rural and urban areas	2014-2015	R 3 240 000.00
DsD Free State	Community Development learnership	Unemployed and employed youth	Current financial year	R 200 860.00 for stipends excluding tuition, accommodation ad catering
Nelson Mandela Children Hospital project	Postgraduate management training and clinical work experience	237 employed nurse, managers, paediatric nurses and administrative staff	after the opening of the hospital	R 22 053 680.00
Triest Training Centre	Skills and training i.e. ABET and ACADEMIX programme	Adult with intellectual disabilities	Current financial year	R 1 104 000.00
DoH Western Cape	Training of enrolled nurses	Community members from disadvantaged backgrounds i.e. informal settlements and isolated rural areas	Not indicated	R 2 683 700.00
Swiss-South African Cooperative Initiative	Training of artisans (Accelerated Apprenticeships for employment)	Unskilled, unemployed youth in GP,KZN and MP	2 and a half years	R 16 860 000.00
SAFELTP	Training of epidemiologist	Health professionals in the SA public health system	2 years	R 2 800 000.00
Perkin Elmer	Training to install, repair and operate analytical equipment	South African unemployed citizens	1 year	R 1 870 000.00
QASA	Workplace skills experience	Disabled unemployed South African	1 YEAR	R 802 000.00
Rural development and Agrarian Reform	Training for animal health Diploma	Prospective students from 1st to 3rd year	3 years	R 6 240 000.00
DENOSA	Strengthen capacity for nursing leadership and management	Nurses	Not indicated	R 1 732 500.00
	Funding for leadership for change programme	Nurses		R 4 375. 00
Nelson Mandela Children's Hospital	Health and support staff training programme	• 33 qualified nurse managers • 150 qualified registered nurses • 15 artisans with technical skills • 30 Registered allied health workers	1 year	R 25 668 440.00
Nelson Mandela Metropolitan University	Short course learning in social development	Social development practitioners, auxiliary workers	Not provided	R 187 500.00
	Bursaries for social work students	Social work students	4 years	R 177 944.48 per learner
	Bursaries for Bpharm students	50 Bpharm students	4 years	R 15 739 900.00
	Bursaries for Bcur and Bcur extended programme	Prospective students	4-5 years	R 4 798 563.00
SAWID	SAW learnership	South African	1	R 83 250.00
Thuso Skills Development and Training Centre	Early childhood development	Teachers and caregivers	1 year full-time and 2 years part-time	Not provided
Emeliah de Heer-Menlah	Bursary for a student	MBChB student	6 years	R 42 660.00 excluding accommodation
CEFA	Training of community development practitioners	Unemployed south Africans in Eastern Cape	18 months	R 2 250 000.00
DsD KZN	Bursaries for Bachelor of social sciences students	Bachelor of social sciences students	4 years	Not indicated

Stakeholder/Institution	Training or education need	Target group	Duration	Estimated budget
DoH	Bursaries for Scarce skills	Prospective students scarce skills	1-6 years depending on the programme	Not indicated
Durban university of technology	Mobile health sciences clinic	Health sciences students	Not indicated	R 2 260 900.00
Ampath trust	Funding of National Diploma Biomedical Technology	Prospective students	3 years	R 124 510.00 per student annually
Arikonisaho training college	Funding for community health work	Disadvantaged youth and adults	1 year	R 2 000 000.00
Dimentia	Funds to train carers	Carers	2 years	R 437 000.00
DoH Gauteng	Diagnostic radiography learnership	Prospective disadvantaged students	3 years	R 3 195 000.00
	Funding for 25 hospital chief executive officers	Hospital CEOs in Gauteng province	Not indicated	R 6 699 975.00
DsD Eastern Cape	Training and development interventions	DsD officials	Not indicated	Not indicated
	Funding for artisanship	Youth in the Eastern Cape	3 years	R 41 423 000.00
	Funding for workplace experience	Social work graduates		R 1 000 000.00
East Cape Midlands TVET college	Funding for Primary health work course	Unemployed South African	3 years	R 65 114 584.00
Enabled 2013	Community Health work	South Africans youth, including persons with disabilities	1 year	R 24 000.00 per learner
Kgabaganang	Community health worker	South Africans	1 year	Not indicated
DoH KZN	Sign language training for in-service employees	Employees	Not indicated	Not indicated
Louis Pasteur Private Hospital	Enrolled and auxiliary nursing funding	Students		R 80 000.00
Mount Croix animal hospital	Vet assistant training	Learner	Not indicated	Not indicated
DoH	Community development practitioners	Practitioners employed by the national and provincial government	Not indicated	R 5 000 000.00
	Funding for training, mentorship and incubation of cooperatives	South African registered cooperatives that are struggling to sustain themselves	2 Years	R 2 447 916.00
DsD	Funding to train social development provincial coordinators on facilitation skills	Provincial coordinators	Not indicated	R 150 000.00
	Food and nutrition training for community development practitioners	Community development practitioners	Not indicated	R 5 000 000.00
DsD Limpopo	Social work graduates internship	Social work graduates	1 year	R 2 415 300.00

