

Community Service for Health Professionals



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The one-year period of community service (CS) for health professionals has been implemented since 1998, with doctors, dentists and pharmacists now being routinely allocated to a 12-month period of service in public institutions, on completion of their formal training. A further 7 professional groups will follow in 2003, including physiotherapists, occupational and speech therapists, clinical psychologists, dieticians, radiographers and environmental health officers. The aim of CS, according to the Department of Health, is “to ensure improved provision of health services to all citizens of the country”. The chapter reports on a number of findings that are measured against this overall goal.




With respect to the responses of all three professional groups currently undergoing CS, there were a number of patterns that were notably similar. Firstly, despite difficulties and frustrations, the majority felt that they had made a difference and had undergone some professional development. Overall, most described their experience of the year as positive in retrospect, but only a minority reported that their attitude had become more positive during the year. Supervision of CS doctors, dentists and pharmacists by more senior professionals was found to be significantly poorer in rural than in urban settings. The dentists showed the greatest gap, between their skills and expectations as university graduates, and the needs and context of oral health in the public service. CS pharmacists, who had completed their internships in the retail sector, were also initially disorientated in the public health sector, but their skills and knowledge were valued and appreciated particularly where there had been no pharmacist before. Doctors varied widely in their level of preparedness not only in skills but also in attitudes. Language gaps were also found to be a factor.



CS highlights the general management deficiencies in the public health system. All groups expressed dissatisfaction at the conditions of service in the public sector, but particularly the pharmacists, many of whom had exposure to the private sector during their internships. Many of the dentists, who have a particular reliance on specialised equipment and supplies, found themselves unable to perform any but the most basic procedures.


A feature of all these young professionals is the alarming proportion of between 20% and 45% that are planning to work overseas after their CS.

Recommendations include the need for a comprehensive national plan for the recruitment and retention of health professionals in rural and under-served areas that include other




complementary strategies besides CS. Health Science Faculties need to address the gaps between the skills and attitudes of their graduates, and the realities of the health of the South African public as experienced by CS professionals. Supervision of CS professionals in rural areas needs to be improved through direct support by health managers, as well as the support of senior clinicians in the health system, through appropriate promotions and acknowledgement. The CS strategy should be reviewed after 5 years, to evaluate whether it is achieving the goal for which it was instituted.


Introduction



The one-year period of compulsory CS for health professionals has been implemented since 1998, with doctors, dentists and pharmacists now being routinely allocated to a 12-month period of service in public institutions on completion of their training. A further 7 professional groups will follow in 2003, including: physiotherapists, occupational and speech therapists, clinical psychologists, dieticians, radiographers and environmental health practitioners. The experiences and lessons learnt from the first few years of the programme are therefore of importance to the effective utilisation of this pool of human resources.



CS professionals are young and relatively inexperienced, largely in need of supervision and support in order to practice their professions effectively within the constraints of the South African public health service. The role of the universities is crucial in preparing their graduates appropriately for this year – which can be regarded as a ‘test-drive’ of their products, on a challenging test ground. How well they are able to perform, respond to the challenges, adapt to local circumstances and contribute meaningfully wherever they are placed, is a function of their resourcefulness as individuals, their education, and the context in which they are placed.



This chapter reports on the personal experiences of doctors, dentists and pharmacists who have participated in CS, based on an annual exit survey conducted by the national Department of Health since 2000, as well as a number of other smaller studies. It does not attempt to analyse the impact of this programme on the health system and health services as a whole.

According to the Department of Health: “the main objective of Community Service is to ensure improved provision of health services to all the citizens of our country. In the process, this also provides our young professionals with an opportunity to develop skills, acquire knowledge, behaviour patterns and critical thinking that will help them in their professional development.”^a The reported results must be measured against these overall goals.

^a Department of Health letter addressed “Dear Intern”, Public Service (Community Service): 2000.

CS Doctors



Medical doctors were the first to participate in the CS programme and are the largest professional group to have undergone CS each year. The pioneer cohort of 26 CS doctors was mostly allocated to urban hospitals around the country in July 1998.

A qualitative survey was carried out through a few on-site visits by the national Department of Health (DoH) at the end of 1998. The survey revealed that there was generally positive feedback. Specifically, it was reported that there was adequate supervision, and the CS doctors' attitudes were positive. Concern was expressed at that time that there would not necessarily be posts available for those who wished to continue to work in the public sector after their year of CS. Secondly, those in rural placements felt that it was unfair that those placed in large urban hospitals were advantaged in terms of access to training opportunities, both during the year as well as for subsequent registrar posts.



In January 1999, 1 088 (92% of the total number of interns eligible for CS) were allocated to government institutions around the country. Of these, only 25% were in hospitals that are designated as rural or under-served sites and therefore qualify for rural allowance. Thus the majority were placed in relatively urban institutions, and this pattern has not changed significantly since then.



A thorough review of the first year of implementation was carried out in 1999,^{1,2} based on focus group discussions in 3 rural provinces and a national exit questionnaire. A low response rate (27%) to the questionnaire in 1999 limited the generalising of the results. However, further analysis showed that the profile of the respondents closely matched that of the target group, therefore some conclusions were drawn. The national Department of Health assisted by the author, has continued to monitor the responses of CS doctors through exit questionnaires in subsequent years. These have drawn significantly better response rates (51% in 2000 and 77% in 2001) allowing valid statistical analysis as well as the description of trends. The results of this ongoing monitoring system form the basis of most of the results reported here.

'Uptake' and 'Turn-up'



The first cohort represented 92% of the potential pool of applicants, consisting of 1 182 interns from 1998. This is termed the 'uptake' of CS. A total of 94 interns therefore chose to delay their CS year, leave the country, or not to register at all. Of these, a small proportion applied for CS but did not 'turn up' for duty at their allocated site, presumably for similar reasons. Turn-up rates by doctors have remained between 92 and 95% in subsequent years (Figure 1).



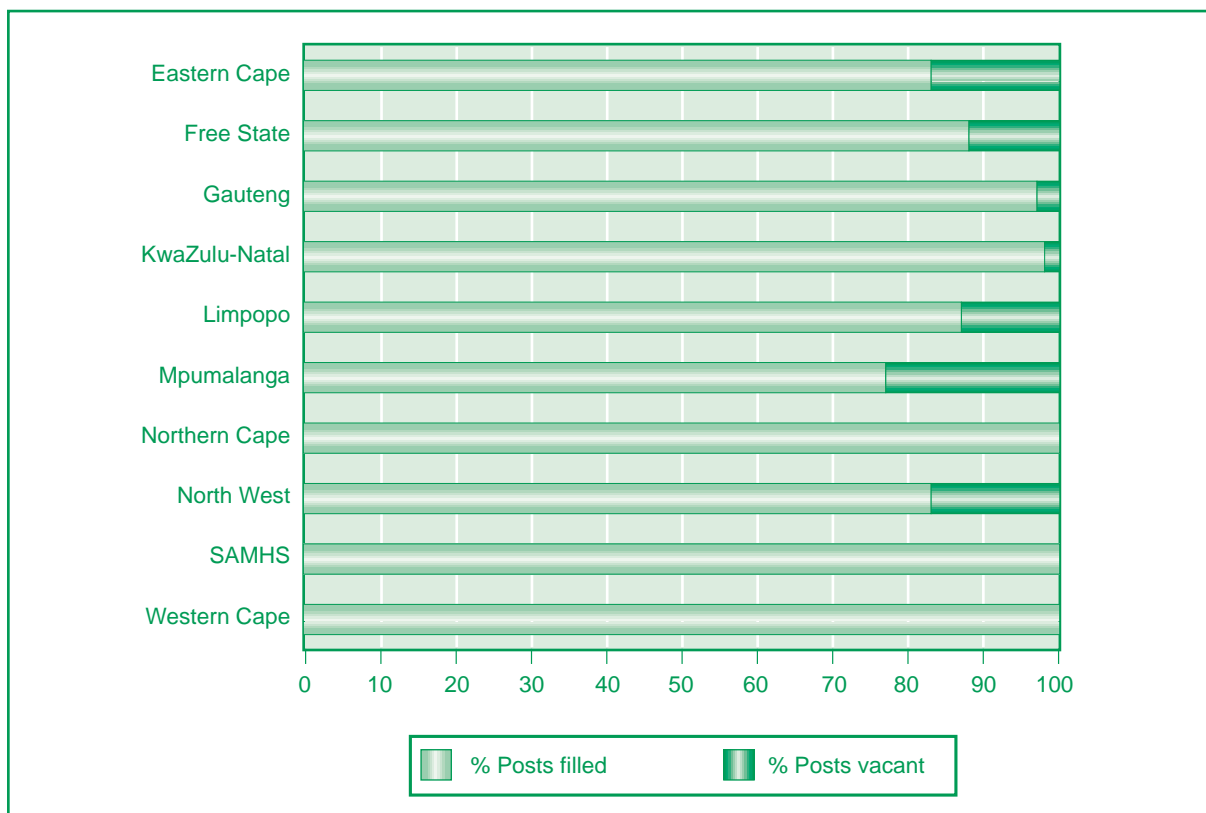
Application and Allocation Process

Allocations to approved sites for CS allows each applicant five initial choices, which are coordinated nationally in a ‘first round’ of allocations. This first round normally places approximately 85% of applicants, and the remaining 15% are asked to name another five choices, which go into the ‘second round’. The 5% who are not placed in the second round are allocated wherever the remaining posts are identified around the country. It has emerged, however, that the mostly rural provinces are not filling all their available posts in rural hospitals, as these are unpopular choices and tend to be left until the third round of allocations. A number of these doctors then decide to avoid their CS rather than be placed in these rural positions and do not turn up, presumably heading directly overseas. It has been agreed by the stakeholders that those returning from overseas a year after completing internship to do their CS, should be allocated only after all post-interns have been placed, thus effectively dissuading them from returning to the country.

