Perceptions of and attitudes to the Compulsory Community Service Programme for Therapists in KwaZulu-Natal, 2005

Submitted to:

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Submitted in partial fulfilment of the academic requirements for the degree:

Master of Public Health

SUPERVISOR

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27 January 2009

ABSTRACT / SUMMARY

Introduction

Compulsory community service programmes have been initiated in many countries to recruit health care professionals to provide services in rural and under-served areas. However, the success or failure of the Community Service Programme depends largely on the attitudes of the professionals, their understanding of the programme's objectives, their preparedness for working in these areas and their ability to adapt to a new and challenging experience.

Aim

The aim of this study was to assess therapist's perceptions and attitudes about the compulsory Community Service Programme in KwaZulu-Natal in 2005 and to assess whether these changed during the year.

Methods

An observational cross sectional study with a descriptive and analytic component was conducted on commencement and after completion of community service. The therapists completed a self-administered questionnaire before and after their community service.

Results

A total of 126 (89% of 142) therapists responded to the initial questionnaire, 59 (42%) completed the exit questionnaire of which 47 (33%) completed both the questionnaire at commencement and completion of community service. Despite the poor response rate, similarities in perceptions and attitudes were noted with other studies conducted nationally and internationally. At onset 50% indicated that they would work in the public sector in the future and this proportion declined to 35% by exit. Even fewer (24%) said they would work in a rural area in the future. Only 16% reported that they would stay on at the same institution the year after community service. There was also no significant association between therapists collecting a rural allowance and expressing an interest to work in a rural area in the future ($p=0.78$) or staying at the same institution in the years after community service ($p=0.32$). However, therapists working in urban areas were more likely to say they would work in a rural area in the future ($p=0.018$). The comparisons between the occupational catergories showed that for support and supervision, the Speech Therapy and Audiology Forum was considered significantly ($p=0.001$) supportive compared to the Physiotherapy Forum.

There was no significant difference within the occupational catergories in their perceptions of support, mentoring and supervision, attitude, psychological coping, personal and professional gains, safety issues and the amount of community outreach conducted. All groups were similarly resource constrained. Language was a barrier for 50% of all community service therapists and impeded their professional functioning.

Discussion

Despite the challenges experienced by community service therapists the majority felt that they had made a difference in the community in which they have been placed. The obligation to work in rural and under-served areas was personally and professionally rewarding. Particular concerns centred on support, supervision, training, resources and language barriers in providing better service delivery.

Recommendations

To achieve its objectives in relation to compulsory community service, which is to ensure an improved provision of health services to all citizens of the country, the Department of Health should consider multiple strategies including financial incentives such as rural allowances and non-financial incentives to retain health care personnel in rural and under-served areas. A long-term strategy that addresses human resources in a comprehensive manner needs to be developed to improve staffing and quality health services in these areas.

DECLARATION

I, Nasim Khan declare that:

(i) The research reported in this dissertation, except where otherwise indicated, is my original research.

(ii) This dissertation has not been submitted for any degree or examination at any other university.

(iii) This dissertation does not contain other persons' data, pictures, graphs or other information, unless specifically acknowledged as being sourced from other persons.

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ACKNOWLEDGEMENTS

I would like to thank my supervisor Dr. Knight for his input and advice. A special thanks to Tonya Esterhuizen, the biostatistician, who assisted me tremendously and to my family for their patience and support. I wish to acknowledge all community service therapists who participated in the study by completing the questionnaires.

PUBLICATIONS OR PRESENTATIONS BASED ON THIS RESEARCH

Since the completion of the study, clinical areas that therapists have expressed as needing more training on, have been communicated to University of KwaZulu-Natal-Westville Campus from where the majority of the participants came.

The KwaZulu-Natal Department of Health's, Disability and Rehabilitation Programme has also motivated for a central budget for in-service training for all community service therapists. This will assist in gaining competencies in practical management of the various disabilities seen by the therapists.

The needs and gaps identified in the study have been used to design the induction and orientation programmes for new community therapists at the onset of their community service.

Guidelines on mentoring, support and supervision have been drawn up using the Health Professions Council of South Africa's guides, for senior therapists and community service officers.

In 2008, the professional public sector fora for Occupational Therapy, Physiotherapy and Speech Therapy and Audiology are planning a joint training workshop in isiZulu to assist all community service therapists with basic isiZulu to communicate with their clients.

ACRONYMS AND ABBREVIATIONS

CS	Community Service
DOH	Department of Health
KZN	KwaZulu-Natal
KZN-DOH	KwaZulu-Natal-Department of Health
NDOH	National Department of Health
PDOH	Provincial Department of Health
PWD's	Persons with Disability
RSA	Republic of South Africa
WHO	World Health Organisation

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1 CHAPTER 1: INTRODUCTION

1.1 BACKGROUND

The recruitment and retention of professional healthcare workers in rural and under-served areas is a global and complex issue. Both developing and certain developed countries have significant shortages of health personnel in rural and under-served areas. Internationally many reasons have been cited why health care personnel avoid working in these areas. These include feelings of isolation, not feeling like a professional and a lack of support and contact with higher levels of the health system (Hall, 2001). Health care for rural populations has become a priority need to address throughout the world (De Villiers, Van Velden, 1996).

Many strategies have been developed to recruit health care professionals to rural areas. Among these strategies is compulsory community service. Such a strategy was adopted by South Africa in 1998, mandating medical and allied health professionals such as Audiologists, Occupational Therapists, Physiotherapists and Speech Therapists to perform remunerated community service for a period of one year. Only on completion of compulsory community service are they permitted to practice in their respective professions in South Africa. Community service (CS) is part of a broader policy governing the medical and allied health professions in South Africa, and aims to promote and reinforce standards of excellence in the provision of health care especially in under-served areas of the country. The Medical, Dental and Supplementary Health Service Professions Amendment Act of 1998 (RSA, 1998) established the Health Professions Council of South Africa, a statutory body regulating the medical and allied health professions, and enabling the creation of professional boards for the various health professions. The Act lays down the policy for community service for health workers stating that "any person listed in the regulations of the Act shall perform remunerated community service for the period of a year and only on completion of the year will be able to perform in their respective profession" (RSA, 1998).

Community service for therapists providing disability and rehabilitation services namely, Audiologists, Occupational Therapists, Physiotherapists and Speech Therapists began in 2003 in KwaZulu-Natal. Disability and rehabilitation services in South Africa are largely under-developed and quite inaccessible to the majority of the population especially in rural areas (NDOH, 2000). There is an overall shortage of public sector health therapists to provide

disability and rehabilitation services, and often, if available, they are based in better resourced institutions in urban areas. Although most therapists are based at urban hospitals there are too few posts and personnel to provide quality services. A recent report on the status of posts for therapists received from the Human Resources Directorate in the KwaZulu-Natal, Department of Health (KZN-DOH), (2008) indicated that 50% of posts in the Province are not filled (Table 1).

Table 1: Numbers of Therapists posts filled, frozen and vacant in KwaZulu-Natal 2008

Posts	Filled	Frozen	Vacant	Grand total
Physiotherapists	217	214	19	450
	(54%)	(55%)	(61%)	(55%)
Occupational therapists	103	130	7	240
	(26%)	(33%)	(23%)	(29%)
Speech therapists &	80	45	5	130
Audiologists	(20%)	(12%)	(16%)	(16%)
Total	**400**	**389**	**31**	**820**

Source: Human Resources Department, KwaZulu-Natal, Department of Health, Natalia, 2008

Therapists also face many resource constraints. In KwaZulu-Natal (KZN) they not only provide services to urban and rural patients from within the province, but also service patients from other provinces including Eastern Cape and border countries like Mozambique.

The overall prevalence of disability in South Africa (Census, 2001) was 5%. There are estimated to be more than 2 255 000 Persons with Disability (PWD's) in South Africa. The Census reports the proportion of people with different disabilities. The largest proportion (32%) had visual disabilities. Physical (30%), hearing (20%), emotional (16%), intellectual (12%) and communication (7%) of other disabilities made up the rest.

The majority of persons with disabilities live in rural areas and are often the poorest of the poor who are unable to access health care including rehabilitation services.

The Integrated National Disability Strategy (NDOH, 1997), outlines the goal of rehabilitation services, as "enabling Persons with Disability to reach and maintain their optimal physical, sensory, intellectual, psychological, social and emotional levels; to provide persons with disabilities with the tools to change their lives and to empower them with a degree of independence; to prevent secondary disabilities or to reduce the extent of the disability as well as to take into account the specific needs in terms of the different disability groups". The term rehabilitation can be applied broadly to reflect medical, psychological, educational and social rehabilitation including the provision of assistive devices.

Due to the overall shortage of therapists in the public sector and low priority in terms of resources given for disability and rehabilitation services, the study assessed the attitudes and perceptions of all community service therapists placed in both urban and rural areas.

The National Department of Health (NDOH), in consultation with the Provincial Departments, is responsible for the allocation and placement of community service therapists to various hospitals in the province. Community service therapists in KZN are also expected to provide community-based services from clinics in the district. It is recommended that 40% of their time per week is spent at clinics in KZN. Servicing clinics is only a requirement of therapists and not any other category of health worker doing their community service in KZN.

In September of their final year of training, student therapists are asked to select five institutions, in order of preference, where they would want to be assigned for their community service. If not placed in the first round of allocations, this process is repeated until each eligible therapist has been matched with a hospital. The hospital allocated by the provincial department must be one that a therapist has chosen and must be one of those gazetted as community service sites.

The KwaZulu-Natal Department of Health's Disability and Rehabilitation Programme conducts an annual two-day orientation for all therapists at the start of each year. Such a programme has proved to be invaluable to all community service rehabilitation therapists in providing information on various resources, assistance with the social aspects, outlining a sound mentoring and support system and provided specific clinical information that could be encountered during the community service year.

The success or failure of the Community Service Programme depends largely on the attitudes of these health professionals, their understanding of the programme's objectives, their preparedness for doing rural service and their ability to adapt to the new and challenging experience (Cavender, Alban, 1998). Health professionals participating in the mandatory one-year compulsory Community Service Programme are important actors in the implementation, monitoring and evaluation of the community service policy as the programme directly affects their personal and professional lives. Health personnel, unlike other resource inputs into the health system, are not passive role-players in the planning process. Their attitudes and perceptions may either promote or conflict with the objectives, goals and needs of the health service. It is critical to identify areas of support and areas of possible resistance by this important professional group to the human resource planning process (Sanker, Jinabhai, Munro, 1997). The happiness of community service professionals who constitute a sizeable proportion of human resource in under-served areas can ultimately determine the success or failure of health sector transformation (Lehman, Sanders, 2003/2004).