ANNEXURE E
Continuous Improvement Action Plan: Progress Report 2014

Recommendations	Priority and justification QIP: what is done or to be completed.	Resources needed (human and financial)	Action	By when	By Whom	Structure/ person to monitor or sign off	Progress Report September 2014
Alignment of HWSETA priorities to strategic plans and other Government priorities	The HWSETA strategic objectives are drawn from the NSDS III and linked and guided by other government programmes such as HRDSSA , requirements of the New Growth Path, IPAP, outcomes of the MTSF, Rural Development Strategy, new Environment Strategy, human resource for health, NHI and the Skills accord	Research partnerships with Universities and other NGOs in health systems in the sector	Continuously review the HWSETA Strategic Plan to further improve its alignment to other government strategic plans and priorities. Scan the political and government environment for emerging government priorities to be aligned with the HWSETA's priorities	Continuously, until the end of NSDS III	The HWSETA CEO and Executive Management	CEO and Chairperson of the Board	Achieved. This is evident in the current and previous SSP Annual Updates. Furthermore, the HWSETA Projects and Programmes linked to government programmes (as indicated above) have been summarised in a form of a table in Chapter 6 of the 2014 SSP Annual update
Involvement of Board in the development of the SSP	The HWSETA SSP is reviewed and approved by the Skills Development Standing Committee (sub-committee of the board) and finally by the HWSETA Board.	Partnerships with research organisations	Continuously review and approve draft SSP before submission	30 August 30 November 31 January annually	The Skills Development Standing Committee and the HWSETA Board.	CEO and Chairperson of the Board on recommendation of the Board	Continuously Achieving. This has been a standard practice at the HWSETA. The Board is actively involved in the development and approval of the SSP

Recommendations	Priority and justification QIP: what is done or to be completed.	Resources needed (human and financial)	Action	By when	By Whom	Structure/ person to monitor or sign off	Progress Report September 2014
SETA collaboration/ partnerships with TVET colleges and universities	The University of Western Cape, University of Zululand, University of South Africa, Wits University and University of Fort Hare have collaborated with the HWSETA and implement key activities and programmes. 18 TVET colleges collaborate and implement key programmes.	Admin and discretionary grant Budget availability	Identify research projects to be conducted in partnership with the universities. Develop Memorandum of Agreements between the HWSETA and the mentioned universities and TVET's to formalise and Ensure that the partnership is effective and of value TVET colleges to offer HWSETA programmes	3rd Quarter 2013/14 financial year	SDP Executive Manager , ETQA Executive Manager and RIME Executive Manager	The CEO, Exco, ETQA SC, SD SC and Board Quarterly	Achieved. MoUs and MoAs between the HWSETA and the following universities were signed on different projects and programmes: -Durban University of Technology (Development of learning materials for 3 qualifications (i.e. National Certificate Occupational Hygiene & Safety NQF Level 3; FET Certificate Occupational Hygiene & Safety NQF Level 4 and National Certificate Occupational Health, Safety & Environment NQF Level 2); Project-funding teaching aids in a form of cadarvers for the next 2 years; and Board Effectiveness Assessment Project) • University of the Free State (Postgraduate Research Bursary Programme) • Walter Sisulu University (Undergraduate Bursary Programme for B. Degree in Demography and Population Studies, plus another project called Turnaround Intervention for WSU budgeted for R30 mil) • Nelson Mandela University (Undergraduate Bursary Programme and Undergraduate Bursary Programme for B. Curationis, Medical Nurses and Social work) • University of South Africa (Postgraduate Research Bursary Programme) • University of Fort Hare (Postgraduate Research Bursary Programme) • -University of Kwazulu-Natal (Postgraduate Research Bursary Programme) • University of Limpopo (Postgraduate Research Bursary Programme) • University of Zululand (Postgraduate Research Bursary Programme) • University of Cape Town (Postgraduate Research Bursary Programme) • -Wits University (Postgraduate Research Bursary Programme) • University of North West (Undergraduate Bursary Programme for B. Degree in Demography and Population Studies) During 2012/2013 the HWSETA approved nine TVET colleges where 889 learners will be supported in pre-apprenticeship and N-courses. By March 2013 a total of 270 learners were registered and more will be registered at later intake dates during the 2013 academic year. The HWSETA has partnered with four TVET colleges to train learners from rural areas in ECD (NQF level 4) and 8 TVET colleges to train learners on ECD (NQF level 5)
PIVOTAL programmes	PIVOTAL programmes are identified and supported as highlighted in the SSP	Discretionary grant budget availability	Identify PIVOTAL programmes and employers to place students and learners with Support PIVOTAL programmes as per the APP and budget	2nd Quarter 2014	RIME, SDP and ETQA Executive Management and CEO	The CEO, Exco, ETQA SC, SD SC and Board Quarterly	Achieved. In the health sector most of the entry-level learning paths can be classified as pivotal programmes. Learning paths for a number of occupations in the social development sector may also be categorised as such. The HWSETA Learnership model is pivotal in nature as it is employer driven with high component of workplace experience. The learnerships are also occupationally directed and linked to employment.