The largely rural provinces are thus left with unfilled CS posts in the most needy rural areas, whereas CS posts in urban provinces are all filled by the 2nd round allocation, as shown in Figure 2. It is therefore questionable as to whether CS is achieving its objectives in terms of providing staff for under-served areas.

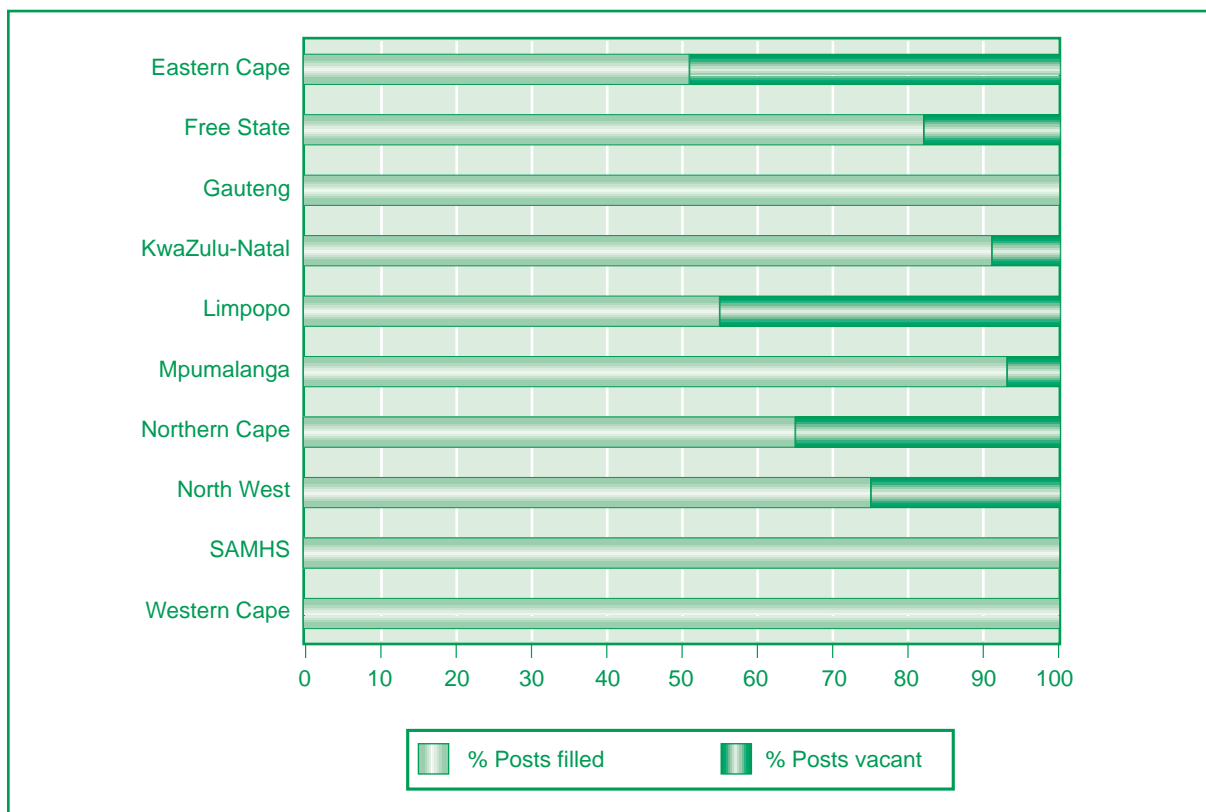
In order to obviate this situation, it was agreed in 2001 that the total number of posts advertised for CS each year should not exceed the total number of intern posts in the previous year, thus eliminating the phenomenon of unfilled posts as far as possible. This will still not prevent those who apply for CS from not turning up if they receive an unfavourable allocation site, but these posts can then be filled by returnees and foreign-qualified doctors.

Figure 1: Proportion of CS posts filled (turn-up) by end of January, by province



Note: SAMHS – South African Military Health Service

Figure 2: Proportion of CS posts filled by end of 2nd round by province



The CS doctors experience

The exit questionnaires show that the majority of respondents felt they had been well orientated, that the CS year had been worthwhile, that they had made a difference and they had developed professionally (see Figures 3 and 4). With regard to professional development, one CS doctor said: *“I have not learnt anything new medically, but I have gained an enormous amount of confidence.”* (See Figure 4)

Figure 3: The percentage of CS doctors in 1999 and 2001 who felt that they had personally made a difference during their CS year

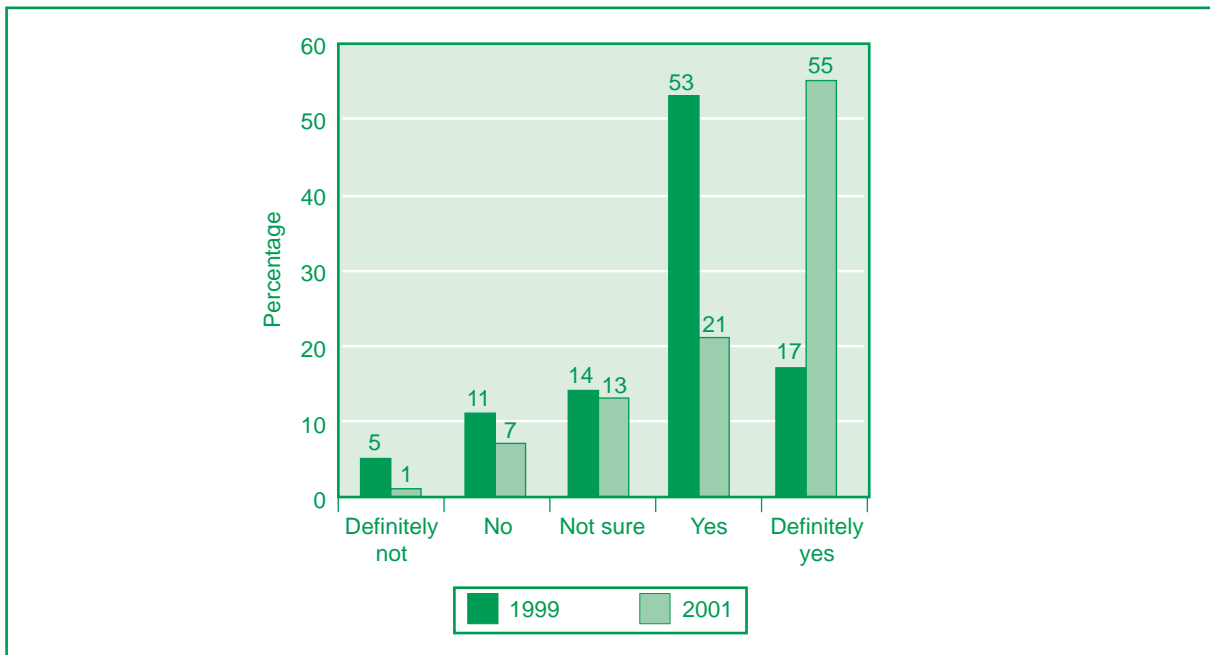
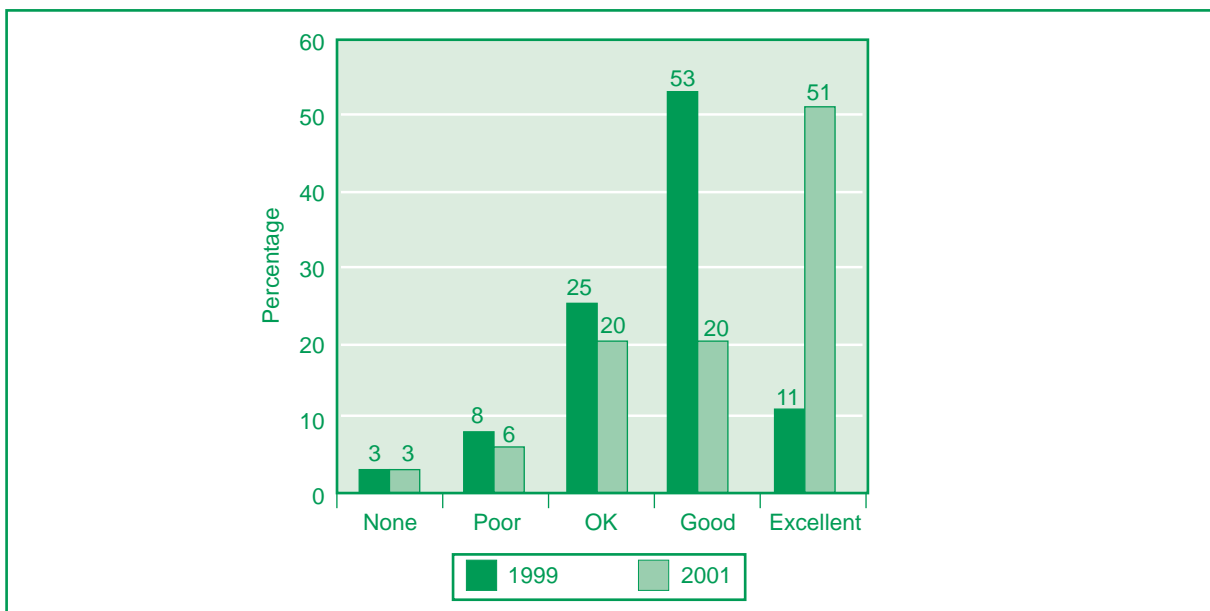
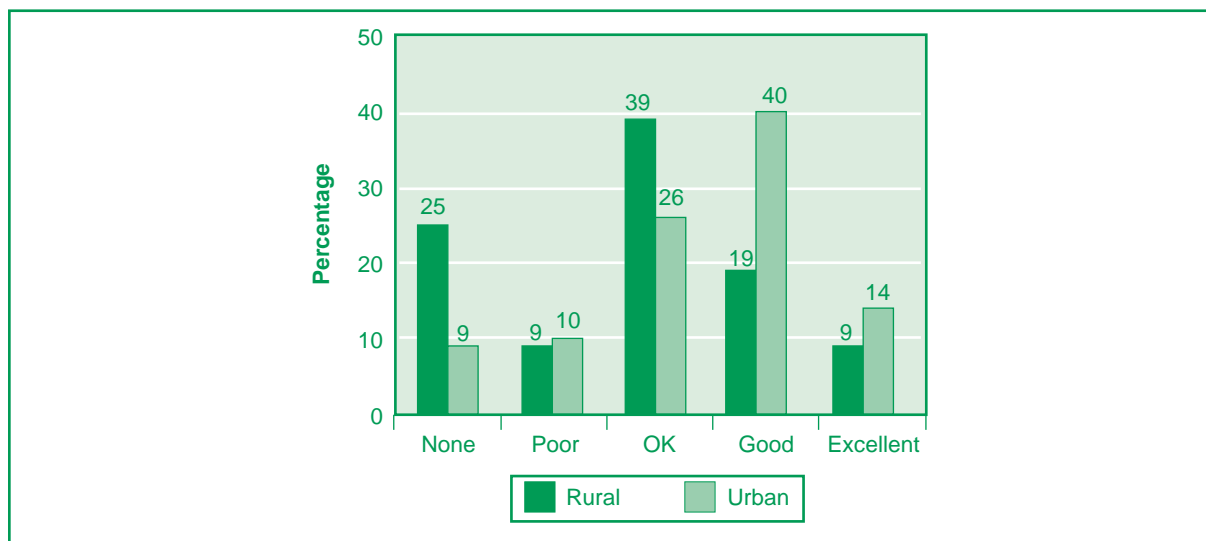