Continual monitoring and evaluation of the Community Service Programme will ensure that its implementation is informed by those particular strategies, policies and programmes that work (Reid, Conco, 1999). A study on the perceptions of hospital managers regarding the impact of community service doctors indicated that community service had improved the delivery of health services, alleviated work pressure and improved the image of hospital managers (Omole, Marincowitz, Ogunbanjo, 2005). The negative aspects were that these young professionals felt unsupported, unable to provide continuity of care and were constrained for resources needed to provide a quality health service due to limited hospital and specifically rehabilitation budgets.

Understanding the therapist's perspective and attitudes is essential and formed the basis of this study These key stakeholders of the Community Service Programme can also provide valuable insights, in terms of the needs, successes and recommendations for improvement that can be used by those planning and managing the service as a whole. By assessing the attitudes and perceptions of therapists undertaking their community service, this study would assist in identifying areas of need as well as successes in the implementation of the programme. As a result, recommendations could be made to enhance the success of

community service, ensuring sustained and improved distribution and effectiveness of therapists in under-served areas and ultimately an improved health status of the community.

1.1.1 What is known so far?

South Africa has a large rural population that live under very difficult environmental conditions. They are badly affected by poverty, disease and the burden of the Human Immunodeficiency Virus/Acquired Immune Defiency Syndrome. The major health care challenge is to provide basic health care to all South Africans including persons with disabilities and to rectify the underlying inequities in the provision of all health services. There is thus a huge need for rehabilitation services provided by therapists. However, due to the legacy of apartheid, medical and other health professionals are concentrated in urban areas.

In KwaZulu-Natal, 54% of the population live in rural areas (PDOH, 2006/2007), where the need is greatest for health care professionals (Reid, 1999). Many district hospitals are struggling to find sufficient staff to deliver the core package of primary health care service demanded by the National Department of Health (NDOH). There is an inequitable distribution of resources as well as a maldistribution between the public and private sector (SAHR, 2003/2004). In South Africa, the private health services consume a larger budget on health care than the public sector does. The private sector employs the majority of health care personnel while catering for only 23% of the population. In addition, policies such as the provision of free services to persons with disabilities (NDOH, 2003), has resulted in a substantial increase in patient caseloads, which was not matched by a concurrent increase in health personnel (Buthelezi, Wadee, Makhanya, 2002).

South Africa is also struggling to retain skilled health professionals due to migration to developed countries, negatively affecting the already strained health services in the country where they have been trained. Training institutions have been attempting to review their curriculum and their admission criteria to respond to the local needs in an attempt to address past inequities (Abdool Karrim, 2004). Other countries such as Canada, Australia and Pakistan and many developing countries have noted similar migration in their health care workers that exacerbate gaps in health service delivery. Migration causes a loss of professionals that might potentially reform, organize, stabilize and expand the health system

(Jamsheer, Talati, Pappas, 2006). A further problem with human resources, in particular medical and allied health professions has been the inadequate numbers produced by training institutions. Furthermore most health science students come from the more urban areas that have better access to good schooling and training institutions. According to Moomal and Pick (1998) the production of health care workers in South Africa remains very limited in meeting the needs of health services. This was supported by Abdool Karrim (2004) who also felt that as part of the management of public health services the conditions under which professionals work needs to be addressed. Another challenge is for newly qualified professionals to be able to translate theory into practise and also to be aware of their skills gaps (Cameron, Blitz, Durrheim, 2002).

Since 1994, the democratic government of South Africa has developed many enabling policies to improve access to services. The Department of Health's policy of primary health care through the district health system was introduced to bring health services closer to the people. Disability and rehabilitation services form an important component of primary health care. The White Paper for the Transformation of the Health System (NDOH, 1997) aims to distribute health personnel throughout the country in an equitable manner. Access to health care would also be improved by the Compulsory Community Service Policy (Reid, 2001).

Community service in South Africa began in 1998 amid much controversy. The policy challenged the legitimacy of the then health minister, Nkosazana Zuma, and its implementation was highly contentious. It dominated newspaper headlines, creating a furore among young doctors, medical students and opponents of the African National Congress Government, who viewed the policy as being comparable to military conscription. Participants and stakeholders, central to the community service policy include health professional bodies, academic institutions, Non-governmental Organizations, political organizations, the media, health practitioners and the government. The Community Service Policy was intended to redress the imbalances in health care provision created by the previous apartheid government policies. It was reinforced by the strong political will of the ruling party to deliver on its promises of "a better life for all". While there may have been disagreement about the most appropriate way to redistribute personnel to under-served areas, universal support for the principle behind the policy was not in question (Reid, 2001).

The purpose of community service was to provide health professionals to previously disadvantaged communities in order to ensure an improved provision of health services to all citizens of the country. It also provides an opportunity for newly qualified professionals to develop skills, acquire knowledge, behaviour patterns and critical thinking, which could help them in their professional development (Reid, 2001). However, it also raised other issues such as the emigration of health care professionals and public and private sector imbalances of health professionals. In addition it highlighted the ever present reality that the rural incentives provided by government were offset by many disincentives. In particular more needed to be done to improve working conditions in under-served areas (Couper, 1999).

Prior to the implementation of the Community Service Policy for health professionals, the government employed a number of strategies to address the distribution of personnel to rural and under-served areas. These included the deployment of Cuban doctors in rural hospitals, the introduction of a rural allowance as a financial incentive to keep doctors in rural areas and attempts to establish inter–government agreements to curb the brain drain.

Local initiatives have also been undertaken to address the problem. In Northern KwaZulu-Natal, the Friends of the Mosvold Scholarship recruit local students to work in hospitals near to where they live. If found suitable as potential professional health workers they are provided with scholarships to study in health sciences at a tertiary education level. In return, when qualified they are obliged to work in the rural hospital in the area from whence they came. Each student has a contract to work in the area dependant on the number of years of the scholarship (Ross, Couper, 2004). The scholarship scheme also provides support and mentorship while students are training. Peer support groups and facilitation of holiday work experience allows for easier integration of these professionals into the workplace once they qualify (Ross, 2007). Lessons and examples from this successful programme can be used in the training and mentoring of community service therapists.

The context and nature of their work and of the environment in which they practise are essential factors in the health care professional's decisions to continue working in rural areas (Couper, Hugo, Conradie, Mfenyana, 2007).

More recently, the DOH launched their Human Resources for Health Plan (RSA, 2006) which attempts to address the issue of human resource management and development more

comprehensively. It aims to ensure that the country possesses a steady supply of appropriately qualified, adequately trained, highly skilled and appropriately remunerated health workers.

1.1.2 What needs to be known?

The long-term impact of community service must be evaluated in terms of the effect it has on the health status of rural and under-served communities. The short-term outcome of the programme in terms of the intention to retain health care professionals in under-served areas and strategies instituted to achieve this is also important. The immediate ouput of the programme needs to determine how therapists perceive community service in terms of their understanding, preparedness and adaptability. This study will determine whether the concerns about compulsory community service raised by doctors internationally and within the country are similar to those of local community service therapists. It is also important to know if concerns raised are centred on the professional work aspects of community service itself or whether the problems are managerial or logistical inadequacies in the programme. The study attempts to determine whether there are changes in attitudes and perceptions from the time when therapists commence their community service to the time of its completion. It would also determine whether these differences are associated with occupational category, race or gender. The recommendations made by current community service therapists once their term has been completed will assist in planning, monitoring and evaluation of the Community Service Programme in KwaZulu-Natal.

1.1.3 What is the importance of this study and how will the study solve the problem?

Community service therapists who are directly involved in the Community Service Programme possess valuable insights into the needs, successes and recommendations for improving the programme. Research into the programme for therapists will provide greater insight into their experiences, perceptions and attitudes, which will assist in informing and improving such placements. Therapists doing community service in KZN are also unique in that they need to spend 40% of their time providing services at clinics in the district so will also provide useful insights into the disability and rehabilitation needs at primary health care clinic level. The Department of Health's objective of increased and improved coverage of

services in under-served areas is partly realized by the Community Service Programme and can contribute to other strategies already in place or envisaged to be implemented.

There are many factors that influence therapist's decisions not to work in rural and under-served areas. The perceptions and attitudes of therapists in community service will provide useful information relating to these factors to all policy-makers, the provincial Rehabilitation Programme, universities and permanent therapists involved in the Community Service Programme. It will facilitate more effective planning, implementation, monitoring and changing of community service for therapists in KwaZulu-Natal and will improve service delivery to the patients. The effectiveness of the Community Service Programme needs to be improved in order to achieve the Department of Health's objective of retaining health care professionals in the public sector and ultimately improving the health status of the community. The current study will also inform the future research agenda in the field.

1.2 STATEMENT OF THE PROBLEM

Many therapists do not remain in rural service and under-served areas once their one year of compulsory community service is completed. The effectiveness of the Community Service Programme is influenced by the therapist's attitudes, perceptions and understanding of the programme, as well as the level of support received at the outset and during the course of the compulsory community service year.

The factors that impede implementation of the community service policy and that require change need to be identified. Successes of the programme need to be documented so that they can be implemented more widely. These include the reasons why some therapists remain or return to public sector service, especially in rural and other under-served areas.

1.3 PURPOSE OF THE RESEARCH

The purpose of this study is to assess the therapist's attitudes and perceptions to the compulsory Community Service Programme in KwaZulu-Natal, and to identify the strengths and weaknesses of the programme and make recommendations to enhance its success.

1.4 SPECIFIC OBJECTIVES OF THE RESEARCH

- To assess the attitudes and perceptions of therapists at the beginning and on completion of their community service, in relation to their understanding of the objectives, as well as their knowledge, preparedness, personal and professional benefits, and adaptability to the programme.
- To identify differences in attitudes and perceptions amongst different occupational catergories, namely Audiologists, Occupational Therapists, Physiotherapists and Speech Therapists.
- To identify whether differences in attitudes and perceptions of therapists are associatied with their gender, marital status, choice of placement and race.
- To make recommendations for future community service for therapists to the Department of Health and the training institutions.
- To inform the future research agenda in the field of compulsory community service for therapists in South Africa.