Recommendations	Priority and justification QIP: what is done or to be completed.	Resources needed (human and financial)	Action	By when	By Whom	Structure/ person to monitor or sign off	Progress Report September 2014
Usage of OFO in skills analysis and reporting	SSP is reviewed to include the usage of OFO version 2013 in the 2014/15 financial year	Administration budget availability	Change the usage of OFO code to version 2013. Workshop employers on the WSP submission requirements and use of OFO version 2013 Draw scarce and critical skills and Pivotal List with OFO codes version 2013	1st and 2nd Quarter 2014/15	RIME, SDP and ETQA Executive Management and CEO	The CEO, Exco, ETQA SC, SD SC and Board Quarterly	Achieved. This has been achieved in the 2014 SSP Annual Update. This is inclusive of OFO codes in the Scarce Skills List and Pivotal List
Targets with budgets included in the SSP	SSP is reviewed to include the quantitative and qualitative targets and the budget	None	Include in the strategic plan chapter of the SSP measurable qualitative and quantitative targets to be achieved in line with the SMART principle Incorporate the budget to be utilised by the HWSETA in meeting its strategic objectives in the SSP annual update	3rd Quarter	RIME, SDP and ETQA Executive Management, CFO and CEO	The CEO, Exco, ETQA SC, SD SC and Board Quarterly	Achieved. Detailed quantitative and qualitative targets and budget have been incorporated into the 2014 SSP Annual Update.
Registered Learnerships with DHET	Expired and new learnership are identified and registered with the DHET/QCTO/SAQA	Admin and Discretionary budget availability	Engage SAQA/QCTO in relation to the registration of new qualifications Engage with key employers such as DSD and DoH in respect of support for new qualifications in areas such as mid level skills	Ongoing	SDP and ETQA Executive Managers	CEO, SDP SC, ETQA SC and Exco	Achieved. A new qualification for pharmacy general assistant is currently being developed at NQF level 4 and the HWSETA is a Qualification Development Partner (QDP) with the South African Pharmacy Council. The HWSETA has committed itself in the registration and funding of learnership for this mid-level skill. A new qualification “Community Health Work” pitched at NQF level 3 and occupationally based, has been developed and submitted to SAQA for registration. Currently awaiting feedback from SAQA.
Improving the HWSETA internal research capacity	Appoint staff and research partners to operationalise research strategy and implement the research agenda for the financial year 2014/15 Appointed a research partner to assist in the annual update of the SSP for the year 2014, and also to share research skills to strengthen internal research capacity	Admin and Discretionary budget availability	Appoint 3 research interns for a maximum period of 12 months to strengthen internal research capacity. Mentor the research interns through coaching with a possibility of appointing 2 of those research interns on a permanent basis. Send all research staff to research methods training at least once a year. Review the performance agreement of research staff to include one publication per year	2nd Quarter in 2014/15	RIME Executive Manager and Corporate Services Manager	The CEO, CS and RIME Executive Manager	90 achieved. Monitoring and Evaluation Manager has been appointed to strengthen the HWSETA research capacity. Two researchers have been appointed. A head-hunting process for the position of an Impact Assessment practitioner responsible for impact studies on the HWSETA projects and programmes has commenced. Anticipate to finalise the recruitment process in October 2014.

ANNEXURE F
HWSETA's Pivotal Skills List

SETA Name	Short/Medium / Long Term	Period	Occupation Code	Occupation	Specialisation/ Alternative Title	Intervention Planned By The SETA	NQF Level	NQF Aligned Y/N	Quantity Needed	Quantity To Be Supported By SETA	0-100	101-1000	1001 & Above	Comments
HWSETA	MEDIUM	2014/15	263507	Social Worker	Supervision Substance abuse Trauma and interpersonal violence	Bursary Programme for Professional Degree	4 to 8	Y	6986	175		175		Mostly needed in EC (Kind Sabata Dalindyebo, Makana, Nelson mandela Metro, Lukanji, Mbhashe, Maletswai, Umzimvubu, Baffalo City), KZN (Umsunduzi District Municipality) and GP (JHB Metro). HWSETA supported 373 learners throught the bursary programme in 2013/14. This is over and above the DSD Scholarship Programme.
HWSETA	MEDIUM	2014/15	226201	Pharmacist	Hospital Pharmacist Retail Pharmacist Pharmacist Assistant/Technician	Bursary Programme for Professional Degree, Learnership programme & Internship	5 to 8	Y	2282	1386			1386	Mostly needed in KZN (Ethekwini), MP (Mbombela) and GP (JHB Metro). 42 students studying towards a Bachelor of Pharmacy have been supported by the HWSETA through the Bursary Programme in 2013/14 1303 students (Pharmacy Assistant) were supported by the HWSETA through the Learnership Programme in 2013/14.
HWSETA	MEDIUM	2014/15	222108	Registered Nurse	Medical and Surgical	Bursary Programme & Learnership Programme	5 to 8	Y	2026	200		150		Mostly needed in KZN (Umnambithi, Ulundi & Umhlathuze), EC (Umzimvumbu) & NW (Mafikeng). 1646 learners were supported by the HWSETA through the Learnership Programme and 72 through the Bursary Programme in 2013/14.
HWSETA	MEDIUM	2014/15	341201	Community Worker	Community Health Worker Community Development Worker Community Development Practictioner	Learnership Programme and Skills Programme	2 to 5	Y	1283	200		200		Mostly needed in EC (Kind Sabata Dalindyebo, Makana, Nelson mandela Metro, Lukanji, Mbhashe, Maletswai, Umzimvubu, Baffalo City), KZN (Umsunduzi District Municipality) & FS (Mangaung). The HWSETA together with the DoH and QCTO have developed a Community Health Work Qualification pitched at NQF level 3. 56 Students (Health Promotion Qualification) from the EC were supported in partenrship with Walter Sisulu University in 2013/14