Figure 4: The percentage of CS doctors in 1999 and 2001 who reported that they had experienced significant professional development during the year



Doctors in ‘rural’ hospitals, so defined by the payment of a rural allowance, reported more negatively on the level of clinical supervision as compared to those in urban institutions (Figure 5). With regard to supervision, one CS doctor in a rural hospital said: *“We can handle most medical problems as we have good theoretical knowledge, but we don’t know if we are doing it right.”*

Figure 5: Reported level of clinical supervision experienced by CS doctors in rural and urban sites in 2001



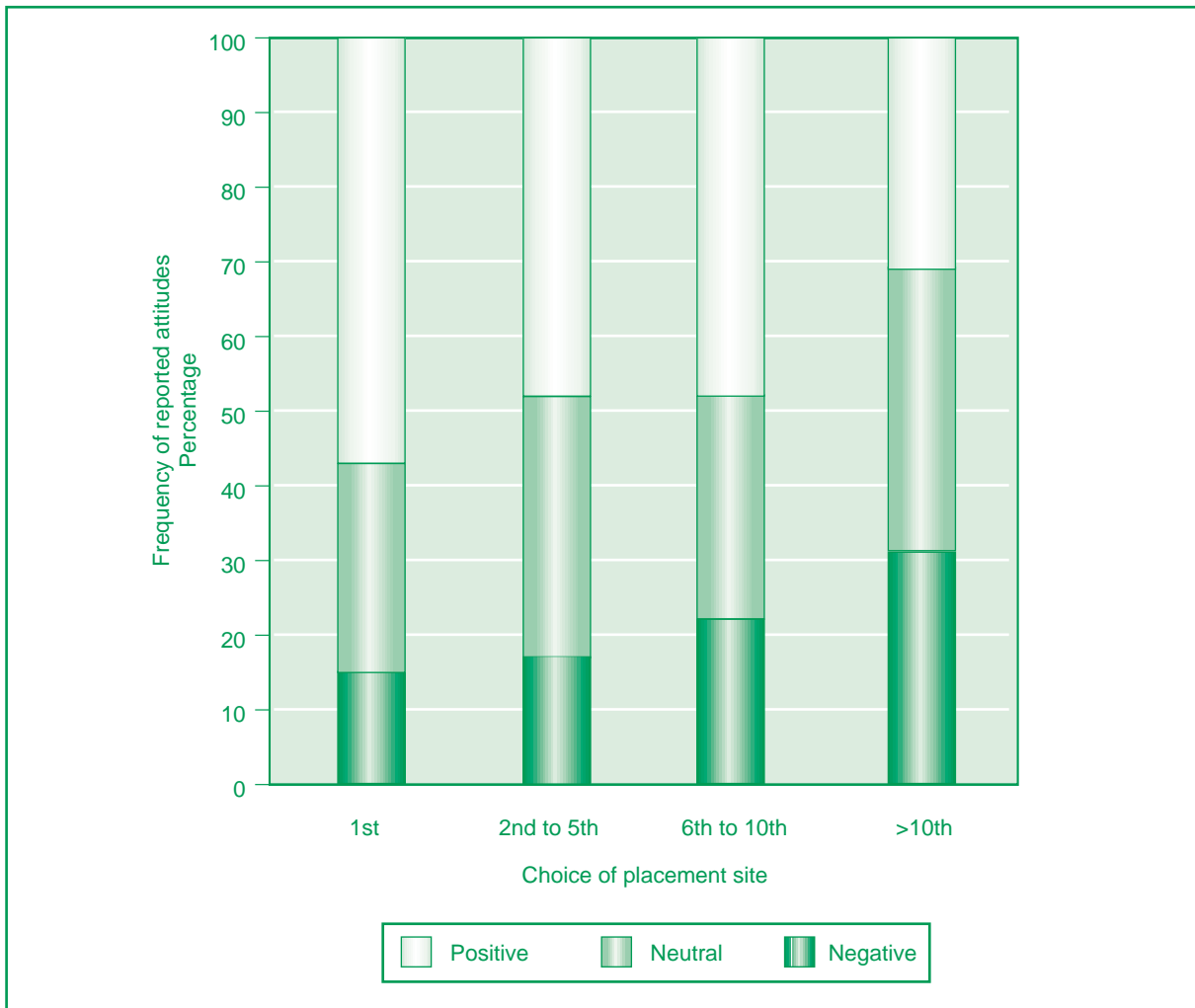
Just over half (55%), reported that they were generally positive about CS and their attitudes did not change over the course of the year. Those who were allocated to hospitals which were not among their first five choices, were less positive about CS by end of the year as compared to those who had been placed at the institution of their first choice (Figure 6). A frequent comment was as follows:

“It all depends on your attitude [to CS]: if you make the most of it, then you can handle most things.”

Only a handful of respondents (15%) were able to study towards a post-graduate qualification during the year – mostly those placed in urban sites.



Figure 6: Reported attitudes of CS doctors to community service, relative to their choice of placement site



Skills and competencies

A qualitative assessment of the skills and competencies of interns and CS doctors was carried out by a task team of the DoH in 2001. It was based on the findings of the National Confidential Enquiry into Maternal Deaths in 1998, which revealed that the skills of junior doctors were lacking and this was a cause of some cases of maternal death.³ The study reported on four major inter-related themes including technical skills, ‘soft’ skills, supervision, and management support in 15 district hospitals in rural areas of Eastern Cape, KwaZulu-Natal and Limpopo Provinces.

Skills and competencies of doctors generally refer to clinical skills, or ‘technical’ medical skills such as clinical diagnosis and management, surgical and other procedural skills. The Task Team found that the priority technical skills required among junior doctors related to emergency procedures, particularly Caesarean sections, anaesthetics and resuscitation skills. *“Obstetrics is scary – when things go wrong they can go horribly wrong”*,





said one. Also necessary were the less urgent competencies as well as the need to make clinical decisions in the absence of complete diagnostic information, where diagnostic facilities are limited.

In addition to the technical competencies, the task team found that issues such as attitude, teamwork, confidence and communication, were equally important in the delivery of quality medical services. These were referred to as 'soft' skills. Deficiency in 'soft' skills in a number of individuals and hospital teams significantly hampered the provision of quality medical services as a whole. CS doctors and interns are often thrust into situations of clinical responsibility without the personal maturity needed to work as part of a team. The level of attitudinal adequacy to face the challenges of the public service was found to be critical in determining the quality of the medical services. A diagrammatic representation of the themes and findings is shown in Figure 7.