1.5 ASSUMPTION UNDERLYING THE STUDY

Health professionals participating in the mandatory one-year compulsory community service are important actors in the implementation, monitoring and evaluation of the policy as this directly affects their personal and professional lives. It is therefore important to determine the attitudes and perceptions of therapists to their community service experience, in order to inform planning of rehabilitation services in KwaZulu-Natal.

1.6 OPERATIONAL DEFINITIONS USED IN THE RESEARCH

Rehabilitation therapists – refer to all Audiologists, Occupational Therapists, Physiotherapists and Speech Therapists working in disability and rehabilitation in the KZN-DOH.

1.7 SCOPE OF THE STUDY

The study was conducted in all hospitals in KwaZulu-Natal employing community service therapists in 2005.

1.8 ORGANIZATION OF THE REPORT

The report consists of the following chapters:

Chapter 1 is the introduction and outlines the background to the research, gives a statement of the problem being addressed and lists the study objectives.

Chapter 2 presents the literature review of the field of community service and related issues in order to contextualize the research question and the findings of the study.

Chapter 3 describes the methods used in this master-level research project.

The results are presented in Chapter 4.

Chapter 5 contains the discussion and conclusions based on the research findings in the light of available scientific literature.

Chapter 6 provides recommendations and conclusions.

1.9 SUMMARY

The introduction to the study of compulsory community service for therapists in KwaZulu-Natal, 2005 outlines the background, statement of the research problem and the aims and objectives of the current study. The next chapter will present the literature review covering the field of community service and related issues.

relevant for this study. There are no formally published studies evaluating community service for therapists in South Africa. The informal research conducted by the Rehabilitation Programme has not been analyzed statistically as the response rate was very low. However, from the evaluations in 2003 and 2004, as well as the studies conducted on doctors, several themes have emerged which are explored in this literature review. These include concerns around mentoring and supervision, problems with logistics such as accommodation and transport, training issues, professional work within communities, language barriers, service delivery issues and numerous personal concerns of rehabilitation therapists. The findings of the studies on doctor's and the informal evaluation conducted by the KZN-DOH's, Rehabilitation Programme in 2003 and 2004 (PDOH, 2003 & 2004) are used as baseline data for this study.

2.4.1 Purpose of community service internationally

Compulsory programmes for physicians and other health care professionals have been initiated in many developing countries, since the shortage of physicians in rural and under-served areas constitutes a problem globally. The underlying assumption for the creation of the programme is that the increased presence of professionals will improve the health status of these populations, which exhibit higher rates of morbidity and mortality as compared with urban populations (Cavender, Alban, 1998). Historically, various programmes have been undertaken to mitigate urban-rural imbalances in the distribution of physicians. According to the World Health Organisation (WHO), countries must ensure regular monitoring of their efforts at improving equitable distribution of health personnel and how inequity of human resources impact on the health status of communities (Hall, 2001).

2.4.2 International experience with community service

In the 1920's rural communities in both Canada and the USA offered incentives to recruit physicians, including salary increases and free housing. Scholarship incentives tied to the rural service requirement were also provided. Canada has integrated educational programmes at a number of universities that aim to increase student and resident participation in rural health care. A further aim is to encourage medical professionals to take up practice in rural areas. Canada is also attempting to consider policy issues and ethics regarding migration or active recruitment from developing countries through government-to-government

negotiations (Chan et al, 2005). The National Health Service Corps deployed in the United States of America in 1971 provides a means whereby medical graduates can repay their study loans by working in under-served facilities (Reid, 2001).

Mexico established the first compulsory medical service programme in 1936. The programme involved a six-month period working in an under-served area and was subsequently extended to a year. Cuba and the Dominican Republic also commenced compulsory medical service of programmes in the 1960's. Ecuador commenced community service in 1970 and required all medical, dental and nursing personnel to complete a year of community service as a condition for obtaining a license to practice (Cavender, Alban, 1998). In the Ecuador study, it was found that community service did not succeed in providing the medical attention needed and integral to the rural population. The community service doctors often lacked the essential diagnostic and therapeutic tools essential to practice their profession in these needy and under-served areas. It was also discovered that their training had only oriented them to work in urban as opposed to rural settings. However, they reported that the community service experience provided them with an insight into the deplorable conditions under which rural people live. They learned practical skills, gained greater confidence and found the experience personally and professionally rewarding (Cavender, Alban, 1998).

In Pakistan, no compulsory community service policy exists but due to the huge migration of professionals certain incentives have been instituted to improve rural health care (Jamsheer, Talati, Pappas, 2006). Preference is granted to those who have completed 3 years service in under-served areas when competing for training posts for specialization. Other studies in Australia and Canada report recruiting students from rural backgrounds, expanding rural undergraduate training and expanding opportunities for rural post-graduate training to attract health workers to rural practise (Wilkinson *et al*, 2003; Chan *et al*, 2005; Dauphinee, 2006).

2.4.3 Experience with community service in Africa

Nigeria, which has the closest comparable community service scheme to South Africa, has had a National Youth Service Corps since 1975, which allocates all graduates from tertiary education to compulsory service for a year. No choice is given and approximately 90% end up in needy rural areas. In Nigeria, it has now become accepted as part of every

professional's career. The professionals are given a special uniform and have status within the community they serve.

2.4.4 Experience with community service in South Africa & KwaZulu-Natal.

A number of studies in South Africa focussed on the experiences of community service of medical doctors. Studies by Reid (2001, 2002) on doctors, dentists and pharmacists revealed that the majority of them felt they had made a difference to the population they served during their community service year, which they described as positive outcome. They did however, complain that supervision, support and mentoring was inadequate. There were language barriers, gaps in skills and knowledge and many managerial and administrative difficulties to overcome.

A similar study in Mpumalanga (Maseka, Ogunbanjo, Malete, 2002) on the perception of doctors to their community service year at Shongwe hospital revealed that whilst they agreed with the idea of community service they were unhappy with the implementation. The doctors alluded to feelings of remoteness and isolation, lack of social amenities and poor administration at the hospital at which they were based. Academic support and academic teaching were identified as areas that needed improvement. A positive consequence was that they gained confidence, especially in practical medical skills, and were exposed to various unusual pathologies that enriched them professionally.

In many studies, the importance of support and mentoring was highlighted as key to assisting newly qualified professionals doing community service. Couper (2005) reported on a study that developed mentors for doctors in Northern KwaZulu-Natal. He evaluated the mentor's perceptions and found that it allowed established professionals an opportunity to share experiences and ideas and learn from mistakes that they had made. It encouraged communication and feedback within the medical team, and an opportunity to develop knowledge and skills through meetings and informal interaction.

Orientating new personnel especially to rural settings is very important. This should proceed beyond administrative orientation to include exposure to aspects of organizational behaviour, beliefs, culture and values in different health settings (Couper, 2002). Proper orientation will minimise "culture shock" due to the strain of adaptation, sense of loss, confusion and depression of a newly placed community service officer (Couper, 2002). In addition, ongoing

mentoring is vital to support community service therapists throughout the year. In a study with doctors Couper (2005), indicated that mentoring processes assist in stimulating thinking and learning, create an opportunity for sharing and an avenue to discuss mistakes made in a constructive and supportive manner.

The KwaZulu-Natal Rehabilitation Programme conducted qualitative surveys at the end of 2003 and 2004 to determine perceptions of community service therapists. Information obtained from these surveys was used as baseline information to inform this study. An average of 142 rehabilitation therapists have undergone compulsory community service annually in KwaZulu-Natal during the last 3 years (Table 2).

Table 2: Numbers of Community Service Therapists placed in KwaZulu - Natal from 2003–2005

YEAR	2003	2004	2005
Physiotherapists	67	71	68
	(51%)	(47%)	(48%)
Occupational therapists	40	46	38
	(30%)	(31%)	(27%)
Speech therapists and	25	33	26
Audiologists	(19%)	(22%)	10
			(25%)
Total	**132**	**150**	**142**

Source: Human Resources Department, KZNDOH, Natalia, 2005

practical mechanisms aimed at ensuring equitable distribution and ongoing support of all staff. Such support is crucially important to health personnel as it increased worker satisfaction and enhanced the quality of work.

2.7 STRENGTHS AND WEAKNESS OF OTHER STUDIES

The small sample size of many of South African studies cited limits their generalisability and the low response rate undermines their statistical validity. Due to the selection bias those who responded may have been more positive about their experiences (Reid, 2001).

2.8 FURTHER RESEARCH NEEDED

Further research is required on the impact of the Community Service Programme on service delivery and its influence in retaining health care personnel in rural and under-served areas. According to the World Health Organisation (2001), both politicians and the public may believe that rural service needs can be met, merely through the increased presence of health care personnel in under-served areas. Just having the people in place may have minimal impact on health status. On completion of their obligatory service, doctors were even more opposed to such service in rural areas (Reid, 2001) and the reasons for this requires further investigation.

2.9 SUMMARY

There is a paucity of literature on the attitudes and perceptions of health care personnel and in particular therapists involved in community service programmes nationally and internationally. The studies in South Africa provide useful insights in terms of the strengths and weaknesses of the local Community Service Programme that can add value to the body of knowledge. Getting the research into policy and practice however remains an ongoing challenge.

3 CHAPTER 3: METHODS

3.1 INTRODUCTION

An observational cross sectional study design was used to ascertain the attitudes and perceptions of rehabilitation therapists to their compulsory community service experience in KwaZulu-Natal. The therapists were questioned using a self-administered questionnaire on commencement of their community service and again on completion of their community service. All Audiologists, Occupational Therapists, Physiotherapists and Speech Therapists doing community service in 2005 were included in the study.

3.2 TYPE OF RESEARCH

This health systems research aims to improve the health system by, providing relevant and timely information to health managers involved with planning and managing the Community Service Programme.

3.3 STUDY DESIGN

An observational, cross sectional study design with a descriptive and analytic component was utilised and data was collected at two points in time, namely on commencement and after completion of community service of rehabilitation therapists in KwaZulu-Natal during the period January to December 2005. A cross-sectional design, although being a weak study design and low in the hiecrachy of evidence, was chosen as it is the most cost effective and easy design to answer this health service research question. Alternate study designs are explored later in the dissertation.