SETA Name	Short/Medium / Long Term	Period	Occupation Code	Occupation	Specialisation/ Alternative Title	Intervention Planned By The SETA	NQF Level	NQF Aligned Y/N	Quantity Needed	Quantity To Be Supported By SETA	0-100	101-1000	1001 & Above	Comments
HWSETA	LONG	2014/15	221101	General Practitioner	Anesthesiologist Cardiologist Dermatologist Gynaecologist Neurosergeons Obstetrician Oncologist Paeditrician Urologist Physician Psychiatrist	Bursary Programme for Professional Degree	8	Y	1280	50	50			Mostly needed in KZN (Umsunduzi, Umhlathuze and Ethekwini Metro), MP (Mbombela) & GP (JHB Metro). 60 students were supported by the HWSETA through the Bursary Programme in 2013/14. This is over and above the DoH Scholarship Programme
HWSETA	SHORT TO MEDIUM	2014/15	222104	Registered Nurse	Community Health	Bursary Programme, Learnership Programme	2 to 4	Y	564	200		200		Mostly needed in the EC (King Sabata Dalindyebo).
HWSETA	MEDIUM	2014/15	222105	Registered Nurse	Critical and Emergency	Bursary Programme, Learnership Programme	5 to 8	Y	429	200		200		Mostly needed in the EC. 72 students from the EC were supported in partnership with Walter Sisulu University in 2013/14
HWSETA	MEDIUM	2014/15	321101	Medical Diagnostic Radiographer	Radiologist	Bursary Programme	5 to 8	Y	389	200		200		Mostly needed in KZN (Ulundi)
HWSETA	MEDIUM	2014/15	263508	Child and Youth Care Workers		Learnership Programme	4 to 8	Y	264	200		200		Mostly needed in KZN (Msunduzi) and FS (Mangaung). The HWSETA trained 427 learners in Child and Youth Care through its Learnership Programme
HWSETA	MEDIUM	2014/15	222201	Midwife		Bursary Programme & Learnership Programme	5 to 8	Y	172	172		172		Mostly needed in GP (JHB Metro)

ANNEXURE G Synopsis

This synopsis highlights key national policies that impact the health and social development sector as well as factors that constitute major shifts in the sector. The synopsis sets out skills needs for the sector and briefly outlines the methodology used to determine skills development needs. Finally, the skills development priorities for the HWSETA are identified together with the interventions and resources to be allocated to address those priorities.

Key Policy Drivers

A multitude of national policies and Constitutional principles impact strategic planning and service delivery in the health and social development sector, and thus delineate the skills sets required for the sector. Key policy drivers include the Constitution of the Republic of South Africa, 1996; the National Development Plan 2030, the National Health Insurance Scheme; the White Paper for Social Welfare and the White Paper for Post-school Education and Training.

The National Development Plan (NDP) addresses South Africa's vast socio-economic challenges and provides a multi-dimensional framework with priorities to eliminate poverty, reduce inequality and create a decent living standard for all. Prominence is given to three vital areas: economic growth and job creation; education and skills; and building a capable and developmental state. Two of the central priorities of the NDP are to improve the quality of education, skills development and innovation, and to build the capability of the state to play a developmental role. For this purpose specific interventions are needed to build human capital and service capacity through education, vocational training and work experience.

According to the NDP, the health system as a whole requires strengthening and the human capacity to provide care and manage services must be developed. A key goal is the introduction of National Health Insurance (NHI) to provide universal healthcare coverage and primary healthcare teams to care for families and communities. The NDP envisages a social development system that provides social protection and adequate social welfare services for vulnerable groups, children and the elderly. Social protection services to children will focus on improving access to nutrition, healthcare, education, social care and safety. Early childhood development is of national importance. The NDP conceives of an effective social development system that delivers better results for families and marginalised communities. Another goal is to provide income support to unemployed persons in the form of public works programmes, community development and labour market incentives that offer training and skills development. The NDP recognises that these goals can only be attained if the skills deficit in the social welfare sector is addressed.

The White Paper for Social Welfare of 1997 reshaped welfare policies and moved the delivery of social services to a rights-based approach. Almost two decades on the White Paper continues to give direction to a developmental and preventive family-centred and community-based approach for social welfare interventions. New legislation which became operational since 2010 such as the Children's Act, 2005 and the Older Persons Act, 2006 commands the provision of social welfare services that acknowledges and protects human rights, improves the quality of life and enables human development. The NDP also supports the provision of developmental social services to advance human dignity and to create human capability to participate fully in the economic, social and political life of the country.

In the animal health sector, policy goals to expand agricultural production, maintain food security and improve livelihoods are driving the demand for veterinarians, veterinary technologists, veterinary health technicians and primary animal healthcare workers.

The 2013 White Paper for Post-school Education and Training outlines strategies to create an integrated post-school education and training system that meets the country's developmental needs as well as those of workplaces in the public- and private sector. A core objective is to strengthen cooperation between education and training institutions and the workplace. In future more prominence will be given to work-integrated learning to better prepare learners for the labour market. The roles of SETAs are re-defined to "mediate between education and work", with their main focus on developing the skills of the existing workforce and to provide the skills pipeline to existing workplaces. SETAs will support training programmes that lead to qualifications and awards recognised by industry, rather than on short courses. Work-based learning such as learnerships and internships in the non-artisan fields will also be expanded, and SETAs will be expected to facilitate work-based partnerships between employers and educational institutions.

The National Skills Development Strategy (NSDS III) sets eight strategic goals for skills planning and skills development, namely, credible skills planning; increased access to occupationally focused training; growth of the public TVET college system to respond to the country's skills needs; improved literacy and numeracy skills amongst youth and adults; better use of workplace-based skills development; training and development support for cooperatives, small enterprises, NGOs and workers; building public sector capacity for improved service delivery and to adopt a professional, developmental role; and building career and vocational guidance.

Major Shifts in Health and Social Development Sector

Adjustments are being made to the way health and social services are delivered with the introduction of mid-level workers and changes to the scope of practice of many health professionals. Increasingly the focus is on community-based care to treat the ill and maintain the health of the healthy and on support to families and persons in need. Social welfare services are becoming more development directed and the service-delivery platform is being broadened. Non-Governmental organisations (NGOs) are vital delivery partners of government to provide a range of social development services, but often lack the capacity to serve communities, train workers and meet the required standards of corporate governance.