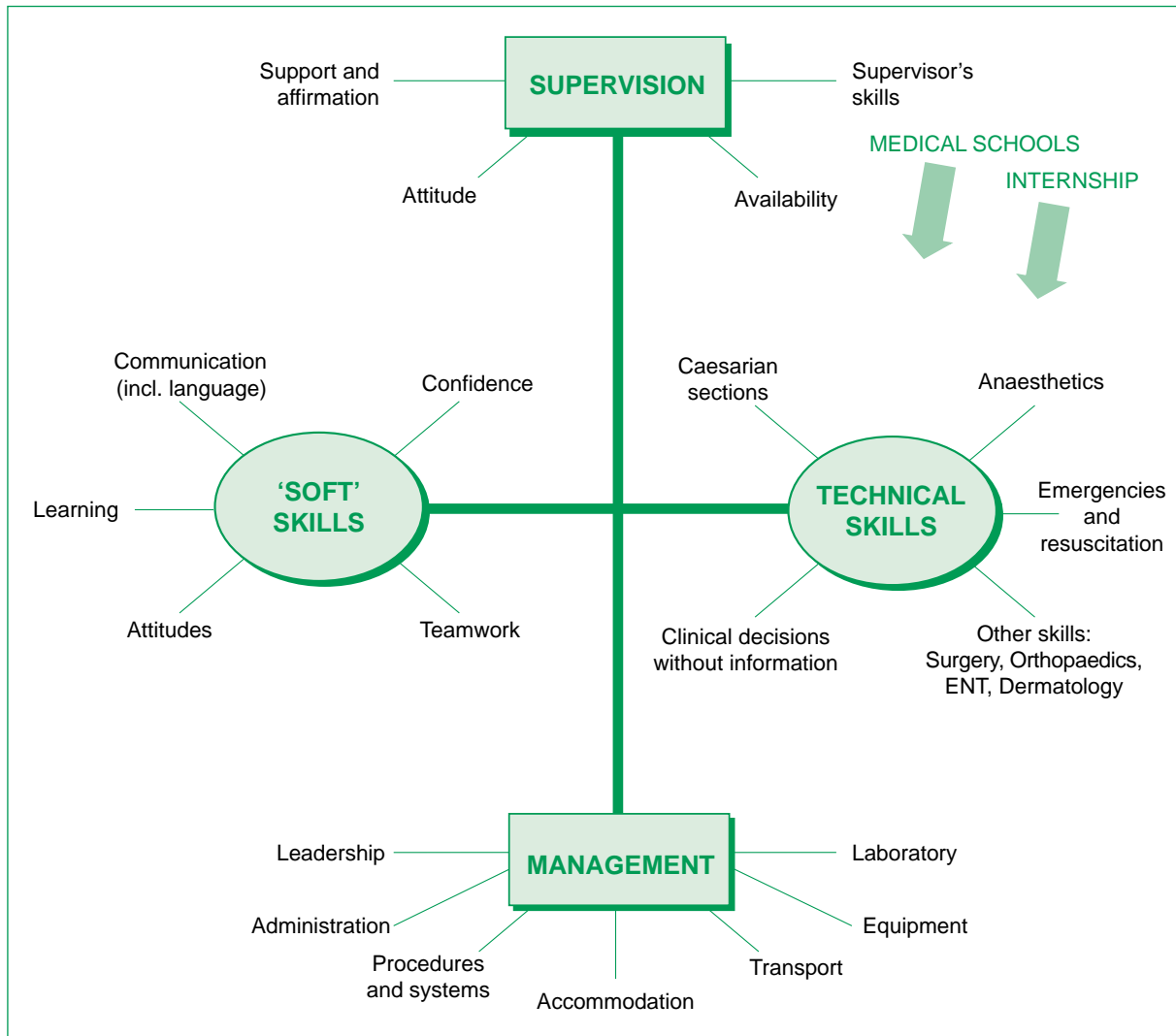
The skills, competencies and attitudes of CS doctors and interns were significantly enhanced or hampered by two other factors at the hospitals visited by the task team, viz: the degree of supervision available to them, and the management capacity of the institution. In terms of supervision, the level of competence and confidence of the more senior doctors was critical in making the CS doctor's work a positive learning experience. Many of the senior doctors are foreign-qualified, and do not share the background and cultural norms of their junior colleagues. Despite this, many contributed their experience and teaching willingly, while others did not see the support of junior South African doctors as their responsibility. Their availability was variable, especially in isolated rural situations where community service doctors were unsupervised by full-time colleagues.

The management capacity at hospital, district and provincial level, was found to play a significant role in the provision of quality care. Although this was not the direct focus of the task team, it is clear that many medical procedures cannot be carried out without the necessary equipment, drugs, supplies or transport. Thus, although the skills and competencies of the doctors may be sufficient, they were unable to perform their tasks satisfactorily in situations where the necessary management and systems were faulty or absent. This was found to be the case in a sufficient proportion of institutions to present it as a major theme of the inquiry. Management capacity affected not only issues of administrative function such as those mentioned, but it was noted that the quality of leadership and the support of teamwork also contributed significantly to the optimum utilisation of human resources in the public sector.

In another study by De Villiers done in district hospitals in Western Cape on skills and competencies of doctors, it was found that CS doctors lacked skills and needed increased supervision which required the resident medical officers to constantly train new recruits at the beginning of each year.⁴ Also, the CS doctors ordered more X-rays and laboratory tests, due to their relative

insecurity and reliance on special investigations coming from larger teaching hospitals, which put a strain on hospital budgets particularly at the beginning of each year.

Figure 7: A diagrammatic representation of the major themes arising from the Department of Health Task Team investigation into the skills and competencies of interns and CS doctors 2001



An unpublished study carried out on a sample of 41 CS doctors in rural KwaZulu-Natal in 2000 by industrial psychologist, Dhaniram, revealed that CS doctors experienced significant levels of stress and burnout as measured by 3 different objective tools.⁵ The highest stressors were found to be career development and responsibility for people, followed by work overload, role ambiguity and conflict in the workplace.

Future plans of CS doctors

Respondents to the exit questionnaires answered questions on their work plans for the following year. Two trends have become apparent: firstly there is an increasing proportion of CS doctors intending to work overseas, which has risen from 34% in 1999 to 43% in 2001. This is mirrored by the second

trend, viz: the decreasing proportion of doctors planning to remain in the public service – 42% in 1999 to 38% in 2001 (Figure 8). Less than 10% go straight into private practice, and the remainder are unsure.

Figure 8: Where CS doctors intend to work after their community service year (1999-2001)

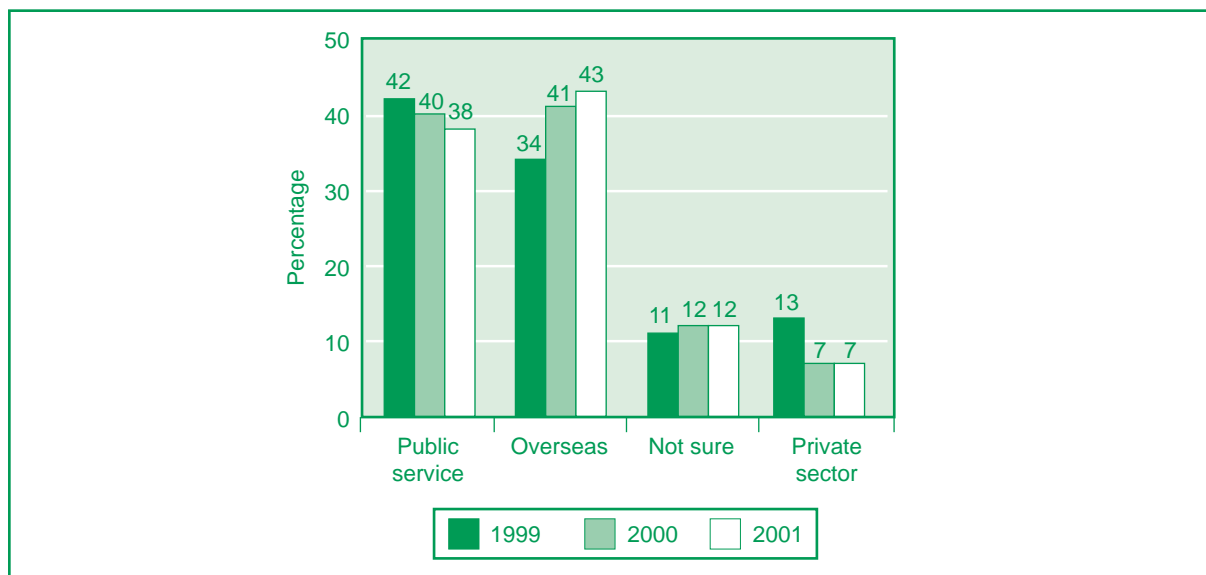
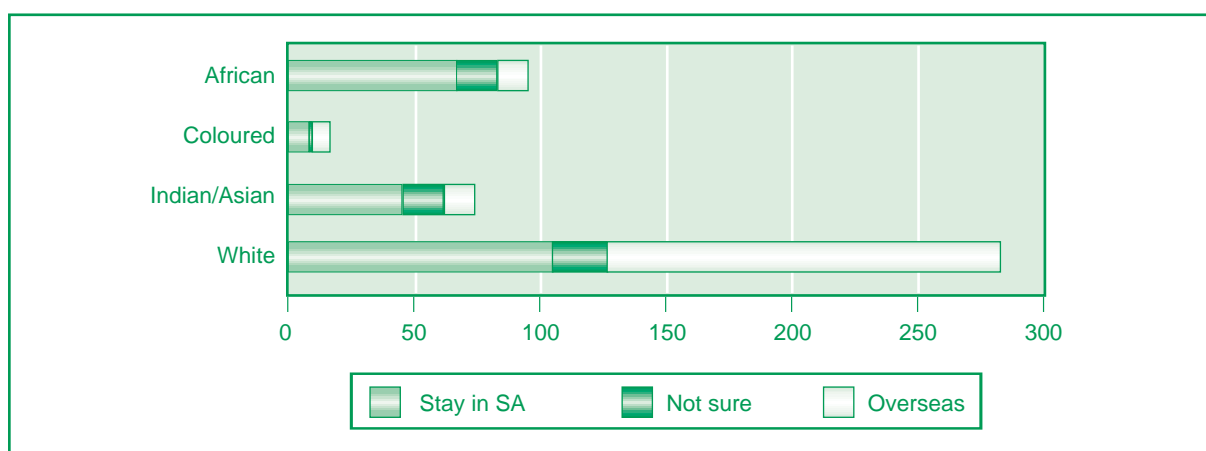