3.4 RESEARCH POPULATION

All rehabilitation therapists placed in community service posts in KwaZulu-Natal during 2005 comprised the study population. No sampling was undertaken. All community service therapists were thus included in the sample which reduce the possibility of selection bias. The study was conducted in all hospitals in KwaZulu-Natal where community service therapists

were placed and this included a mixture of urban and rural hospitals (Appendix 1: Gazetted sites for community service - 2005).

3.5 DATA SOURCES

3.5.1 Measurement instruments

The self-administered questionnaire on which the data collection tools for this study were based, was developed by Professor S Reid to evaluate community service in the medical profession. The questionnaire had been used by Reid in 1999, 2001, 2002, 2003, and 2004. The questionnaire to be administrated at onset of the community service year was amended by reducing the number of questions that community service therapists required to answer and was also made more relevant for therapists rather than doctors. This was done by the researcher prior to the annual induction and orientation programme to which all community service therapists were expected to attend. The exit questionnaire was further refined following a series of focus group discussions with Speech Therapists and Audiologists at the KwaZulu-Natal Speech Therapy and Audiology Forum meetings in 2004. At this stage of the development of the questionnaire, it was not given to the Occupational and Physiotherapy Fora. Common themes and ideas that emerged from the Forum discussions were included in the revised questionnaire used in this study at the time of completing conpulsory community service.

The revised exit questionnaire also included more open-ended questions, which were not used in the original questionnaire used to assess doctors or the questionnaire used at the onset of the community service. It also focussed on issues such as the community outreach component of community service, language difficulties experienced and working with the disability sector, topics which were specifically relevant to therapists in KwaZulu-Natal.

However some of the data variables assessed in the pre (onset) and post (exit) questionnaire were not identical. As a result, there were limitations in assessing changes in attitudes and perceptions between commencing and completing their community service. Certain data adjustments had to be made in order to make meaningful comparisons.

During 2003 and 2004 the KwaZulu-Natal Health Department's Rehabilitation Programme conducted an in-house evaluation of community service therapists working in the province. The common concerns and issues expressed by therapists in these evaluations were also considered in the development of the questionnaires used in this study (Appendix 2 & 3: Onset & Exit questionnaires).

3.5.2 Variables

Variables included in the self-administered questionnaires included:

- Biographical and demographic details, including age, gender, and university attended;
- Place of work and occupational category;
- Understanding of the community service policy and objectives;
- Attitudes and perceptions of therapists to community service;
- Preparedness for community service;
- Adaptability to rural experience;
- Benefits of the programme both personally and professionally; and
- Recommendations for future community service.

3.5.3 Reliability of measurement instrument

Prior to the distribution of the questionnaire to the study participants it was given to several Speech Therapists and Audiologists attending a Forum meeting. This was done as part of the process of validating the questionnaire and to ensure the questions were not ambiguous, that the correct language was being used and that the questions being asked were clearly understood by therapists. The questionnaire was also sent to representatives from the Physiotherapy and Occupational Therapy Fora requesting input on the content of the questions as well as to assess the format, sequencing and understandability of the questionnaire. The suggestions of the various professionals were effected on the final questionnaire. Once the questionnaire had been amended it was again given to the Speech Therapy and Audiology, Occupational Therapy and Physiotherapy Fora chairpersons at a regular meeting of the Rehabilitation Programme to check that all changes to the questionnaire had been incorporated as recommended. As a result of the validation process it was felt that there was agreement between the three professional groups for the tools used in

this assessment. It was concluded that the questionnaires would provide good inter-observer reliability.

3.5.4 Measures to ensure validity

3.5.4.1 Internal validity

Internal validity was improved by using a census of all rehabilitation therapists doing community service in KwaZulu-Natal in 2005. A number of measures were carried out to improve the response rate of both the pre and post community service questionnaire completion (section 3.5.5). The processing of data and analysis was undertaken with the guidance and help of a biostatistician. Open and closed-ended questions were employed to improve the validity and reliability of the questionnaire and reduce possible information bias.

3.5.4.2 External validity

The study population constituting all rehabilitation therapists doing community service in KwaZulu-Natal in 2005 is reflective of therapists in provinces with a similar rural/urban structure only. The results could not be generalisable to Gauteng and Western Cape as they serve a population with a greater proportion of people living in urban areas than in KwaZulu-Natal.

3.5.5 Data collection

The study used a repeat cross-sectional design and data was collected on commencement and again at the completion of the rehabilitation therapist's community service. Data was collected from the therapists by means of a self-administered questionnaire. At the commencement of the compulsory community service year all rehabilitation therapists were expected to attend an orientation and induction workshop. The commencement questionnaire was distributed at this workshop and completed by all community service therapists at the meeting.

The questionnaire to be completed at the end of community service and consent form was e-mailed to all the community service rehabilitation therapists using the e-mail address of the

public hospitals in the 11 districts of KwaZulu-Natal where they had spent their year. Following the e-mailing of the questionnaire each therapist was telephoned to confirm the receipt thereof in an attempt to encourage their completion of the follow up exit questionnaire in order to improve the response rate and so reduce selection bias. The respondents were requested to post, fax or e-mail the completed questionnaires back to the primary researcher. The questionnaires was required to be submitted a month prior to the completion of community service (end of November 2005). Non-respondents were followed up by yet a further e-mail or telephone call two weeks before the completion of their community service in mid-December 2005.

3.5.6 Data handling

3.5.6.1 Data quality assurance

All data was cross-checked for completeness, legibility and consistency. The researcher worked with both the data capturer and the biostatistician to decide how to deal with fields that had missing data. Some questionnaires were returned with some specific questions not having been completed.

3.5.6.2 Data capture

Both open-ended and closed questions were included in the exit questionnaire. The researcher was assisted by the biostatistician to code all the data and determine the scales of measurements to be used prior to analysis. The EPI-INFO programme was used for data collation

3.5.6.3 Data processing and analysis

Data processing and analysis was done with SPSS.

3.5.6.4 Data dissemination

The research findings emanating from this study will be disseminated through the Occupational Therapy, Physiotherapy and Speech Therapy and Audiology fora in the province. It is anticipated that at least one peer-reviewed scientific publication will be prepared describing the key findings and recommendations of the study. The findings and recommendations will be shared with the Rehabilitation Programme, universities, hospitals and participants in KwaZulu-Natal.

3.5.6.5 Statistical analysis

3.5.6.5.1 List of possible confounding bias

Possible sources of confounding bias which might influence the attitudes and perceptions of therapists to their community service experience include the gender, race, occupational catergory, the training institution attended, receiving a rural allowance and where they were placed during their year of community service.

3.5.6.5.2 List of associations to be measured

Cross tabulation was undertaken to measure the association between two variables (categorical) using Chi Squared tests. The attitudes and perceptions of community service therapists were scored on a scale of 1-4. Questions on a common theme were grouped, given weighting and scored by summing across the items to generate thematic scales. These continuous numeric scales were analyzed quantitatively. Comparisons were drawn between groups using independent t-tests (in the case of two groups such as gender) or ANOVA (in the case of more than two groups such as occupational catergory) with Bonferroni post hoc multiple comparison tests also being employed.

Data collected on commencement and again on completion of community service was compared using frequency tables and cross-tabulation. McNemar's Chi Square tests were used to assess the statistical significance of any differences in proportions of perception and attitude reported from pre to post (using < 0.05 as the cut off for significance) community service.

3.6 ETHICS

3.6.1 Biomedical Research Ethics Committee

Ethical approval was granted by the Biomedical Research Ethics Committee of the College of Health Sciences, University of KwaZulu-Natal (Appendix 4 – Ethics clearance).

3.6.2 Permission to conduct the survey

The KwaZulu-Natal Department of Health's Rehabilitation Programme and the Head of Department gave permission for the study to be conducted. The questionnaires were mailed

to hospital managers requesting them to encourage community service therapists to complete them (Appendix 5: Letters of permission from Department of Health).

3.6.3 Confidentiality and informed consent

Every attempt was made to ensure that responses received remained confidential. The questionnaires were anonymous, however the researcher alone was able to determine the identity of the respondents by comparing demographic data such as gender, race, marital status, training institution and site of placement. The categorisation as a rural placement was made by the therapist indicating that they had received a rural allowance. All data was securely stored (Appendix 6: Informed consent).

3.7 SUMMARY

In the methods chapter, the type of study, study design and sample population are described. It further outlines the data sources, description of the data collection tools, statistical processing and analysis used in the study. Ethical considerations are also included. The results of the study will be presented in the next chapter.

4 CHAPTER 4: RESULTS

4.1 INTRODUCTION

The results chapter summarizes information obtained from the study, categorised according to the study objectives. The data is presented under the following headings:

- Demographics of the respondents;
- Change in perceptions and attitudes of therapists during their compulsory community service;
- Attitudes and perceptions in the different occupational categories of therapists;
- Thematic analysis of perceptions and attitudes of therapists; and
- Associations between different variables.

4.2 DEMOGRAPHICS OF THE RESPONDENTS IN THE STUDY.

The self–administered questionnaires were distributed to 142 rehabilitation therapists at the commencement of their community service year during the annual induction and orientation workshop held for rehabilitation therapists in KwaZulu-Natal in 2005. Despite this, only 126 (89%) completed the initial questionnaire, and only 59 (42%) completed the exit questionnaire immediately prior to completing their compulsory community service year. A third (47 - 33%) of respondents completed both the initial and exit questionnaire.

Therapists were placed at 59 gazetted sites[a], of which 32 (54%) were situated in rural[b] areas and 27 (46%) were urban sites (Table 3).

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[a] A site refers to all hospitals where therapists were placed for community service. The South African government published the names of 59 hospitals in KwaZulu-Natal where therapists could apply to complete their community service.

[b] Rural sites are defined as hospitals where health care practitioners are allocated a monetary incentive for working (rural allowance).