The 2011 Green Paper on the National Health Insurance Scheme confirms a major shift in national healthcare policies, away from hospital-based care to a range of primary healthcare services delivered in health districts via home-based services, school-based services and agents in municipal wards. The Human Resources for Health South Africa – HRH Strategy for the Health Sector: 2012/13-2016/17 sets targets for the production and deployment of health professionals and health workers to enhance access to services and improve quality in the health system. The Department of Health (DoH) identifies seven key foundations to improve health outcomes: to deploy community health workers (CHWs) in primary health care teams; to enhance nursing capacity and provide for a predominantly nurse-based health system; to plan for skilled mid-level workers to address the acute shortage of health professionals; to increase the number of general health professionals; to increase the number of selected specialist doctors; to increase the number of public health specialists; and to develop more academic clinicians. The strategy recommends that stakeholders such as the DoH, statutory councils, faculties of health sciences and SETAs focus their actions in three thematic areas: improving the supply of health professionals and equity of access to trained health workers; education, training and research; and improving the working environment of the health workforce.

Various reports by the Department of Social Development (DSD) confirm the severe shortage of social workers and social auxiliary workers to deliver the comprehensive social services envisioned by legislation for children, the elderly, youth, families, children in conflict with the law, and communities affected by social crime. Despite a substantial Government-funded scholarship programme to boost the ranks of registered social workers, the absorption of graduates in the public sector has been disappointing, mainly due to budget and structural constraints. The NDP underscores the need to boost the numbers of social service professionals and sub-professionals in five categories in particular: social workers, auxiliary or assistant social workers, community development workers, child and youth care workers and early childhood development (ECD) practitioners. Efforts are underway to establish the various the emerging social service professions and occupations; to outline scopes of practice; to set qualification frameworks; and to regulate them.

A major shift taking place in the health and social development sector pertains to education, training and skills development. Globally, and also in South Africa, it is recognised that health professionals and social services workers need to be trained across multiple health and social contexts so as serve the needs of local populations. Higher-level qualifications required for entering several fields in health sciences and social welfare services are under development. Several entry-level qualifications in the field of nursing, pharmacy, pre-hospital emergency medical services and social auxiliary work are moving away from the FET level to a higher education platform. This development has implications for training capacity at HEIs and the skills development needs of the current workforce.

The recent introduction of generic norms and standards for social services will identify skills gaps among current social work professionals and drive the need for greater access to workplace-based learning and for the development of occupation-specific technical skills.

Methodology Used to Identify Skills Needs

Information and data on skills development needs were obtained from various sources. Strategic documents, including strategic plans of the DoH and DSD, as well as academic articles relevant to skills development in the sector, were used. Budget- and expenditure reports published by the National Treasury and a number of strategic documents that became available after the submission of the SSP in January 2014 were used. Feedback received from interviews held with sectoral- and industry experts and role-players in the sub-sectors for human health, animal health and social development was incorporated in this SSP update.

Various data sources were used to analyse and construct a profile of the health and social development sector. Data from the workplace skills plans (WSPs) submitted by private sector employers to the HWSETA were combined with data extracted from such plans submitted by public sector employers to the Public Service SETA (PSETA) and used to determine the scarce skills list. MEDpages, a comprehensive private database of health service providers in the private sector, was used to analyse employment in the private healthcare sector. Numbers from the MEDpages database were used for professionals who typically operate from small independent practices in the private sector. Data extracted from the registers of social service professionals, health professionals and para-professionals maintained by the statutory councils were analysed.

Information from the Education Management Information System (EMIS) and the Higher Education Management Information System (HEMIS) kept by the Department of Basic Education and the Department of Higher Education respectively was also used. Extensive desktop research was conducted on various aspects of the South African health and social development sector and incorporated into the SSP.

Overview of Skills Development Needs in the Sector

The demand for skills exists at all levels in the health and social development sector: from high-level specialist skills (e.g. community development professionals, general medical practitioners, specialist professional nurses, environmental health practitioners and social workers) to mid-level skills (e.g. enrolled nurses, emergency care workers, pharmacy mid-level workers, non-clinical technicians and artisans) to low-level skills (e.g. community health workers, community caregivers and ancillary health workers).

Primary and secondary research by the HWSETA indicates a significant need to expand workplace-based training and to provide experiential learning opportunities in the sub-sectors for health, social welfare and veterinary services. In the health sector, capacity in clinical training platforms is severely strained and more health academics and health educators are needed to train and guide learners in the health sciences. With the introduction of new qualification frameworks set in higher education, bridging programmes are required to elevate the skills base of the current workforce in areas such as nursing, emergency care and pharmacy.

More students in the various social services fields require access to better quality workplace training and for this purpose the ranks of workplace supervisors, assessors and moderators need to be strengthened.

In the social development sector the most pressing skills development need is for supervision training of social workers. More social workers require occupation-specific technical training to supervise and guide lesser experienced colleagues and social auxiliary workers (SAWs). Another priority is improving the skills base of SAWs and for the HWSETA to strengthen quality assurance processes to ensure that the training of these mid-level workers is of the required standard. Further education and training interventions are needed to improve the skills base and professionalism of the current social services workforce, especially with regard to occupation-specific technical skills, specialisation and work-readiness.

In the health sector, vastly improved management and leadership skills are needed to provide functional services across all levels of facilities and to manage the health workforce. In particular, skills development is needed in the areas of leadership and general management, quality and performance management, resource utilisation, information technology, managing facilities, financial management, procurement and accountability (including the ability to hold staff accountable).

In order to deliver effective social and development services on behalf of the state, NGOs require skills in governance and organisational management.

In the animal health sector, veterinarians and para-veterinary professionals are needed. Veterinary professionals need “day one skills” to be ready for general animal health practice, while large numbers of animal health technicians need to be trained in primary animal healthcare.