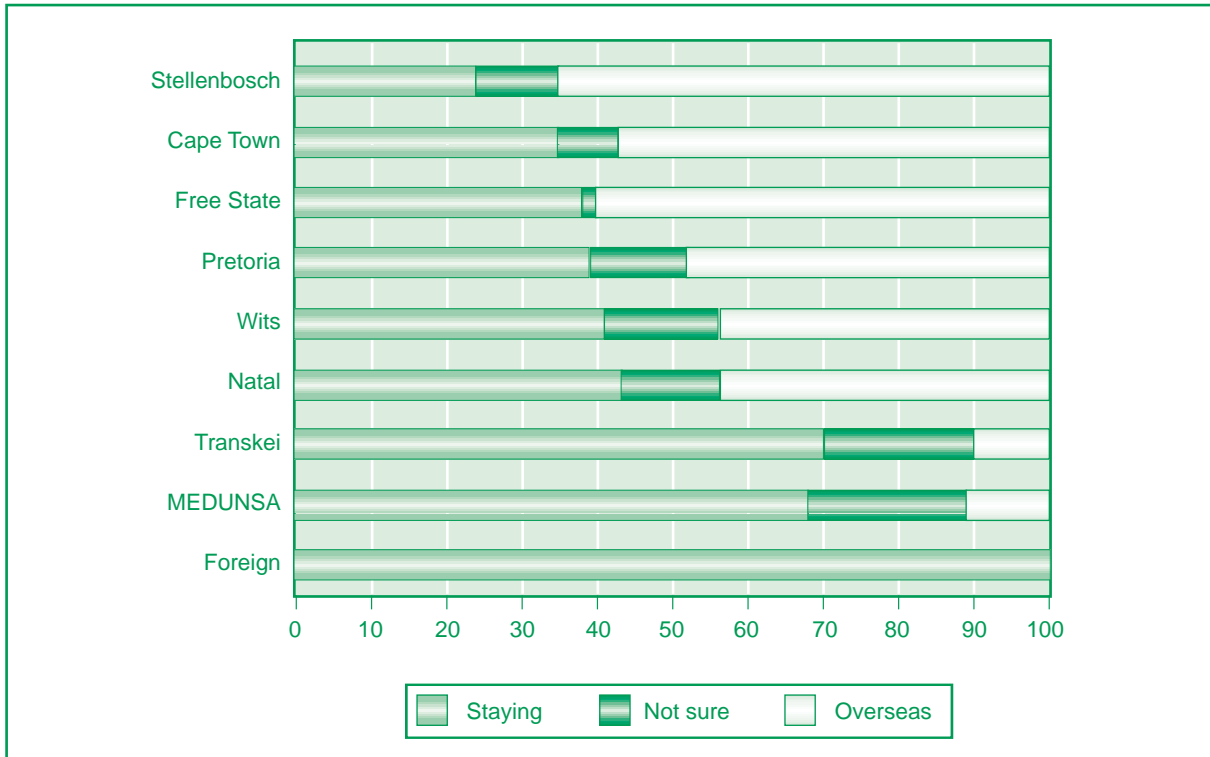
Figure 9: Intentions of CS doctors of different racial groups in 2001



Over half of the white CS doctors intended to work overseas the following year, compared to around 10% of African doctors, and around 40% of both Indian and Coloured doctors (Figure 9). There were significantly large differences in the intentions of the respondents when analysed according to university of origin, with the majority of Stellenbosch, UCT and Free State university graduates heading overseas, while the majority of MEDUNSA and UNITRA graduates intended to remain in South Africa (Figure 10). These patterns have remained unchanged over 3 years. These reported plans to work overseas were mostly short-term, as 70% said that they were planning to return to South Africa, 5% were planning not to return and 25% were unsure, and could presumably therefore be persuaded to either continue working in a foreign country, or return to SA – depending on which option

offered the most favourable circumstances. This is a significantly large group of young doctors, amounting to approximately 300 per year, and every effort should be made to attract them back to the country.

Figure 10: The intentions of Y2001 CS doctors, in relation to the university of origin



When asked whether they would consider working in a rural or under-served area in the future, around 20% said that they would consider it. There was no significant difference in these responses between those who were placed in rural hospitals compared to those in urban hospitals. In other words, there are over 200 young doctors in the country each year who would willingly choose to work in rural and under-served areas, even at the end of their community service. Given the right incentives, this voluntary cohort could achieve the primary purpose of the whole programme of community service at a much lesser cost than coercing all medical graduates into grudgingly filling posts, most of which are in large urban hospitals.



CS Dentists

The first group of 173 dental graduates began their CS year in July 2000, and were allocated to sites in all 9 provinces as well as the SA Military Health Service. In 2001, the largest number (34) were placed in the North West Province. Approximately 25% of the total number of CS dentists were allocated to rural sites for which they received a rural allowance. Nearly a quarter (22%) of the first group of dental graduates in 2000 that were eligible,

decided not to do community service, and presumably left the country. The proportion was significantly reduced with the second cohort when only 7% did not take up CS posts.

An initial qualitative evaluation of their experiences was undertaken by the DoH staff assisted by the author, through focus group discussions of CS dentists in 6 provinces, in December 2000. Structured interviews were also held with the provincial coordinators of CS dentists. A brief questionnaire was also administered to 93 (52%) of the CS dentists, half of whom were working in rural sites. This was followed by a postal survey to all CS dentists carried out by the University of Stellenbosch in March 2001, to which 58 people responded (35%) rate was obtained.⁶ Finally, the national exit questionnaire was carried out by the DoH on the second cohort in May 2002, with a response rate of 42%.

The CS dentists experience

The qualitative results are summarised in Figure 11. Graduates emerging from dentistry schools have a level of skills far greater than those required by their placements as CS dentists in the public health system. They feel that their skills are not being utilised appropriately, as they are largely performing extractions only. They feel that their more complex skills are wasted.

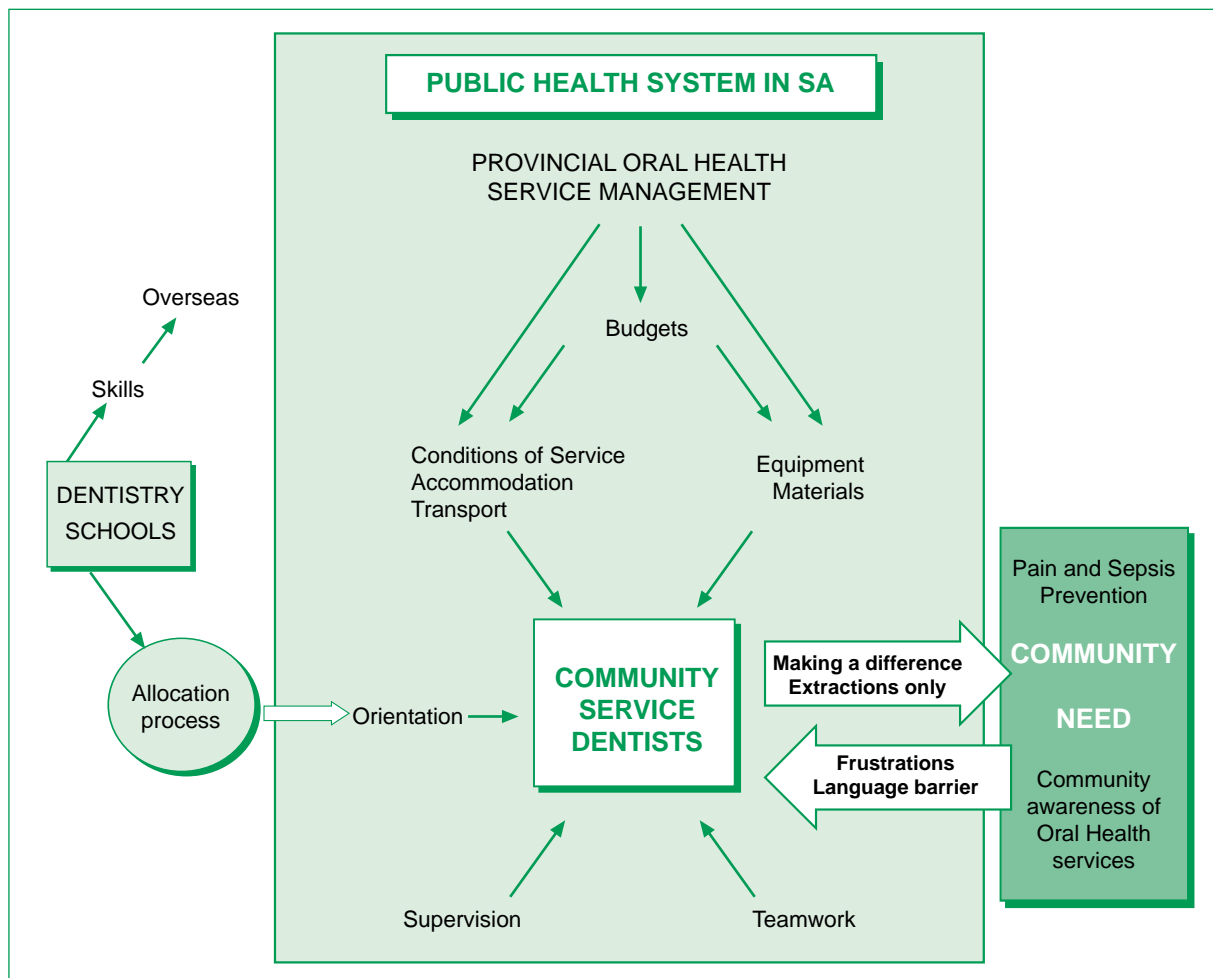
“I received a first world training to work in a third world institution,” is a typical comment, *“I learned a hundred times more at university but now I am just doing extractions which is boring and frustrating.”*