Table 3: The occupational category, gender and type of placement site of therapists (number & percentage) that completed both initial and exit questionnaires about compulsory community service in KwaZulu-Natal, 2005

	Number	Physio-therapy	Occupational Therapy	Speech & Audio	Male	Female	Rural	Urban
Questionnaires sent	142	73 (51%)	35 (25%)	34 (24%)	14 (10%)	128 (90%)	67 (47%)	75 (53%)
Initial questionnaire responses	126	55 (43%)	35 (28%)	36 (29%)	11 (9%)	115 (91%)	59 (47%)	67 (53%)
Exit questionnaire responses	59	20 (34%)	11 (19%)	28 (47%)	4 (7%)	55 (93%)	24 (41%)	35 (59%)
Both initial and exit	47	12 (26%)	10 (21%)	25 (53%)	2 (4%)	45 (96%)	20 (43%)	27 (57%)

4.3 CHANGE IN RESPONSES DURING THE YEAR OF COMMUNITY SERVICE

There were 48 respondents who answered both questionnaires. One respondents questionnaire was excluded from the analysis as most of the responses were incomplete. Changes in attitudes and perceptions of therapists between completing the initial (at onset) and exit (post community service) questionnaires were measured in this group. The direction of the change was also noted.

The following attitudes and perceptions of therapists were compared:

- Understanding the objectives of the community service policy;
- Availability of information on the community service policy for therapists;
- Availability of hospital orientation;
- Recommendation of the placement site for future placement of a therapist;
- Perception how tertiary education equipped the therapist for community service;

- Supervision of community service therapists;
- Intention to remain in the public sector; and
- Concerns about personal safety during the community service year.

Four of the attitudes and perceptions of therapists changed from negative or neutral at onset to positive at exit or remained positive from onset to exit to the compulsory year of community service (Table 4).

Table 4: Community service therapists' attitudes and perceptions that changed for the better or remained positive during their community service in KwaZulu-Natal, 2005

	Number / % initially	Number / % at exit	Actual change	McNemar's Chi ^{2} test	p value
Understanding of the community service policy	32/47 (68%)	41/47 (87%)	13/15 (87%)	3.76	0.052
Availability of policy information	17/47 (37%)	25/47 (52%)	18/25 (72%)	8.56	0.036
Availability of hospital orientation	17/47 (37%)	30/47 (63%)	20/31 (65%)	12.52	0.006
Recommend their site for future placement	38/44 (86%)	41/44 (93%)	3/44 (6.7%)	0.17	0.683

4.3.1 Understanding of the community service policy

Rehabilitation therapists understanding of the policy and objectives of compulsory community service was assessed to determine if this would affect their understanding and perception of the purpose of community service. A borderline statistically significant (p=0.052) change for the better in the understanding of community service had occurred in 87% (13/15) of therapists. They had changed from being neutral about the objectives of the community service policy at onset to being positive concerning the performance of community service as a good policy at exit.

4.3.2 Availability of information on community service policy

The availability of information on policy, procedures and guidelines on community service is critical for the therapist to be able to function effectively and possess the capacity to familiarize them to working in the public sector. Nearly three quarters (18/25 - 72%) of the

respondents who answered both questionnaires had changed their minds that general policy information was available to them. The finding was statistically significant (p=0.036).

4.3.3 Availability of hospital orientation

Hospital orientation is especially relevant for community service therapists in the absence of having peer therapists to support them when placed at an institution providing a rehabilitation service for the first time. There was a change for the better in the perception of information being available from onset to exit. A statistically significant (p=0.006) proportion (20/31-65%) of therapists who initially disagreed or were neutral at onset regarding information about hospital orientation, reconsidered their perceptions to agree that information on hospital orientation was available to them.

4.3.4 Recommendation of the placement site for future placement.

Finding out whether community service therapists would recommend their placement site to future community service therapists was assessed. At onset 86% (38/44) of community service therapists indicated that they were not resentful or upset about the site at which they were located and, at exit, 93% (41/44) maintained they would recommend it as a site for such future placement. This result was not statistically significant (p =0.683).

Three attitudes and perceptions of therapists changed for the worse during their year of compulsory community service (Table 5).

Table 5: Community service therapist's attitudes and perceptions that changed for the worse during their community service in KwaZulu-Natal, 2005

	Number / (%) initially	Number / (%) at exit	Actual change	McNemar's Chi ^{2} test	p - value
Tertiary education	30/47 (64%)	23/47 (49%)	17/47 (36%)	3.82	0.281
Supervision	31/47 (66%)	16/47 (34%)	24/47 (51%)	15.13	0.002
Personal safety	13/47 (28%)	20/47 (43%)	15/47 (32%)	4.22	0.239

4.3.5 Tertiary education equipping therapists for community service

This variable was assessed to determine if therapists felt that their tertiary education equipped them with the necessary skills, competencies and knowledge to be able to function effectively during their community service year. The attitudes and perceptions of community service therapists changed by 36% (17/47) for the worse as, at onset, the perception of more therapists was that they were academically and professionally equipped for community service than at exit. This negative change in attitudes was not statistically significant (p=0.281). The various occupational catergory of therapists listed different specific educational gaps in their training (Table 6).

Table 6: Expressed area of additional training needed by community service therapists of different occupational categories in KwaZulu-Natal, 2005

Occupational class	Area of training
Occupational therapists	Splinting
	Hand therapy
	Paediatrics
	Stroke
	Tuberculosis
Physiotherapists	HIV/AIDS
	Cerebral Vascular Aneurysm
	Sports injuries
	Bells Palsy
Speech therapists & Audiologists	Specialized tests,
	Auditory Brainstem Response Testing
	Pseudohypacussis
	Dysphagia
	Neonatal Intensive Care
	Cerebral palsy
	Neonatal feeding

4.3.6 Supervision

Supervision and support is recognized as an important requirement for professional development of young professionals undergoing community service. The study asked community service therapists about the supervision they received from senior peers and mentors. Initially, two thirds (31/47 - 66%) anticipated they would receive good support and supervision. However having completed a year of community service this had reduced significantly (p=0.002) with only 34% (16) feeling that they had experienced adequate professional, discipline specific supervision during the year.

4.3.7 Concern regarding personal safety

One of the concerns expressed by therapists providing community service is that of their personal safety. Therapists were asked at the outset of their community service year whether there personal safety could be compromised. At exit more (43% vs 28% - p=0.239) felt that community service had increased their personal safety risks.

Table 7: Community service therapist's attitudes and perceptions that changed for the worse during their community service in KwaZulu-Natal, 2005.

	Number / (%) initially	Number / (%) at exit	Actual change	McNemar's Chi ^{2} test	p - value
Tertiary education	30/47 (64%)	23/47 (49%)	17/47 (36%)	3.82	0.281
Supervision	31/47 (66%)	16/47 (34%)	24/47 (51%)	15.13	0.002
Safety	13/47 (28%)	20/47 (43%)	15/47 (32%)	4.22	0.239

The intention to remain in the public sector also changed for the worse during the year of compulsory community service for therapists.

4.3.8 Intention to work in the public sector.

According to the Department of Health, one of the purposes of community service is to retain therapists in the public sector once the year of community service is completed. The study compared therapists intention to remain in the public sector at onset to that of working in the public sector in subsequent years. The intention to work in the pubic sector declined from that prevailing at onset when 50% (24/48) of therapist indicated they would consider working in the public sector, to only 35% (17/48) that they would choose to remain in the public service. Of those who had indicated that they wish to leave the public service 29% (14/48), reported that from community service they would go into the private sector, 19% (9/48) would go overseas and 17% would seek alternate work but outside the public sector.

During the year of community service the perceptions that therapists made a positive contribution to persons with disability did not vary much from onset to exit with therapists on the whole remaining positive about how they were improving the health status of people.

4.4 ATTITUDES AND PERCEPTIONS OF DIFFERENT OCCUPATIONAL CATERGORIES OF COMMUNITY SERVICE THERAPISTS.

In this section the second objective of the study namely to identify the attitudes and perceptions amongst the different occupational categories was studied. The tertiary education and training received, support from hospital managers, supervision and mentoring by peers, availability of resources to practice professionally, outreach service obligations, language and working with interpreters, general attitudes & coping, personal safety, personal & professional gains, and future career plans were investigated and compared. The data for this objective was obtained from 59 therapists who completed the self-completed exit interview. Only 48 of these had completed the initial questionnaire. Both closed and open-ended questions (including questions on training, supervision, availability of resources, community outreach, language and future career plans) from the exit interview questionnaire were used to obtain information for this objective. The open-ended questions were not included in the questionnaire administered at onset of community service for therapists.

4.4.1 Training

Having completed a year of compulsory community service in an underserved area, 56% (33/59) of therapists felt their training was adequate and that they were well equipped to work in an under-served or rural area of KwaZulu Natal, whereas 44% believed that they were not so equipped. This was not statistically significant (3.82, p=0.281). There were no significant differences between the occupational catergories in relation to perceptions about the adequacy of training at exit

Perceptions of the adequacy of training had deteriorated during the year of community service (section 4.3.5). In the open-ended question analysis therapists indicated that they needed to have learnt more about management and administration of health and rehabilitation services at University. Of those who perceived that their training was insufficient or inappropriate, the ability to speak the local language (isiZulu) in order to perform professionally and understanding of cultural issues were aspects specifically mentioned as being lacking in their training.

4.4.2 Support, supervision and mentoring

It is important that young professionals are supported and mentored during their community service. It is envisaged that through proper supervision by senior personnel community service rehabilitation therapists would develop skills and competencies to enhance their professional and personal development. Comparisons between the occupational catergories of therapists were conducted so that if they there were differences in the perceptions of different occupational catergories that they could learn from each other, particularly where one catergory of therapists was able to supervise, mentor and support their community service therapists better than the others. The study included questions on various aspects of support supervision and mentoring to investigate this topic. These included assessing the perception of support from the professional forums, from senior therapists and from hospital managers (Table 81). A continuous numeric score was devised from the responses to questions that used categorical variables[c] in order to compare the responses from the different catergories of therapy professionals in relation to the role of the professional fora, assistance from senior therapists and supervision by peers.

4.4.2.1 Professional fora as a means of support.

The therapists working in the public sector were affiliated to the KwaZulu-Natal Professional Fora of Speech Therapy and Audiology, Occupational Therapy and Physiotherapy. These three Fora operate under specific terms of reference and a mandate from the Department of Health that recognizes their contribution to the health service for persons with disabilities in the province. Each Forum meets quarterly in the province to discuss issues relating to their particular professional occupational category.