HWSETA Skills Development Priorities and Interventions

The HWSETA will adopt strategies to improve corporate governance and service delivery to stakeholders. Effective financial controls will be put in place to support timely and automated reporting in accordance with regulatory and Board requirements.

In accordance with the developmental and transformation priorities of the NSDS III, the HWSETA will give preference to skills development for disadvantaged learners who lack the relevant technical, reading, writing and numeracy skills to access employment. The HWSETA's interventions are specifically linked to the NSDS III objectives, namely:

1. Establishing a credible institutional mechanism for skills planning.
2. Increasing access to occupationally directed programmes.
3. Promoting the growth of a public TVET college system that is responsive to the sector, local, regional and national skills needs and priorities.
4. Addressing the low level of youth and adult language and numeracy skills to enable additional training.
5. Encouraging better use of workplace-based skills development.
6. Encouraging and supporting cooperatives, small enterprises, worker initiated, NGO and community training initiatives.
7. Increasing public sector capacity for improved service delivery and supporting the building of a developmental state.
8. Building career and vocational guidance.

The table below summarises the HW SETA's projects and programmes and their linkages to NSDS III. The HWSETA will continue to assess the success and impact of these skills development interventions and engage with stakeholders so as to contribute to the training and development needs of the sector.

	Sub-programme	No	Indicator title	Precise Definition	Five-year target	2015/2016 target	2015/2016 budget	NSDS III Objectives
ADMINISTRATION	**Research, Information, Monitoring and Evaluation**	5	Percentage artisans and unemployed learners funded by HWSETA find employment within 6 months of completion	This is an enumerator indicator to indicator 4 and 1 for unemployed learners. It measures the number of artisans and unemployed learners, after going through training, who obtains employment. It seeks to establish the needs for artisans and other critical skills in South Africa based on the principle of supply and demand. A qualified artisan is a person who has been awarded a certificate of competency. The ILO defines 'decent work' as productive work which generates an adequate income, in which workers' rights are protected, and where there is adequate social protection providing opportunities for men and women to obtain productive work in conditions of freedom, equality, security, and human dignity . This indicator also measures the number of months an unemployed learner takes to obtain a decent job. Obtaining employment will be measured from the day an employment offer is made.	80% (11365)	80% (1380)	Admin budget	1
		12	Number of applied research reports completed and signed off that inform planning	A research activity is defined as any perusal of materials related to skills development and HWSETA, such as desk review, surveys, etc. Applied research is a form of systematic inquiry involving the practical application of science. It accesses and uses some part of the research communities' (the academia's) accumulated theories, knowledge, methods, and techniques, for a specific, often state-, business-, or client-driven purpose. Applied research is compared to pure research (basic research) in discussion about research ideals, methodologies, programs, and projects. Evaluation of training includes research reports on areas such as dropout rate and analysis and impact analysis.	31	5	R 563 000	1
		13	Number of post graduate research students funded in the health and welfare field	This indicator measures the number of post graduate research students funded by HWSETA. This indicator also measures the number of support programmes funded to support develop and expansion of research in the sector. Counting from this indicator will commence upon the implementation of the programme. Lastly this indicator will also measure the number of post graduate students with access to employment opportunities after graduation. New post graduate research students refer to registered students in higher education institutions for higher degrees that have a research component in the curriculum and have registered for the first time. Funded refers to issuing of funding approval letter and signing of Memorandum of Agreement and where applicable release of tranche payments as per the Memorandum of Agreement.	540	75	R 4.770 mil	1, 2
	Corporate Services	15	Number of learners reached through HWSETA career development awareness programmes	This indicator measures the number of career awareness drives and documents created and distributed with information on the labour market to guide learners on career opportunities in specified areas of work. This indicator also measures the number of learners who are undergoing the career development/guidance programme. Career guides will be mapped to qualifications for all sectors. Reached in this context refers to learners recorded in the register of career fairs or career exhibitions.	79 000	11 500	R 500 000 Admin. budget	8
		18	Percentage of filled positions in the HWSETA	This indicator measures the fraction of jobs in the HWSETA that are open but have not been filled. Vacancy rate is defined as the number of job vacancies to the sum total of employment and job vacancies.	94% (84)	94% (81)	R 850 000 Admin budget	
		20	Percentage of HWSETA processes automated and integrated	This indicator measures the fraction of work processes that are automated and integrated. It includes the efficiencies derived from the use of the document management system and the creation of a paperless environment. Automation and integration refers to the development and deployment of the ERP system as approved by the HWSETA board	95% (111)	70% (36)	R 2 mil	

