Integrating Social Determinants into Health Workforce Education and Quality Standards - A Case Study: Eswatini

Background

Introduction:

There is a global consensus that addressing the social determinants of health (SDoH), the circumstances in which people are born, grow, live, work, and age, is key to reducing health inequities. To deliver relevant, quality care effectively and equitably, the health workforce—including health professionals, regulators, planners, managers, and community health workers—must understand the complex factors that influence the health of patients and communities, and they must possess competencies to mitigate the negative effects of these factors.

The Local Health System Sustainability Project (LHSS) developed a case study series to identify, analyze, and document successful efforts to integrate SDoH into health workforce education and training, regulation and quality assurance, and service delivery. The project identified the Eswatini Nursing Council (ENC) as one of only a few nursing councils in the Africa region that has collaboratively developed national entry-to-practice competencies for four nursing qualifications (General Nursing, Midwifery, Community Mental Health Nursing, and Community Health Nursing) that also account for SDoH.[1, 2]

This case study describes and analyzes the ENC's efforts to strengthen the competence of nursing graduates to address the population's health needs by introducing entry-to-practice competencies as the basis for a national licensing examination, and for incorporating SDoH into these competencies. The ENC's rigorous and collaborative process offers insights for other countries of similar contexts aiming to bridge the theory-practice gap by aligning competencies with health needs and SDoH.[1,2]

Objectives of this case study are:

1. Explain the key steps for entry-to-practice nursing competencies development and the integration of SDoH into these competencies.
2. Describe the perceived enablers and barriers for integrating SDoH or non-medical factors into entry-to-practice nursing competencies and identify successful practices.
3. Understand the perceived anticipated effects of integrating SDoH into entry-to-practice nursing competencies for student learning and clinical practice.

Methodology:

The case study team chose the ESC based on expert recommendations. After obtaining international and local ethics approval, the team reviewed published articles, and the websites and policy documents of relevant authorities. They conducted semi-structured interviews with four expert members of the entry-to-practice competencies development team: three academic and clinical faculty from nursing education institutions based in rural and urban regions and one regulatory expert from the ENC.

Health System and Human Resources for Health Context:

The Kingdom of Eswatini (formerly Swaziland) is a small landlocked country in sub-Saharan Africa (SSA) and is bordered by South Africa and Mozambique. In 2020, almost 76 percent of the population of 1,184,821 lived in rural areas although the urbanization rate has slowly increased over the past decade.[3]

Table 1: Country Background Data

Income level	Lower middle income
Total population (millions), 2019	1,184,821
Prevalence of HIV among adults aged 15-49 (percent), 2020	26.8%
Life expectancy at birth (years, both sexes), 2018	59
Infant mortality (per 1,000 live births), 2020	37
Maternal mortality (per 100,000 births), 2017	437
National poverty rate, 2017	58.9%
Poverty headcount ratio at $1.90 a day (percent of population), 2016	29.2%
Access to health services (UHC effective coverage index), 2019	53.4%
Health expenditure (percent of total expenditure), 2018-2021	10.1%

The country has the world's highest prevalence of HIV, endemic tuberculosis, and widespread poverty and malnutrition (Table 1). The maternal mortality ratio is below the SSA average of 535 per 100,00 live births but well above the average of 412 for least-developed countries.

The infant mortality rate has decreased significantly, from 68 per 1,000 live births in 2005 to the current (2020) rate of 37, well below the SSA average of 50. Non-communicable diseases like diabetes and associated conditions, stroke, and ischemic heart disease fall within the country's top 10 health challenges.[3, 4]

In 2010 (latest available data), the private for- and not-for-profit sectors comprised 60 percent of health facilities in Eswatini; this included NGO vertical programs for HIV and AIDS, tuberculosis, and malaria, and an extensive network of mission hospitals and clinics.[5] Access to health services—i.e., progress toward Universal Health Coverage (UHC)—increased from 35.0 percent in 2010 to 53.4 percent in 2019.[3] Additionally, 80 percent of the population live within 8 km of a health care unit and over 60 percent have access to a unit within an hour.[5, 6]

Improving population health and the quality health care is a foundational thread in the country's Policy for Human Resources for Health (2012) and the Human Resources for Health Strategic Plan for 2012-2017. The policy and strategic plan emphasize strengthening regulation and quality assurance systems for health workforce education across the education pipeline. Ensuring health workforce skills match health priorities and needs, and improving the quality of care and health outcomes for rural and underserved populations is crucial for the country's development agenda. These and other national documents, for example, the Eswatini Health Essential Care Package, reference elements of the concept of SDoH such as the importance of addressing the social needs of and improving health and social services and access for rural populations, women, and disadvantaged groups (persons with disability, children, youth, and the elderly).[5-10]