The KwaZulu-Natal Disability and Rehabilitation Programme staff attend these meetings, contributing academic and management inputs as well as the supporting activities of each of the Fora. The Programme has also granted a mandate to Fora members to mentor and support all community service therapists. All community service therapists are encouraged and supported to attend the Forum meetings to listen to issues, raise their concerns and

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[c] The Chi Square test was not an appropriate test to assess statistically significant differences between the various occupational categories of therapists as the sample size was too small, and there were too many cells with low values in the cross tabulation / contingency tables.

contributions. The community service therapists were asked about the level of support received from their respective Fora.

Table 8: Comparison of the mean numerical score* allocated to different occupational categories of therapists in relation to support, mentoring and supervision received during the community service year in KwaZulu-Natal, 2005

Occupational categories:	Professional fora Score (no. of therapists)	Assistance by senior therapists Score (no. of therapists)	Supervision Score (no. of therapists)
Speech therapists	3.78 (18)	2.31 (16)	2.72 (18)
Physiotherapists	2.47 (19)	2.83 (18)	2.70 (20)
Audiologists	3.80 (10)	2.20 (10)	3.22 (09)
Occupational therapists	3.10 (10)	2.40 (10)	3.09 (11)

Score = continuous numeric score devised from categorical variables. A higher score reflects better support/assistance/supervision.

When the mean level of support received from the different fora was compared, a highly significant overall difference was found ($p<0.001$) between the occupational catergories. Bonferroni post hoc tests revealed that a significant differences existed between Audiologists and Physiotherapists, with Audiologists scoring a higher mean (3.8; n=10) and Physiotherapy (2.4; n=19) the lowest score will ($p=0.002$). This forum was perceived to be the least supportive. In addition, there was a highly significant difference in support between Speech Therapists (mean = 3.7) and Physiotherapists ($p<0.001$).

4.4.2.2 Supervision and mentoring

This relates to the support given to community service therapists from senior rehabilitation professionals based at the same or neighbouring hospitals. Some of the senior therapists were from the same occupational catergory as the community service therapists whilst others were assisted by senior therapists from other catergories within the rehabilitation sector. Overall there was no significant difference in mean supervision level or mentoring score between the

professions (p = 0.596 and p =0.856 respectively). Audiologists had the highest mean score for supervision (3.2; n=9) and Physiotherapists the lowest score (2.7; n=20). Overall 41% (24/58) indicated that they experienced good supervision.

Analysis of the open-ended questions supported the contention that two thirds (66 % - 38/58) of community service therapists reported no supervision, poor supervision, or inadequate supervision and that they were the sole therapist in their institution. Perceptions of the adequacy of support and supervision had deteriorated during the year of community service (section 4.3.6).

4.4.2.3 Assistance by seniors

In addition to support from the Professional Fora and senior rehabilitation therapists, community service therapists were assisted by other senior health professionals at the hospital where they were alocated. There was no difference between the occupational catergories (p = 0.436) in this regard. Again the Audiologists (mean score = 2.2) and Speech Therapists reported the best assistance from senior health professionals, followed by the Occupational Therapists and lastly the Physiotherapists (mean score = 2.8).[d] The mean difference between the scores for the Audiologists and Physiotherapists was not statistically significant (p = 0.971).

Overall, the majority of community service therapists 67% (37/58) agreed that senior health professionals at the hospital were perceived not to be available to assist them or were received not to be particularly supportive.

4.4.2.4 Support from hospital management.

Therapists were asked if they were given support during their community service year by the hospital management team. From the responses obtained, the Audiologists and Speech Therapists received most support from management.

[d] As the question was negatively phrased the lower the mean the better the assistance received.

4.4.3 Availability of resources

There was not a statistically significant difference between the occupational category of community service therapists in how they assessed the space allocated for working, availability of transport to perform community work, parking space for their cars or residential accommodation ($p = 0.536, 0.295, 0.799, 0.508$ respectively, Figures 1, 2, 3, 4). Eighty nine percent (8) of Audiologists, 82% (9) of Occupational Therapists, 75% (15) of Physiotherapists and 65% (14) of Speech Therapists affirmed that they had adequate space to provide their specific therapy in a professional manner (Figure 1). Regarding transport for outreach activities 63% (5) of Audiologists, 91% (10) of Occupational Therapists, 65% (13) of Physiotherapists and 82% (14) of Speech Therapists had transport available (Figure 2). Parking was available for 88% (7) of Audiologists, 73% (8) of Occupational Therapists, 72% (13) of Physiotherapists 69% (11) of Speech Therapists (Figure 3). Living accommodation was available to 25% (2) of Audiologists, 40% (4) of Occupational Therapists, 29% (4) of 50% (10) of Physiotherapists and Speech Therapists (Figure 4) on site during their community service year.

From the open-ended questions the therapists indicated that they had found it difficult to access resources to perform adequately. Some used their own resources and other therapists were able to secure private sponsorships for basic equipment. There was no specified budget for therapy and in many hospitals a full range of basic equipment required to support a specific professional therapy activity was missing. Where a new therapy service was needing to be established in the hospital, the time taken to set up the department was very slow. Community service therapists also reported that they required more therapy resources that were culturally appropriate for isiZulu speaking clients.

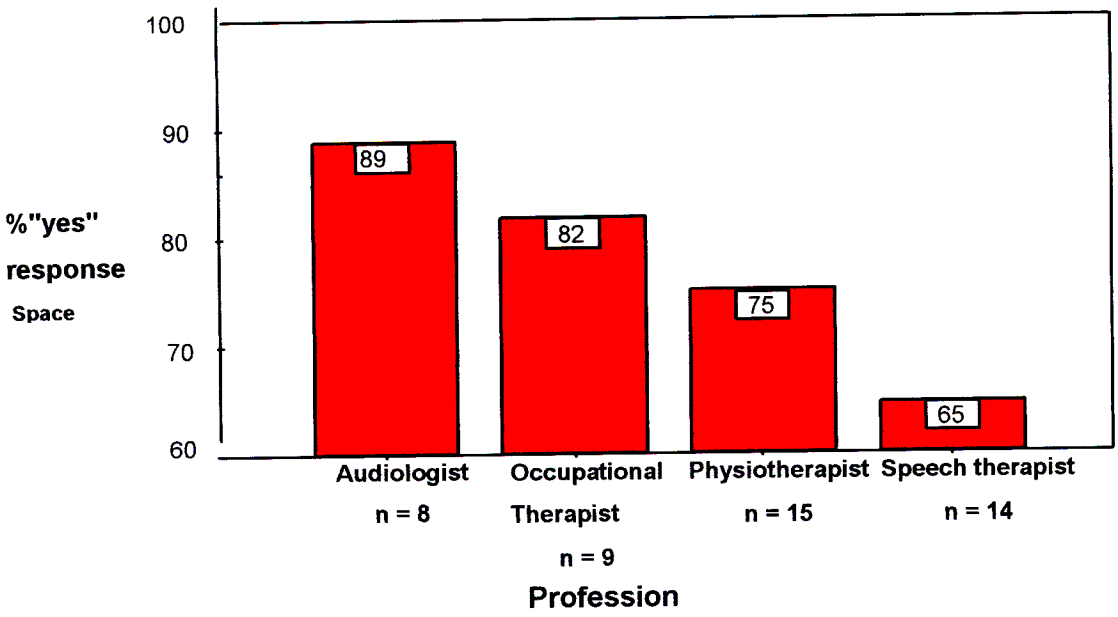

Figure 1: Perceived adequacy of space for different community service occupational category groupings allocated to work in KwaZulu-Natal, 2005.

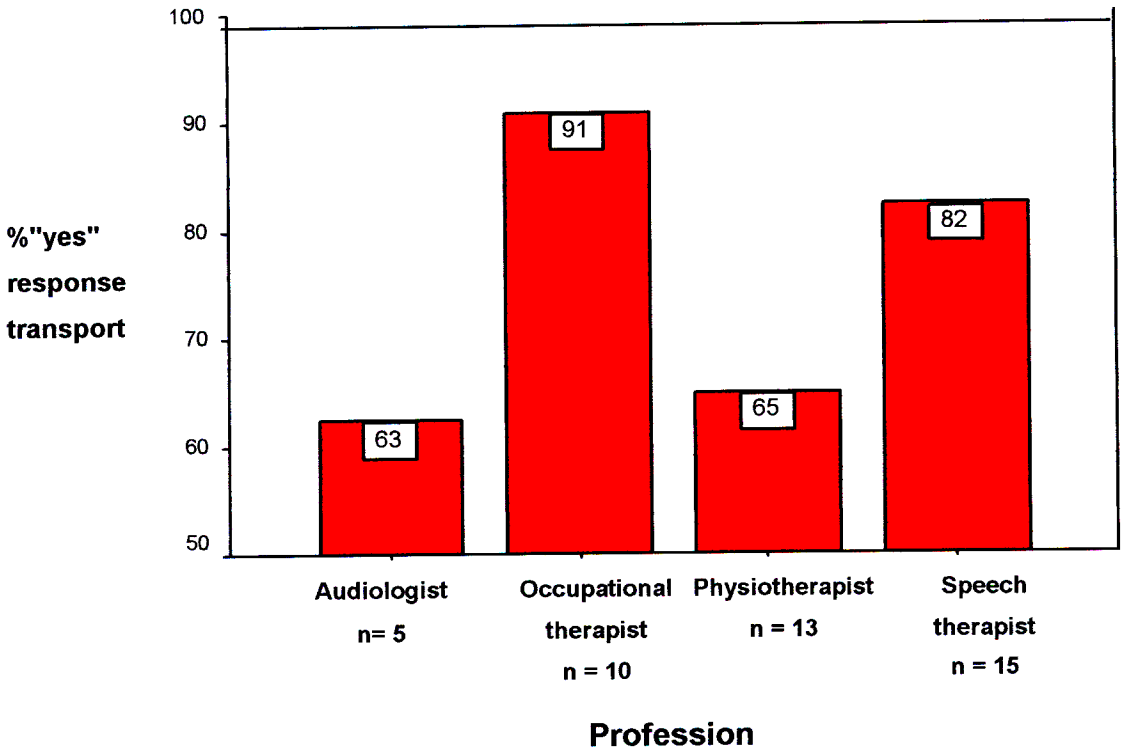

Figure 2: Perceived adequacy of transport for different community service occupational category groupings given to conduct their therapy outreach services during their community service year in KwaZulu-Natal, 2005.