A number of challenges and constraints were identified including:

- Inadequate orientation (this is supported by the quantitative results)
- CS exposed dentists to the problems and limitations of the public health system, and particularly those affecting Oral Health Services (OHS) at provincial level, such as:
 - Low budget allocations for OHS
 - Unavailability of equipment and supplies
 - Unavailability of accommodation at rural sites
 - Lack of transport to reach outlying clinics
 - Poor supervision particularly in rural sites.

There was great variation between provinces and the quality of provincial management emerged as a key factor. Supervision was significantly poorer in rural as compared to urban sites. Some CS dentists had managed to work as part of a team, whereas others found themselves extremely isolated and lonely.

Figure 11: A diagrammatic representation of the major themes arising from the CS dentists focus group interviews



Allocations

The allocation process was widely criticised by the first cohort for being too late and taking place during their final exams. Furthermore it was felt to be unfair, as new posts became available after the second round of applications, and there was inadequate information available about the placement sites. The process was felt to lack transparency, as the criteria used for allocating them were not clear. As expected, only those who received their first choices, and bursary-holders were satisfied with the procedure. Some hospitals were unaware that CS dentists were posted at their hospitals until their arrival, which added to the confusion.

Making a difference

The majority 63% felt that they were making a difference especially in areas where dental services were previously non-existent. Some dentists started their own programmes such as: brushing and schools oral health promotion programmes. However, most of the CS dentists did not get involved in preventive strategies in the community. A minority felt that they made no



Skills gap

difference at all. One of the community dentists indicated that his “initial enthusiasm was dampened” because of lack of equipment and materials which inhibited providing high quality care. Some felt that they were doing more harm than good to their patients. Others felt that they were doing the work of a dental therapist (extractions and nothing else).

A common theme related to the gap between the skills that dentists are taught at university, and the skills required by community service in the public health service, is reflected in the following comments:

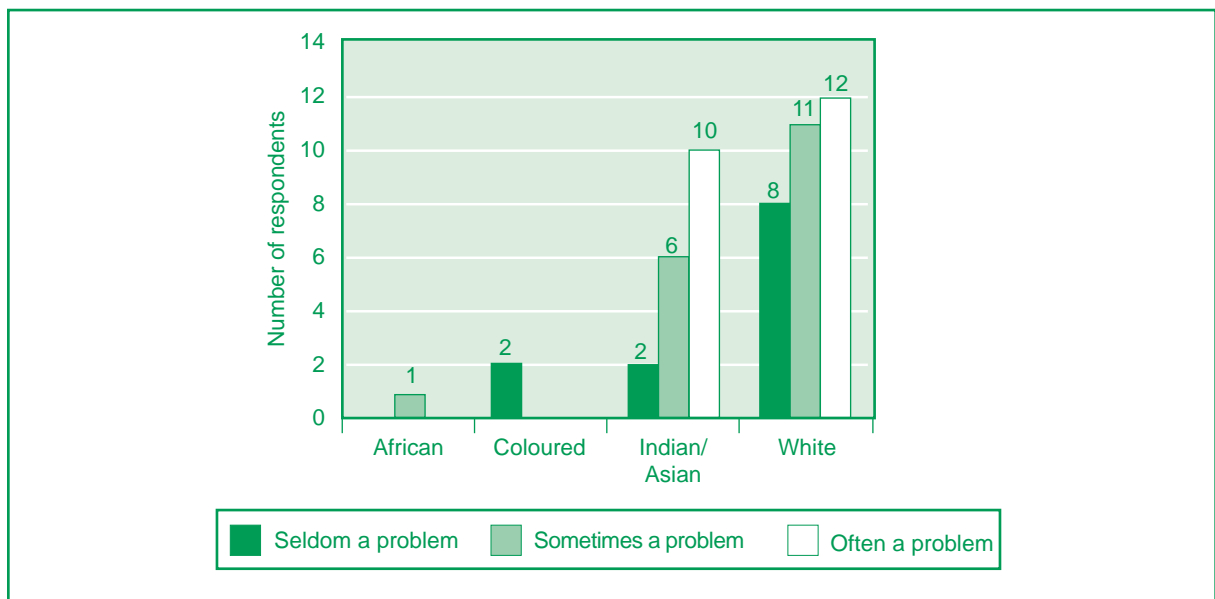
“We are over qualified for Community Service.”

“I only use a small portion of the knowledge I received.”

“I learned a hundred times more at university but now I am just doing extractions, which is boring and frustrating.”

Many CS dentists were resentful that they were losing these skills through lack of use during their first year of practice. Even the fitting of dentures, which was identified as a major need in the community, could not be done at many sites because of the lack of equipment and materials. CS dentists felt that dental therapists or oral hygienists could have done the work they did. A number of CS dentists particularly whites and Indians were frustrated by not being able to communicate with their patients (Figure 12).

Figure 12: The number CS Dentists who identified language as a barrier between them and their patients, by race





Equipment shortage

Many CS dentists felt that the service to their patients was severely limited due to lack of equipment. Since dentistry is so highly dependent on technical equipment and consumables, this point was a major concern and was strongly emphasised by those CS dentists who were placed in rural areas. Almost 25% reported that they did not have a full set of instruments, and one-third said that they often experienced shortages in equipment for primary oral health care. This was particularly an issue in the Limpopo Province. Some also proposed that more research should be done to determine whether or not the sites allocated for CS dentists are actually functional. In provinces where the Oral Health Services budgets are subsumed into general hospital budgets, this is difficult. However, some provinces performed well with regard to provision of equipment and the usage of their budget, and this seemed to relate to the quality of the provincial management of OHS.



Community awareness and under-utilisation

Some of the CS dentists in certain rural areas saw only a few patients a day and had plenty of time on their hands. It seems that there was lack of community awareness of the availability of free dental care in their public health facilities. Some CS dentists reported to be seeing only five patients a week particularly those allocated to the Free State and Limpopo Province. One CS dentist in the Limpopo Province who was placed in a rural area commented that there was a shortage of patients: *“I’m sitting around not doing anything, losing skills and dying of boredom. If there are no patients we should not be forced to sit around and do nothing. At least let us work half days, so we can take up music or painting to keep ourselves busy.”* However, in some provinces such as KwaZulu-Natal, CS dentists complained of being too busy with extractions to do anything else. The appropriate utilisation of human resources requires careful planning, and those provinces which have strong provincial management of oral health services, keep their CS dentists productively occupied.



Conditions of service

Lack of adequate accommodation in rural areas was a common complaint. Some CS dentists who did not receive the rural allowance felt that no incentives were given to compensate for the social and geographical isolation, even though the rural allowance was given to dentists in more rural sites. The salary was felt to be low, presumably by comparison to what they could be earning in the private sector. The lack of responsiveness of certain provincial departments also came in for criticism, following administrative problems such as late payment of salaries, leave approval etc. Few CS dentists had been given clear job descriptions, and little information was available regarding conditions of service. The lack of transport to get to outlying clinics was a frequent frustration.





Supervision and teamwork

Supervision was a major problem in rural areas, though less of an issue in urban centres. Where there was no other full time dentist around, the CS dentists were expected to cope on their own. The presence of a regional coordinator alleviated problems, but most areas have provincial coordinators only. Some found themselves without dental assistants or even cleaners, making the job tedious and slow. Where there are dental assistants who have been in the job for years, the new CS dentists had to negotiate their own place within the team, which some did more successfully than others. Many found themselves having to perform tasks that they did not anticipate, such as ordering medical supplies, motivating for equipment, and negotiating for transport to visit clinics.

Future plans

The University of Stellenbosch study of the first cohort in 2000 revealed that 38% of respondents were planning to enter private practice, 24% planned to remain in the public sector, and 35% were planning to leave the country. The 2001 exit questionnaire revealed that 45% were intending to enter private practice, 10% to remain in the public sector, and 42% to go overseas. However, care needs to be taken when interpreting these findings as the studies involved very small numbers.



Summary

There has been limited success through CS in terms of providing access to certain oral health services. However, the community needs for sepsis prevention and preventive programmes is starkly contrasted with the expectations of dental graduates of practicing high-tech dentistry. This is illustrated by the huge 'skills gap' between community oral health needs, and what CS dentists can do. CS for dentists highlights many of the general issues and problems in the health system (e.g. OHS management, budgets, equipment, transport, conditions of service). The differences between rural and urban placement sites are marked, especially in terms of supervision. The appropriateness of universities in continuing to produce dentists at high cost, many of whom go on to leave the country, needs to be reviewed.