SKILLS DEVELOPMENT PRPOGRAMMES AND PROJECTS

Sub-programme	No	Indicator title	Precise Definition	Five-year target	2015/2016 target	2015/2016 budget	NSDS III Objectives
Projects	2	Number of employers participating in work-based training	This indicator measures the number of employers (all organisations working with HWSETA to implement skills development programmes) who are implementing employee development programmes. This includes private and public entities. Evaluation and participation means workplace has been validated and the learners allocated as per the approval schedule and the Memorandum of Agreement signed.	755	140	Included in learnerships and skills projects budgets	2
	4	Number of apprentices funded and enrolled to become artisans through HWSETA funding	This indicator measures the number of artisans trained with HWSETA funding. (The artisan is a technically skilled person. Whilst he/she will mainly do manual work, these skills require a fairly high degree of scientific and engineering knowledge and a considerable amount of experience in the electrical trade).The tasks of the artisan in the workplace could entail: installation, maintenance, repairs, and servicing and operating of, for example, control systems, generators, transformers, power lines, etc .Funded refers to issuing of funding approval letter and signing of Memorandum of Agreement and where applicable release of tranche payments as per the Memorandum of Agreement. Enrolled refers to registration with both the training institution and HWSETA Seta Management System This is a denominator to indicator 5.	1000	100	R 6.500 m	2
	6	Number of HWSETA funded students in higher education institutions funded for high-level scarce skills	This indicator measures the number of learners who graduate in courses listed as scarce skills. Scarce Skills refers to those occupations in which there is a scarcity of qualified and experienced people, currently or anticipated in the future, either because (a) such skilled people are not available or (b) they are available but do not meet employment criteria. Funded refers to issuing of funding approval letter and signing of Memorandum of Agreement and where applicable release of tranche payments as per the Memorandum of Agreement.	1735	280	R 11.4 mil	2
	7	Number of students enrolled for work-experience and experiential learning programmes funded by the HWSETA	Experiential learning refers to a spectrum of meanings, practices, and ideologies which emerge out of the work and commitments of policy makers, educators, trainers, change agents, and 'ordinary' people all over the world. This indicator seeks to collect data on a number of learners who are practicing the theory learnt in class or at an organisation to which they are attached as a partial fulfilment of the requirements of their course. Enrolled refers to registration with both the training institution and HWSETA Seta Management System Workplace experience and experiential learning refers a course, or a portion of a course, requiring students to participate in a supervised workplace experiential learning, directed field study, internship, cooperative, or cooperative work term course that is related to their program of study or training. It is also viewed as having four basic elements of learning in the workplace: experience, practice, conversations and reflection where at least 70% of workplace learning is through on-job experiences and practice 20% of workplace learning is through others (coaching, feedback and personal networks) 10% of workplace learning is through formal off-job training (Jennings, C: 2009).	4084	400	R 9.6 mil	2, 3
	9	Number of cooperatives in the health and social development sector whose skills needs are funded by the HWSETA	This indicator measures the number of co-operatives whose skills development needs are assessed for the purposes of closing the gaps. It also measures the number of co-operatives linked with trainings programmes meant to benefit their members for its development and growth. Lastly this indicator measures the number of projects supported by the NSF for the benefit of the co-operatives and small businesses. The National Skills Framework provides the basis for high quality, flexible, nationally consistent vocational education and training which meets industry needs and which employers can trust. Co-operatives are defined as an autonomous association of persons united voluntarily to meet their common economic, social, and cultural needs and aspirations through a jointly owned and democratically controlled enterprise. Co-operatives are those organizations established in terms of the co-operatives Act, 2005 (Act 14 of 2005). Funding in respect of these organizations includes start-up funding and skills development funding linked to worker initiated training.	145	20	R 1 mil	6

SKILLS DEVELOPMENT PRPOGRAMMES AND PROJECTS

Sub-programme	No	Indicator title	Precise Definition	Five-year target	2015/2016 target	2015/2016 budget	NSDS III Objectives
Projects	10	Number of small and emerging businesses funded	This indicator measures the number of small and emerging businesses that have undergone skills needs inventory for the purposes of expanding developmental support. The indicator also measures the number of projects identified and designed to help small and emerging businesses to develop and grow. A small or emerging business is a business that is privately owned and operated, with a small number of employees and relatively low volume of sales. Small businesses are normally privately owned corporations, partnerships, or sole proprietorships. Funded refers to issuing of funding approval letter and signing of Memorandum of Agreement and where applicable release of tranche payments as per the Memorandum of Agreement.	685	100	R 1.3 mil	6
	11	Number of skills development projects funded to support NGOs, Cobs and trade unions	This indicator measures the number of skills development projects meant to benefit NGOs, CBOs, and Trade Unions. The scope will be limited by the number of users who can access the projects, the people affected, the partners involved, or other restrictions as appropriate. Pilot projects could be initiated in new areas whose purpose is to test whether the projects are working as they were designed.	1145	175	R 4. 725m	6
	22	Number levy-exempt organisations funded by the HWSETA	This indicator measures the number of workers who benefit from funding earmarked to non-levy paying organisations. Levy paying employers who submit Workplace Skills Plans and Annual Training reports qualify to receive mandatory grants based on their submission having been made by the 30 April 2014. This submission must be compliant in all respects as determined by the HWSETA.	760	120	R 5. 042 m	
	17	Number of learners in TVET colleges and other public colleges (and the number of associated learners) enrolled for vocational training courses funded by the HWSETA	This indicator measures the number of TVET colleges and other public colleges offering vocational training. TVET colleges include the former Technical Colleges although Colleges of Education, Manpower and Skills centres, and some former community colleges were also merged during the restructuring process with Technical Colleges to form the new TVET colleges. Vocational training will be defined as an organised educational programme that is directly related to the preparation of individuals for employment. The system prepares learners for careers or professions that are traditionally non-academic and directly related to a trade, occupation, or 'vocation' in which the learner participates. Public colleges include pubic nursing colleges and other colleges reporting to a Government Department or State Institutions. Enrolled refers to registration with both the training institution and HWSETA Seta Management System. Funded refers to issuing of funding approval letter and signing of Memorandum of Agreement and where applicable release of tranche payments as per the Memorandum of Agreement.	9450	1 000	R 9 mil	3
	14	Number of projects funded through discretionary grant aimed at the public sector education and training	This indicator measures the number of funded projects focused on improving the institutional framework for public education and training so as to improve delivery of services in those areas. Funded refers to issuing of funding approval letter and signing of Memorandum of Agreement and where applicable release of tranche payments as per the Memorandum of Agreement.	29	5	R4.1 mil	7
Learning programmes	1	Number of programmes funded through grants to develop and address middle level skills	Programmes will be defined to mean strategies and combination of activities to meet identified needs. Middle level skills are those above routine skills but below professional skills. This includes, but is not limited to Pharmacist assistants, Medical assistants, and Auxiliary Social Workers etc.	32	4	R 4.4 mil	2
	3	Number of learners registered in learnership training programmes	This indicator measures the number of learners enrolled in learnership training programmes funded by the HWSETA. This indicator includes employed and unemployed learners. Registered means learner, employer and training provider details captured in the Seta Management System. Funded refers to issuing of funding approval letter and signing of Memorandum of Agreement and where applicable release of tranche payments as per the Memorandum of Agreement. Funded refers to issuing of funding approval letter and signing of Memorandum of Agreement and where applicable release of tranche payments as per the Memorandum of Agreement.	21500	2450	R 64.679 mil	2, 5