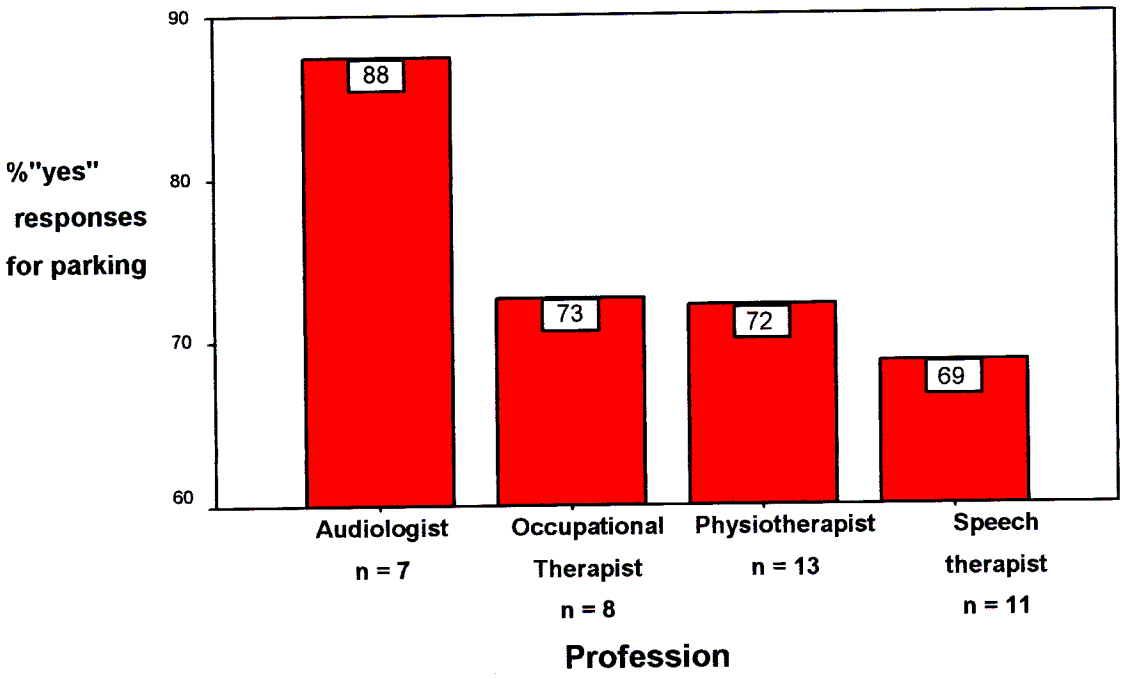

Figure 3: Perceived adequacy of parking space for private vehicles allocated for different occupational category community service groupings in the hospital during their community service year in KwaZulu-Natal, 2005.

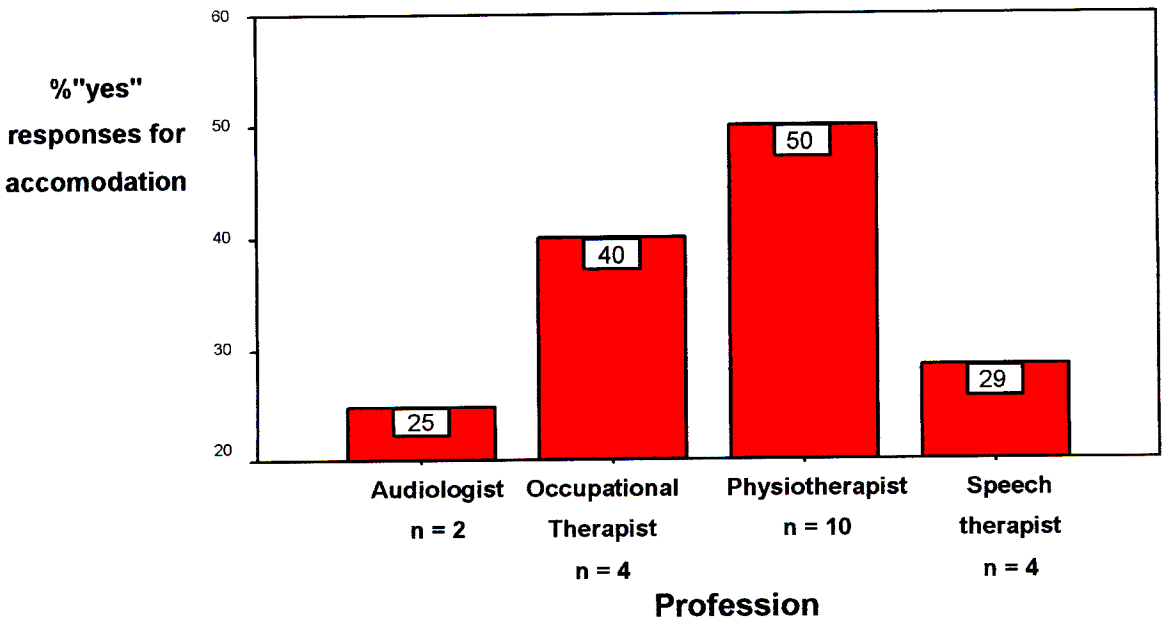

Figure 4: Perceived adequacy of residential accommodation on the premises of hospitals for different community service occupational category groupings during their community service year in KwaZulu-Natal, 2005 (as opposed to them having to obtain private accommodation).

4.4.4 Language and Community outreach

4.4.4.1 Language

Most therapists in KwaZulu-Natal speak English as their first language. This constitutes an impeding factor in communicating with isiZulu speaking clients who form the majority of the caseload of these therapists. As a result they need assistance from interpreters who were not always trained in discipline specific interpretation and merely translate from English to isiZulu and vice-versa. Therapists were asked whether or not it was difficult to conduct therapy through an intermediary.

Even with an interpreter, 33% (19/56) found it difficult to undertake therapy satisfactorily. About 50% claimed that the language barrier impeded their functioning as a professional in this context.

There was a statistically significant difference between mean scores of the professions with regard to their ability to work with an interpreter ($p=0.037$). Since the question was negatively phrased, the Audiologists had the best mean score (2.0; $n=9$) and experienced least difficulty and the Occupational Therapists the most difficulty (mean score 3.0; $n=11$). However, the individual differences between the professional categories was not statistically significant ($p=0.068$).

4.4.4.2 Community Outreach

In KwaZulu-Natal there was an agreement with the then Head of Department Professor Green Thompson in 2003 and the Disability and Rehabilitation Programme that all community service therapists would spend 60% of their work time in the hospital and the remaining 40% of their time would involve providing community outreach rehabilitation services in the district. The outreach service would be provided at various clinics in an attempt to facilitate access to rehabilitation therapy services for people in the community.

There was no significant discernible difference between the groups with regard to the amount of community outreach they were able to perform ($p=0.347$). More than half of community service therapists (54% - 31/57) felt that they had succeeded in their endeavour of providing substantial community outreach. Only a quarter (26% 15/57)) felt that they had failed

completely to conduct any community outreach and 20% managed to at least conduct some community-based rehabilitation service.

The question was phrased negatively so the lower the mean score reflects more community outreach was undertaken. Speech therapists (2.1; n=9) managed to conduct more community outreach and Occupational Therapists (2.91; n=11) the least. The difference between the occupational catergories in relation to community outreach was not statistically significant (p=0.450; 95% CI: 0.3 to 1.99).

Analysis of the open-ended questions revealed that many therapists were able to conduct regular clinic visits but that this was limited due to the huge caseloads prevailing at hospitals, poor clinic infrastructure, transport problems and the poor turnout of clients at the clinics.

4.4.5 Attitude, coping, safety, personal and professional gains

4.4.5.1 Psychological coping

Questions on whether therapists believed they coped psychologically were formulated due to the anxiety expressed by some therapists and their relatives prior to commencing community service about the logistics and possible unrealistic expectations of the compulsory community service year. There was no significant difference between the occupational catergories of therapists (p=0.678) in this regard. The Occupational Therapists coped best, scoring (3.7; n=11) followed by the Speech Therapists and Audiologists and the Physiotherapists (3.3; n=18) [e] The higher mean score indicates that they coped better.

4.4.5.2 Attitude to community service

Attitudes were assessed to determine if therapists had a positive or negative attitude to community service and whether this differed between the different occupational categories. There was not a statistically significant (p=0.903) perceived difference in attitude between the catergories. When they had completed their year of compulsory community service therapists felt that there attitude to community service had changed for the better with 47% (27/57) agreeing that it had changed for the better.

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[e] A higher mean score indicates that they coped better.

4.4.5.3 Risk to personal safety

In the analysis of the open-ended questions 46% (26/57) of all those responding felt that community service had increased the risk to their personal safety. Occupational Therapists and Physiotherapists perceived to be at increased personal risk.

4.4.5.4 Personal difference and personal and professional gains

Therapists were asked if they felt they had made a personal difference to the health service delivery during the year and whether they had gained professionally. There was no significant difference between the professional categories (p=0.999 and p=0.140 respectively) in relation to these two perceptions. This was confirmed by analysis of the open-ended questions where the majority felt they had made a difference professionally, that their attitude was more positive about community service and that their clients were very appreciative.

4.4.5.5 Future career plans

Career plans were assessed to determine whether the year of compulsory community service had made a difference to becoming public service employed rehabilitation therapist's in the future. No statistically significant difference existed between the categories (p=0.832). However, 56% (n=31/56) of therapists agreed that it did not change their plans. The Speech Therapists had the highest mean score[f] (3.3; n=10) indicating that they were more inclined to change their plans compared to the other occupational categories.

The analysis of the open-ended questions showed very varied responses with some claiming that the experience of the year had negatively influenced their plans to change careers and claiming that the year was experienced as both de-motivating and unpleasant. Other therapists felt that it had changed their work ethic positively. They had possessed no choice because of the necessity of fulfilling their bursary obligations.