CS Pharmacists

The first group of 406 newly qualified pharmacists began their year in January 2001, with allocations to all 9 provinces, the SA Military Health Services, and the Dept of Correctional Services. The largest group of 82 CS pharmacists was allocated to KwaZulu-Natal.

An audit of this first cohort was carried out through the national DoH using qualitative and quantitative methods. Nine provincial focus groups of CS



pharmacists were interviewed between July and September 2001, and the major and minor themes arising from these data informed the construction of an exit questionnaire. This was then sent out to every CS pharmacist through the provincial coordinators, with the assurance that responses would be anonymous. 53% responded to the questionnaire providing a baseline for descriptive purposes.

Most CS pharmacists were placed at district hospitals, and 20% were placed at hospitals where other health professionals received a rural allowance, thus designating the facility as rural. However, half of the respondents did not know whether their hospital was classified as rural or not. Most of the CS pharmacists are unmarried females, and the majority received their training at the University of Durban-Westville. Just under half had completed their intern training the previous year in the retail sector.



Application and allocation process

Being the first cohort of CS pharmacists, the application process was poorly organised, and many felt that the allocation process was unfair. The majority felt that they were given inadequate information to make choices, and the allocations were made extremely late in the year. There was some confusion over the availability of CS posts and accommodation and this meant that the situation at the beginning of the year was extremely tense at a number of sites. Those who got their first choices were satisfied, but the 33% who were allocated in the second and third rounds (i.e. not one of their first five choices) were less happy. Although there were formal orientation programmes arranged in some provinces, almost half of the respondents reported that they were not **orientated** to their jobs. A number of CS pharmacists were sent to health facilities where there had never been a pharmacist before, and these experienced particular challenges.



Experiences of CS pharmacists

Notwithstanding these initial difficulties, the feedback from this first cohort was extremely variable, and in many instances, surprisingly positive. The focus group interviews tended to allow the ventilation of suppressed frustrations, especially with regard to hospital management and conditions of service. However, when looked at objectively in terms of the exit questionnaire, the vast majority felt that they had made a difference during the year, and said they had developed professionally as a result of the CS experience. Half described their attitude to CS as positive and the other half as negative, and this appeared not to have changed over the course of the year (Figure 13).



Most CS pharmacists felt valued as part of a team, and took some part in management of the pharmacy or unit. However, there were enormous variations in the quality of management of the pharmacies and hospitals. Some pharmacies and hospitals welcomed and included the new recruits,



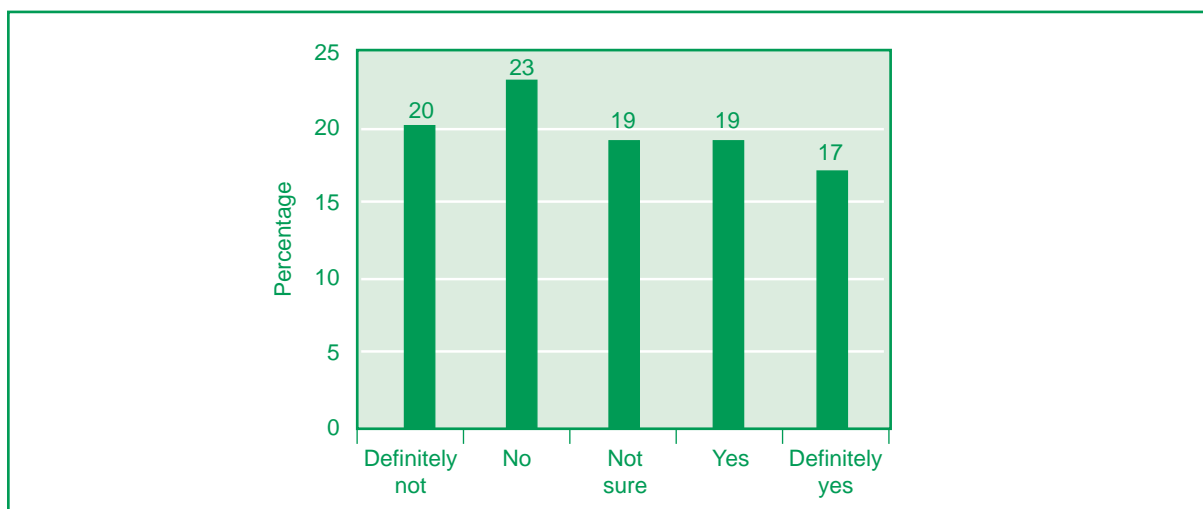
into management and others used them just as another pair of hands.

Pharmacists placed in institutions where there had never been a pharmacist before made a tangible difference, especially in rural hospitals. Examples witnessed by the audit team include:

- Introducing new stock systems and budget control
- Better patient counselling
- Training of primary care nurses on rational drug use
- Attending ward rounds.

Initiative and energy, which CS pharmacists bring to an institution was seen at the Hillbrow manufacturing unit, where two CS pharmacists had introduced new systems and significantly increased the production level.

Figure 13: Responses of CS pharmacists to the question: “Has your CS experience influenced your career plans?”



Written submission from a CS pharmacist at a rural hospital in KwaZulu-Natal:

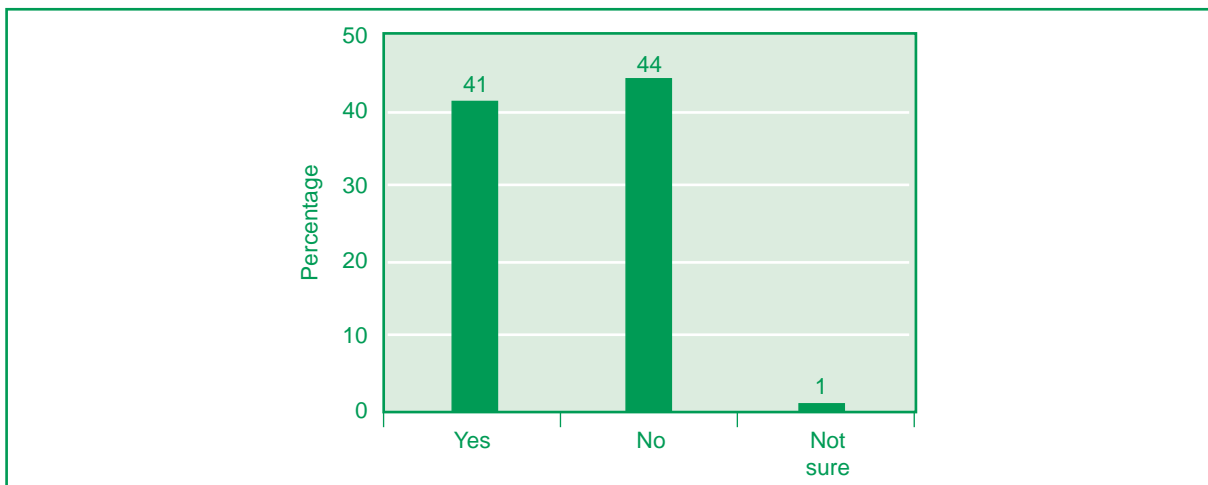


“When I started working at N Hospital there was no pharmacist here before me. All the work was being carried out by the assistants, and I knew there was a lot of work to be done in order to get the pharmacy up to an acceptable standard. I started creating control cards and entering these onto a computer programme, placing the monthly orders, dealing with leave and the staffs’ personal problems, as well as tons of paperwork. I came to the conclusion that the assistants could run the pharmacy without a pharmacist. But before considering applying for a transfer with the Head Office, I decided to change my way of thinking and make the most of the situation. My first objective was to control the budget for drugs and if possible to reduce it ... Don’t get me wrong and think that it is great living in a rural hospital – I would have preferred to have been placed in an urban situation close to family and friends. But community service is here to stay and it is just a matter of accepting and concentrating on the positive and not dwelling on the negative. Giving a year of your life to the community can be seen as good or bad depending on how YOU spend the year. Community service is basically what you make of it.”



Most CS pharmacists felt that their role was not clearly defined, and only 41% had a job description. (Figure 14). About half reported that they felt valued as part of a team, and experienced a satisfactory level of support from pharmacy managers. Even though they were often the youngest members of the team, they were often put in charge of a team of older pharmacy assistants who had been working for years, and this caused some friction where the CS pharmacists were not mature enough to handle the situation sensitively. In other situations, the initiative and new ideas of the CS pharmacists were welcomed and utilised, particularly with regard to computerisation.

Figure 14: Responses of CS Pharmacists as to whether they have a job description



Pharmaceutical services managers were reassured to have a reliable supply of young CS pharmacists each year, even though this meant additional orientation, in the light of the unpredictable turnover of permanent staff.

Many felt under-valued by the salary level of government pharmacists, and the fact that they are not seen as being fully qualified: “*We are seen as students*”, “*I am treated like a donkey-boy*”, “*I am just an extra pair of hands*”.

The vast majority (71%) felt strongly that they would remain in the public service if the salary package of pharmacists were higher.