	Sub-programme	No	Indicator title	Precise Definition	Five-year target	2015/2016 target	2015/2016 budget	NSDS III Objectives
SKILLS DEVELOPMENT PRPOGRAMMES AND PROJECTS	Learning programmes	8	Number of employed and unemployed learners in skills programmes funded by the HWSETA	This indicator measures learners on skills programmes or projects developed to benefit employed workers and unemployed by developing their work skills. HWSETA will only count when programmes are being implemented. Unemployed and employed workers undergoing training on skills programmes will be counted when an employer selects and registers them with the HWSETA in order to improve their skills. Skills programmes are defined as per SAQA definition and include short courses for the employed workers	19150	6100	R 3.2 mil from discretionary grant, Balance funded from mandatory grants	2, 3, 8
		21	Number of learners registered for AET programmes funded by the HWSETA	This indicator measures the number of learners registered for Adult Education and Training that is funded by the HWSETA. This indicator includes those learners funded through partnerships with employers or partnerships with training institutions who are registered examination centres. Registered means learner, employer and training provider details captured in the Seta Management System.	5954	1440	R 5.76 mil	4
		16	Number of TVET College lectures placed in work experience with employers in the reporting period	This indicator measures the number of public TVET college lecturers exposed to the workplace in the health and welfare sector. The objective of the exposure is to ensure that these lecturers are updated on the latest developments and innovations by employers so that they impact this practical knowledge to their students. Placement refers to temporal visitation to employer premises to gain work related experience in the aspect of work that relates to the training programme the lecturer is engaged in.	190	30	R 75 000	
QUALITY ASSURANCE AND QUALIFICATION DEVELOPMENT		23	Number of partnership agreements signed through MoUs outlining areas of collaboration	This indicator measures the number of collaborating partners who have signed a Memorandum of Understanding or a service level agreement to collaborate with HWSETA. A collaborating partner is a person, institution, or association that has signed a service level agreement with HWSETA. Partnerships herein include Universities, TVET Colleges, Councils, Statutory bodies, employer bodies, communities of practice, etc	79	10	R 5 mil	2, 3
		19	The number of skills development training providers accredited to offer full qualifications	This indicator measures the number of new training providers accredited and current training providers re-accredited by the HWSETA in the reporting period. This includes the process of approving learning programmes, evaluating the QMS and conducting site visits. For re-accreditation we would also have conducted successful verification of the learners' achievements. Assessors and moderators will have to be currently registered against the qualifications against which the training providers are accredited or re-accredited. Skills Development Training Providers refers those as defined by the SAQA Act and the HWSETA policy. Accreditation refers to meeting the criteria as set in the SAQA Act and the QCTO Act and policies/regulations and the HWSETA accreditation policies.	280	40	Admin. budget	

ANNEXURE H
Covering Letter

Enq: Ms. Yvonne Mbane
Ref: 14/SSP/L000251

29 September 2014

The Director- General
Private Bag X 174
PRETORIA
0001

Tel: (012) 312 5136
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E-mail: modipane.ma@dhet.gov.za

Dear Mr. G Qonde

HWSETA 2015 - 2020 SECTOR SKILLS PLAN UPDATE

Attached hereto please find the HWSETA Sector Skills Plan, Continuous Improvement Plan, Pivotal Skills List and a Synopsis Chapter for your attention.

The HWSETA 2015 - 2020 Sector Skills Plan reviewed and approved by the duly constituted HWSETA Board comprised of the employer, Labour and Government (DSD&DOH) representatives.

Thank you,
Yours faithfully,

Mr. Hennie Groenewald
Chairman of the Board meeting
held on 25/08/2014

Ms. Yvonne Mbane
Chief Executive Officer

Attachment: **Sector Skills Plan, Continuous Improvement Plan, Pivotal Skills List and Synopsis Chapter**

Attention: Modipane Mahlats

Acknowledgement of receipt.

Received by:____ Date: ____

Signature: ____

Notes

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Phillip Frame Road
Chiselhurst
East London, 5247
043 726 9406/7

Kwa-Zulu Natal/Free State

Clifton Place Ground Floor
19 Hurst Grove
Musgrave
Durban, 4001
031 202 5972/3

Limpopo/Mpumalanga

4A Landross Mare
Polokwane, 0699
015 295 4302

Western Cape/Northern Cape

Tijger Park Building 3
Ground Floor
Willie van Schoor Avenue
Bellville
Cape Town, 7530

Satellite Office:
Northern Cape

Northern Cape Urban TVET College
37 Long Street
Kimberley, 8301
053 839 2083

Satellite Office:
Eastern Cape

King Hintsa TVET College
Admin Centre
218 Mthatha Road
Butterworth
4960
047 401 6400

Health and Welfare Sector
Education and Training Authority
HWSETA