Nursing Human Resources for Health Context:

Nurses constitute over 80 percent of the public and private sector health workforce and lead the implementation of the primary health care approach. Still, the distribution of the nursing workforce mirrors a skewed distribution of health services across the country's four regions. The unequal access to health services and nurses reflects the economic-geographic status of regions, disadvantaging the poorer and more rural regions.[5]

Notwithstanding the link between a sufficient and competent nursing workforce and health outcomes, the availability of nurses and midwives has not kept pace with population growth, health needs, and health expectations. Nurse and midwife availability has decreased by 1,789, from 4,706 in 2018 to 2,917 in 2020, far short of the target of 5,379 by 2020.[5, 11]

Many factors contribute to the severe nursing and midwifery shortage: burnout associated with the high burden of diseases including HIV and AIDS, workforce attrition due to HIV and AIDS, emigration, training deficits, inadequate clinical resources and equipment at all levels of service delivery, poor support and mentoring systems, poor renumeration especially in the public sector, and lack of funded government nursing posts.[5, 8, 12-15]

Nursing and Midwifery Education Context:

The ENC, established through the Nurses and Midwives Act of 1965, regulates, directs, and controls nursing and midwifery education, practice, and conduct in the country, for the benefit of all stakeholders. Part of its mandate is to protect the public from unsafe nursing practices. Currently, four nursing and midwifery education institutions (one government and three faith-based), accredited by the ENC and the Eswatini Council for Higher Education, offer a range of pre-service diploma and degree nursing programs within the higher education band.[2, 16] Clinical training sites include rural and urban clinics and health centers and hospitals accredited by the ENC.

In 2018, the ENC reduced and streamlined intake numbers across institutions and cohorts from approximately 80 per intake to 40 per intake to reduce the burden on clinical services and to ensure students had adequate opportunities for developing clinical competencies. This action followed growing concerns about the work readiness of graduates, including findings from Dlamini et al. that clinical managers, nurse educators, and new graduates themselves believed new graduates were not ready for practice and lacked the ability to implement theory in practice.[15] Closing the theory-practice gap and improving quality of care through regulated entry-to-practice competencies that apply to all nursing graduates and that also speak to the SDoH, was an imperative for the experts participating in this case study.

> 'Initially it [entry-to-practice competencies] was informed by concern raised in practice where there was a gap in between theory and practice among the new graduates. And then a situational analysis was done, and gaps identified which speak to the social determinants of health. So, in the whole process as much as we were looking at the competencies of the newly graduate nurses, we had to consider the community that they must serve and the community in which we live. So, whatever the competencies, they must speak to the social determinants of health.' (Regulatory expert, April 2022)

Entry-to-Practice Nursing Competencies Development and the Integration of SDoH in Eswatini:

The ENC's journey toward closing the theory-practice gap, beginning in 2010 with a national nursing task analysis by the ENC and culminating in 2020 with a national licensing examination based on a set of competencies aligned with the health needs of communities of service, is summarized in Figure 1. Through collaboration, peer review, and consensus, ENC's technical working group of 40 education and practice experts from the ENC and the Ministry of Health and the country's four nursing education institutions[a] produced a robust set of competencies and indicators for general nursing and the specialty areas of community health, midwifery, and mental health (Box 1 and Figure 1).[1, 2, 17]

Box 1: Steps for closing the theory-practice gaps through integration of the SDOH

1. Engaging key stakeholders and surveying the landscape
2. Generating preliminary competencies in general nursing and the specialty areas of midwifery, community health nursing, and mental health
3. Building consensus on competencies through national and international peer review
4. Identifying champions at the four educational institutions to coordinate and move the competency development process forward
5. Refining and validating the competencies in each curriculum of the four institutions
6. Formation of question development teams and questions in the four practice areas
7. Piloting and then implementing the license to practice examination

Figure 1: Eswatini's journey toward closing the theory-practice gap

The SDoH and Entry-to-Practice Nursing Competencies:

The entry-to-practice competencies framework specifically mentions the concept of SDoH and relevant competencies in the general nursing practice area.[17] For example, in providing holistic and safe care to all regardless of social identity characteristics (race, culture, sexual preference, religion, age, gender, or state of health) the general nurse must "*Demonstrate [s] knowledge regarding human growth and development, role transitions, and population health, including the social determinants of health.*" The framework is also replete with evidence of the different elements of the SDoH concept, across all practice areas and competency domains and indicators. For example, indicators for community health nursing speak to the social and cultural context within which health problems, health services, and access barriers/enablers occur (Box 2). The indicators for the provision of quality care appear in all practice domains.[17]