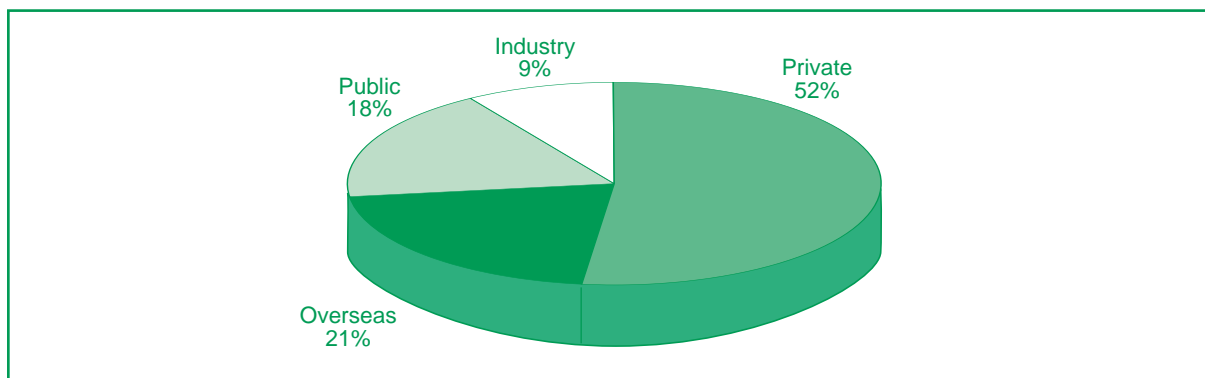
The salaries of pharmacists in the public sector compared to the retail/private sector were clearly insufficient to retain them in areas of need, and these institutions would continue to rely solely on CS pharmacists in the future. This raised the issue of end-of-year handovers and the need to ensure that the systems and initiatives begun by one CS pharmacists were not wasted, but continued by successive CS pharmacists in isolated pharmacies.

With regard to plans for the following year, 52% intended to work in the private sector, 21% planned to go overseas, 18% were to remain in the public sector, and 9% planned to work in industry (Figure 15). Of those intending



to work overseas, about half did not intend to return to the country. Whereas most (60%) said they would not consider working in a rural or under-served area in the future, 13% said they would consider it.

Figure 15: Shows the intended place of work of Y2001 CS Pharmacists the following year



Other Professional Groups: 2003

Seven new groups of health professionals are due to begin their CS in 2003, and planning for their placements is currently underway. These are:

- Physiotherapists
- Occupational therapists
- Speech therapists
- Dieticians
- Radiographers
- Clinical psychologists
- Environmental Health Officers.

The numbers in each group are relatively small, but the same issues that affected the first cohorts of doctors, dentists and pharmacists are likely to affect these graduates as well. A baseline study of entrants' attitudes to and experience of CS within the first months is being planned in collaboration with the World Health Organization (WHO).

Conclusions

Overview

With respect to the responses of all three professional groups undergoing CS, there were a number of patterns that were notably similar. Firstly, despite difficulties and frustrations, the majority felt that they had made a difference and had undergone some professional development. Overall, most described their experience of the year as positive in retrospect, but only a minority



reported that their attitude had become more positive during the year. In other words, the experience of CS appears to have no net effect on young professionals' career plans, but merely delays them by a year. This is in contradiction to the hopes of the Department of Health that establishing the system of CS would positively influence health professionals' future contributions to the health system.

Supervision of CS doctors, dentists and pharmacists by more senior professionals was found to be significantly poorer in rural than in urban settings. Of significance is the finding that around 20% of CS doctors would voluntarily consider working in a rural or under-served area in the future, a cohort that could potentially fill the staffing needs of these hospitals and clinics, given the right incentives. However, only 13% of pharmacists and 6% of dentists shared these career plans.



Gaps in skills and attitudes

It has become apparent that new graduates entering CS, experience a disjuncture between the academic training expectations and the actual conditions in the public health service.

Dentists showed the greatest gap, between their skills and expectations as university graduates, and the needs and context of oral health in the public service. With a few exceptions, they had no idea how to address oral health on a population-based level, and many were reduced to managing pain and sepsis through endless dental extractions, while their costly high-tech skills were unused during the year. The frustration that this generated added to the resentment of having been coerced into CS, and as a result this is probably the most disaffected CS group.



CS pharmacists who had completed their internships in the retail sector, were also initially disorientated in the public health sector, but pharmacists as a group were probably the most appropriately trained for the work required of them during CS. Their skills and knowledge was valued and appreciated particularly where there had been no pharmacist before, and they made a noticeable difference in a number of situations.

Doctors varied widely in their level of preparedness not only in skills but also in attitudes. The DoH Task Team on Skills and Competencies of Junior Doctors highlighted the important issues of the so-called 'soft skills' of teamwork, and highlighted the fact that excellent technical or medical skills are rendered useless in the absence of the ability to handle conflict, teamwork and responsibility. Language gaps were also found to be a factor. The task team also found that the absence of management support in a number of institutions, with regard to laboratory services, transport, equipment and policy issues, made it difficult for the skills of the doctors to be utilised.



All of these gaps reflect on the appropriateness of the curricula at university level to the South African realities in the public service, and also indicate the

need to put in place training programmes to address these gaps, both before as well as during the CS year.

Conditions of service and management

CS tends to highlight the general management deficiencies in the public health system, as each successive group of young professionals encounters the system anew. All groups expressed dissatisfaction at the conditions of service in the public sector, but particularly the pharmacists, many of who had exposure to the private sector during their internships. Many of the dentists, who have a particular reliance on specialised equipment and supplies, found themselves unable to perform any but the most basic procedures.

Where accommodation was provided for CS professionals at rural hospitals, most reported that it was satisfactory, but there was significant variation between provinces. More females than males complained that CS has put them at an increased risk to their personal safety. A few felt that their religious beliefs were compromised by the site of their placements, but this was less than 10 individual respondents in total from all three groups.

A few provinces have attempted to improve the burden of CS in isolated or inhospitable sites by arranging rotations of CS professionals with a 'complex' of institutions, between larger urban hospitals and smaller rural ones. This has worked well in some instances, with 6-month or 3-month rotations, but the educational value of exchange has not been fully realised in other provinces, since CS is regarded as service and not as a training year.

Emigration

A feature of all these young professionals is the alarming number (20% and 45%) that are planning to work overseas the following year. One-fifth of the pharmacists, and just under half of the doctors and dentists surveyed intended to work outside of SA the following year. In the case of doctors, an increasing trend has been documented since 1999, now amounting to around 500 per year. While most intend to return, a significant minority are undecided, and could be swayed either to return or to continue working overseas, depending on the relative attractions. This group needs to be targeted with incentives to return and contribute to the health needs of the country.

Recruitment and retention of professional staff in under-served areas

Three years after the introduction of the CS scheme, the most difficult to staff hospitals still remain without doctors. Additionally the turnover each year burdens senior staff, who have to orientate and train each new group. Moreover, the coercive nature of the scheme gives rise to negative attitudes on the part of a significant proportion of CS professionals, which is difficult to manage, especially in small institutions. This raises the question of whether CS, in engendering a sense of obligation on the part of the newly qualified professionals, actually defeats its own ends as they assume that they have



‘done their duty’ and compensated society for the costs of their studies, after only one year. For the same reason it could also be seen as one of the ‘push’ factors in the current brain drain to overseas. This has been found to be the case with respect to the National Health Service Corps in the USA, where those who were contracted into service in rural areas as compensation for the payment of their education costs, did not remain longer than their service obligations.⁷ This was in contrast to those who chose these situations voluntarily, who tended to stay longer in such communities as they were often those who had grown up in such surroundings. An article from Ecuador about CS, which has been in operation since 1975, similarly challenges the assumption that CS attracts health professionals to remain in under-served situations, and suggests an alternative system based on volunteerism.⁸



There are many other non-coercive strategies that have been shown to be effective in ensuring adequate staffing of rural health facilities, and these need to be put into place. The active recruitment of high school students from rural and under-served areas into tertiary health science education, with appropriate educational and financial support, is a long-term strategy that has been shown to make a difference not only in other countries but also in South Africa.⁹ Secondly, the exposure of undergraduate students to rural and under-served areas during their training, and maintaining the links of those students drawn from rural areas with their communities of origin, will probably increase the proportion of graduates who will consider this a career option. Thirdly, financial as well as non-financial incentives such as housing, extra study leave and postgraduate educational support, can retain practitioners in areas of need.



The factors that will attract health professionals to practice in under-served areas within South Africa are the same in principle as those that would encourage them to remain in the country. A thorough recruitment and retention plan is needed by the Department of Health, in order to prevent the ongoing loss of valuable human resources from the country, and at the same time provide the conditions that will support those who choose to work in circumstances that most prefer to avoid. This demands nothing less than ‘swimming against the stream’, in a globalised economy where health services can be bought by the highest bidder. But it is precisely in these choices that health professionals can demonstrate their willingness to contribute to alleviating the pain and suffering of those who are disadvantaged, motivated not by financial gain but by a commitment to their vocation.



Recommendations for Community Service for Health Professionals

It is recommended that:

- 1 A comprehensive national plan is drawn up for the recruitment and retention of health professionals in rural and under-served areas that includes other complementary strategies besides CS.
- 2 Health Science Faculties address the gaps between the skills and attitudes of their graduates, and the realities of the health of the South African public, as experienced by CS professionals.
- 3 Detailed information on CS should be made more widely available to applicants.
- 4 Rotations between isolated or inhospitable sites and more urban sites for CS be facilitated where appropriate, in each province.
- 5 Rural incentives, both financial and non-financial, should be put in place to retain health professionals in areas of need.
- 6 Supervision of CS professionals in rural areas needs to be improved through direct support by health managers, as well as the support of senior clinicians in the health system, through appropriate promotions and acknowledgement.
- 7 The strategy of CS should be reviewed after 5 years, to examine whether it is in fact achieving the goal for which it was instituted.

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