Box 2: Examples of indicators for community health nursing that mirror elements of the SDoH

- Identifies geographical, psychological, religious, economic, and cultural barriers to the utilization of health services in the community. (Provision of quality of care)
- Demonstrates acceptance and respect of attitudes, beliefs, and cultural values of community members in relation to health services and programs. (Provision of quality of care)
- Demonstrates knowledge of epidemiology, the SDoH, and immunization. (Infection Prevention and Control)
- Uses knowledge of the local culture and context to collaborate with appropriate local leaders and traditional healers in providing community health services. (Information Management Systems)
- Engages intersectoral, multidisciplinary, and local partners in the development and implementation of community-based strategies to improve the health of the community. (Leadership and Management)

[a] Faculty of Health Sciences of the University of Eswatini (public); Faculty of Health Sciences, Southern Africa Nazarene University (faith-based); Good Shepherd College of Health Sciences (faith-based); Eswatini Medical Christian University (EMCU) (faith-based).

There seems to be consensus among members of the entry-to-practice competencies development team interviewed in this study on the meaning and relevance of SDoH to strengthening the quality of nursing care to meet population health needs in their social and cultural context.

Bridging the theory-practice gap by aligning nursing competencies with health needs and the social, economic, geographic, cultural contexts within which they occur is a long-term strategy for addressing the SDoH in Eswatini.

Worth noting is the notion that structural-level SDoH influence patient health as much as the operation of the health system, which in turn influences capacity to provide quality learning opportunities and enforce quality standards.

'…in the other courses you will find an application of the SDoH. It's only in Community Health [where] it's taught in detail… We had to include the living conditions of the community to bring theory to practice, to make our questions more relevant to the situation.' (Education expert, May 2022)

'There is no quality of care unless we attend to the social determinants of health – their background, the demographics, and so on.' (Education expert, May 2022)

'Also, that the country needed to strengthen the health workforce about current health issues such as the HIV/AIDS and TB. HIV and AIDS was the outcome of the many social issues that affected our population (e.g., poverty, unemployment), and nurses were part of solution. Hence, beefing up of pre-service curricula was a long-term strategy that would help alleviate or attend to most of the SDOH.' (Education expert, May 2022)

Lessons Learned on Integrating the SDoH into Entry-to-Practice Nursing Competencies for National Licensure

Key elements of the development process:

- A clear, long-term vision, a timeline with clear milestones, and the sense of collaboration, cohesion, and unity of purpose fostered across the experts as well as across the smaller institution-based curriculum review teams.
- Strong collaborative leadership approach with institutional-level faculty, clinical services, and nurses responsible for championing the process and serving as points of contact with the regulatory authority.
- Ongoing communication about the relevance of the reform to the original problem.

Key enablers to integrating SDoH into entry-to-practice nursing competencies:

- Guiding policy documents outlining the health and social issues and emphasizing the need for greater access to affordable health services and quality care for all populations.
- An evidence-based point of departure for reform, in this case, a national task analysis of the practice gaps of graduate nurses.
- Clear understanding and acceptance at the outset of the process that institutions have their own governing authorities (Senates) and policies and procedures for designing and delivering educational programs that must be factored into the development timeline.

'What really helped is that SDoH that had to be incorporated were evidence based, speaking to the policy of the MOH [Ministry of Health] and with involvement of the MOH at all stages.' (Regulatory expert, May 2022)

'The entry-to-practice [competencies] were welcomed because as academics we understood that we needed some quality assurance system that will help us reinforce learning or kind of compel students to take their work seriously. So, it's like this process helped the school ensure that the necessary skills set was developed to address the health needs of the country.' (Education expert, May 2022)

- A clear mandate and instrument for strengthening the quality of nursing care, such as the entry-to-practice competencies framework and the national license examination.
- Context-sensitive financial and technical support from vested development organizations.

Key barriers to integrating SDoH in entry-to-practice nursing competencies:

- Lack of funding for intensive engagement processes of development and dissemination lengthens the overall competencies development timeline.
- Technical support, if not respectful and cognizant of local expertise and context, can be negatively perceived and interrupt engagement in the development process.
- A barrier, but also potentially an enabler if built into the timeline of subsequent development processes, is the structures and processes individual institutions need to navigate to achieve the reform.

Approaches adopted by the ENC to improve outcomes and impact of integrating SDoH into entry-to-practice nursing competencies:

- The entry-to-practice competencies and the national licensure examination are the ENC's key quality assurance instruments. With this process, the four institutions have aligned their educational curriculums with population health needs and integrated SDoH in their respective program offerings.
- The ENC, and educational institutions and services, anticipate improvements in the competence and quality of nursing provided by graduates on evaluation in 2024/2025.
- Anecdotally, education and regulatory experts expect to see an improvement in the quality of nursing care within the context of political stability and economic growth.
- The ENC plans to evaluate the effect of the entry-to-practice competencies on readiness of new graduates for practice in 2024/2025 if "all goes well." One of the barriers to evaluation is that, for various systemic and financial reasons, not all graduates have been employed, reducing the evaluation sample.

Sources

Peer-reviewed publications, ENC institutional documents, and Key Informant Interviews.

---

1. Seed Global Health. 2019. "Entry-to-practice exam: Mapping the way forward for nursing Liscensure in Eswatini." Retrieved from https://seedglobalhealth.org/entry-to-practice-exam-mapping-the-way-forward-for-nursing-licensure-in-eswatini/#.YJJ-0LUzZPY.
2. Msibi, G., Nkwanyana, N., and Kuebel, H. 2020. "Eswatini nursing council regulatory reforms: Process towards entry to practice examination." *Annals of Global Health* 86, No 1. doi:10.5334/aogh.2800
3. The World Bank Data Base. https://data.worldbank.org/indicator/SP.RUR.TOTL.ZS?locations=SZ&view=chart
4. Maseko, S.N., van Staden, D., and Mhlongo, E.M. 2021. "The rising burden of diabetes-related blindness: A case for integration of primary eye care into primary health care in Eswatini." *Healthcare (Switzerland)*. doi:10.3390/healthcare9070835
5. Ministry of Health. 2012. *Kingdom of Swaziland. Human Resources for Health Strategic Plan 2012/2017*. Mbabane, Swaziland.
6. UNICEF. n.d. *Kingdom of Eswatini: Health Budget Brief 2018/2019*. Mbabane, Eswatini.
7. Eswatini Ministry of Health. 2012. *Policy for Human Resources for Health*. Mbabane, Swaziland.
8. Magagula, S.V. 2017. "A case study of the Swaziland Essential Health Care Package." Discussion Paper 112. Ministry of Health Swaziland, Ifakara Health Institute, and Training and Research Support Centre (TARSC) in the Regional Network for Equity in Health in East and Southern Africa, (EQUINET). Harare.
9. Shongwe, T. 2017. *An assessment of the Swaziland vision 2022 strategic plan: Opportunities and challenges*. University of The Free State, Bloemfontein, South Africa.
10. Eswatini Ministry of Economic Planning and Development. n.d. *National Development Plan 2019/20-2021/22: Towards Economic Recovery. Kingdom of Eswatini*. Mbabane, Swaziland: Kingdom of Eswatini.
11. World Health Organisation (WHO). "The 2022 update, Global Health Workforce Statistics," Geneva: WHO. https://www.who.int/data/gho/data/themes/topics/health-workforce
12. Sibandze, B.T. 2018. "The Process by Which Nurses in Swaziland Develop a Values-based Practice: A Mixed-methods Study." George Mason University. ProQuest Dissertations and Theses. Ann Arbor, Michigan.
13. Kober, K. and Van Damme, W. 2006. "Public sector nurses in Swaziland: Can the downturn be reversed?" *Human Resources for Health* 4, No. 1 (Feb):13. doi:10.1186/1478-4491-4-13
14. Pigoga, J.L., Joiner, A.P., Chowa, P., Luong, J., Mhlanga, M., Reynolds, T.A., and Wallis, L.A. 2020. "Evaluating capacity at three government referral hospital emergency units in the kingdom of Eswatini using the WHO Hospital Emergency Unit Assessment Tool." *BMC Emergency Medicine* 20, No. 1. doi:10.1186/s12873-020-00327-w
15. Dlamini, P., Mtshali, N.G., Dlamini, C., Mahanya, S., Shabangu, T., and Tsabedze, Z. 2014. "New graduates' readiness for practice in Swaziland: An exploration of stakeholders' perspectives." *Journal of Nursing Education and Practice* 4, No. 5:148-58.
16. Eswatini Higher Education Council. 2021. *Quick guide to identifying credible institutions in Eswatini*. Mbabane, Eswatini.
17. Swaziland Nursing Council. 2014. *Swaziland Entry-to-Practice Nursing Competencies: General Nursing, Midwifery, Community Health Nursing, Community Mental Health Nursing.* Mbabane, Swaziland.