4.4.5.6 Staying at the same institution

Only 16% (n=9/59) of the community service therapists who completed the questionnaire at the end of the year indicated that they would stay on at the same institution during the next

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[f] (Mean score = average of responses to ordinal categories for purposes of comparison between the professions. The higher the score, the higher the chances were that they were likely to change their plans as opposed to other professionals).

year. The Audiologists registered the highest score (2.8; n=10) and Speech Therapists the lowest (1.9; n=18) (p=0.19). The reasons therapists supplied for wanting to remain at an institution included its positive working environment, the level of support they received and their exposure to varied and different caseloads of clients.

4.4.5.7 Future placement

Approximately 41% (n=24/59) indicated that they would consider the institution where they were placed as one for future possible work. Occupational Therapists had the highest mean score (3.5; n=11) and Audiologists the lowest score (2.8; n=9) with regards to this question. This was not statistically significant (p=0.218).

4.4.5.8 Working in a rural area in future

One of the objectives of community service is to attract and retain therapists in rural areas. There was no significant difference between the occupational categories (p=0.604) in this regard, with only 24% (n=13) affirming that they intended to work in a rural area in the future.

4.5 THEMATIC ANALYSIS OF VARIABLES FROM EXIT QUESTIONNAIRE

Various questions asked at the end of community service for therapists in KwaZulu-Natal were grouped together according to, common themes. The questions were weighted and combined into a rating scale and a score for each theme allocated. The six themes were education and training, supervision and support, orientation to community service, understanding the local language, coping psychologically and socially and career plans. The questions included to formulate each theme were:

- **Education &Training** - "My tertiary education equipped me well for this year", "My tertiary education needs to cover more practicals at rural sites" "There were clinical areas we needed more practicals on".
- **Supervision & support** - "The professional groups were a good source of support"; "I have experienced good supervision", "My seniors have been available to help me".
- **Orientation** - "I was well oriented to my job by the hospital staff when I arrived", "Information on policies and procedures were readily available to me", "The induction and orientation by the rehabilitation programme has been very useful".
- **Local Language** - "I found it difficult to do therapy with an interpreter" and "The language barrier impeded my functioning".
- **Coping psychologically and socially** - "I have coped well psychologically this year", "the compulsory community service policy is a good one to retain health personnel in rural areas" and the last question for coping and attitude asked if they have a positive attitude to community service at exit.
- **Career plans** - " The experience of the year has not changed my long term career plans", "I intend to stay on working at the same institution next year", If you go overseas are you intending to return to work in S.A." and "would you recommend your site for future placement".

The association was assessed between these six themes and eight different variables namely, occupational category, placement site, race, marital status, choice of allocation, university attended, gender and level of hospital allocated of the community service rehabilitation therapist.

- **Occupational category**

No significant association was observed between the occupational category of community service therapist and their tertiary education & training, the supervision & support they experienced, the orientation to the hospital they received, their coping with and attitude to community service and their long-term career plans. There was a significant association between coping with language issues and which occupational category they belonged to. A one way ANOVA ($p=0.029$), and the Bonferroni tests revealed a significant difference between Audiologists and Physiotherapists with the former having the highest mean score (8.8; n =9) and the latter the lowest (6.8; n =20). Audiologists coped significantly better with the language issue ($p=0.025$).

- **Urban or rural placement**

Those placed in urban areas where the rural allowance was not collected scored higher (mean score 9.8; n =24) and had significantly ($p=0.004$) better supervision than those placed in rural areas (8.1; n =34). There was no significant difference in association between where community service therapists were placed and tertiary education, orientation, coping and attitude, and future career plans.

- **Racial grouping**

Black and Coloured community service therapists coped significantly better ($p=0.049$) with the language issues (mean score 11.50; n=4) than Indians (7.8; n =23) and Whites (6.7; n =27). In relation to coping psychologically and socially with the rigours of community service Indian therapists (10.05) scored better than White therapists (9.07) and the Bonferroni test showed that this was significant ($p=0.067$).

- **University attended**

With regards to the the university that therapists trained at, no valid comparisons could be drawn as the number of rehabilitation therapists in each cell of the contingency table was too small to make meaningful inference. However, there was a significant difference in the perception of how well the universities orientated their community service therapsists for community service. The orientation scale was significant ($p=0.008$), where University of KwaZulu-Natal scored the highest (10.6) and Pretoria the lowest (6.0). This demonstrated

that University of KwaZulu-Natal orientated their community service therapists better than other universities.

- **Gender**

Males coped better with the language (mean score 8.7 vs 7.1 - p=0.001), supervision (mean score 10.5 vs 8.5 - p=0.048) and orientation (mean score 11.0 vs 9.8) issues better than females.

- **Marital status**

Married persons experienced better supervision than unmarried community service therapists. The married persons (n=7) had a higher mean score of 10.00 and those unmarried (n=47) a mean of 8.60.

- **Allocation choice**

Allocation choice was significantly associated with language (p=0.038). Therapists placed in their 2nd to 5th choices scored the highest mean of 8.2, (n=14) and coped best with language issues. The therapists placed in their 6th or greater than sixth choice 7.0, (n=15) and inexplicably therapists placed in their first choice of placements had the lowest score of 6.8, (n=26).

- **Level of hospital**

Tertiary education equipped persons to work best at regional (score 6.0; n=14) and central level (score 7.3; n=3). The best supervision was experienced at a central level (score 11.00; n=3). The highest levels of orientation was experienced at central level (score 11.33; n=3) and worst at community health centre level (score 8.00; n=3) (). Overall no significant differences between the levels of hospital for any scales were discernable.

4.6 SUMMARY OF STATISTICAL ASSOCIATION BETWEEN DIFFERENT VARIABLES

Finally, statistical analyses were made between variables to assess their effect on each other. These variables were:

- Gender and personal safety.
- Marital status and choice of allocation.
- Choice of placement and psychological coping / attitude, changes in attitude and staying at the same institution in future.
- Collecting a rural allowance, and working in a rural site in the future.
- Collecting a rural allowance and staying at the same institution in the future
- Race and personal safety.

- **Gender and personal safety**

Due to the small number of males (4) in the sample no significant association (p=0.204) was found between gender and perception of personal safety, most (75%) did not feel their safety was threatened. Only 32% (17) of the females did not believe that their safety was threatened, 47%; (n =25) had felt unsafe, and 21%; (n =11) were neutral about this issue.

- **Marital status and choice of allocation**

Again, due to the small number of married persons in the sample (n=7), no significant association (p=0.460) was found. Married persons were more likely to obtain their 2-5th choice (3/7) whilst unmarried persons either were allocated their 1st choice or greater than 6th choice.

- **Choice of placement and psychological coping / attitude, changes in attitude & staying at the same institution in the future.**

There was no significant difference between the occupational catergories. Those who are allocated to their higher choice site of placement seemed to fare better psychologically than the others (p=0.181). With regards to attitude to community service, those that were granted first choice placement showed the most positive attitude to community service (p=0.279). All

groups reported that their attitude to community service changed for the better despite where they were allocated (p=0.964).

- **Collecting a rural allowance and working in a rural site in the future.**

There was no significant association between collecting a rural allowance and deciding to work in a rural area in the future (p=0.782). Therapists placed in urban areas (n=21; mean score =3.5) indicated a greater willingness to work in rural areas in the future than those working in rural areas and collecting a rural allowance (n=33; mean score = 3.13). This was statistically significant (p=0.018).

- **Collecting a rural allowance and staying at the same institution in the future.**

There was also no association between collecting a rural allowance and remaining at the same institution in the future (p=0.317). Those collecting a rural allowance had a lower mean (n=31; mean= 2.10) than those who were not collecting one (n=24; mean= 2.38), i.e. those working in rural areas and concurrently collecting a rural allowance were less likely to stay at the same institution in the future.

- **Race and personal safety**

A higher proportion of Indian and White community service therapists perceived that their safety was compromised, as opposed to Black and Coloured therapists. The association was not statistically significant (p=0.349), however, there were only two Black and two Coloured therapists in the sample.

4.7 SUMMARY

The results of this study demonstrated that there was a change in attitudes and perceptions of of therapists during their year of compulsory community service. There were many similarities between the occupational categories of therapists with regards to their experiences. The results will be discussed in details in the discussion chapter of this dissertation.

5 CHAPTER 5: DISCUSSION

5.1 INTRODUCTION

The success or failure of community service depends largely on the attitudes of the health care professionals participating in the mandatory one-year programme. This includes their understanding of the community service policy, their preparedness for performing community service and their adaptability to their experiences. They constitute important role players in the implementation, monitoring and evaluation of the policy. The current study focused on rehabilitation therapists' perspectives of their year working in the public service hospitals in KwaZulu-Natal, to which they were allocated. This study provided valuable insight in terms of the strengths, weaknesses and recommendations for improvement in implementing the policy of compulsory community service for rehabilitation therapists. This will be done by relevant role-players such as the KwaZulu-Natal Disability and Rehabilitation Programme, other Department of Health personnel and universities as perceived by the therapists. This section will provide an analysis of the findings and make comparisons with similar studies both locally and internationally.

5.2 ANALYSIS OF DATA

5.2.1 Similarities and differences with this study and other studies.

Many of the findings reported in the results chapter revealed similarities between the different occupational catergories of therapy groups. Despite the challenges, most of the therapists believed that they had made a positive difference to providing rehabilitation services during their community service year. The findings were similar to those of other research from KwaZulu-Natal (Reid, 2001), where it was reported that, despite all the difficulties in public hospitals many health care professionals have exhibited positive sentiments about community service. There was a realization by doctors that community service for medical practitioners had made a huge difference to the patients served and this provided a motivation for both policymakers and implementers (Reid, 2001, Strachan, 2000), to continue with community service programmes for other categories of health personnel. In the study in Mpumulanga (2002) on doctors perceptions of their community service in Shongwe hospital, it was also found that the relevant group of physicians gained experience,

practical skills, and confidence and reported that a worthwhile experience had been enjoyed (Maseka, Ogunbanjo, Malete, 2002). In Ecuador (Cavendar, Alban, 1998), most physicians allocated to community service, considered the experience rewarding both personally and professionally. They had developed a better understanding of health conditions in rural areas. This study further illustrated that therapists had gained a better understanding of the community service policy and that their attitude was more positive towards the community service programme. These findings can be used to motivate future community service therapists to be encouraged about their year of community service.

In this current study with therapists the researcher also focussed on issues such as language as a barrier to service delivery as well as the amount of community outreach that therapists were able to conduct as these were felt to be relevant to therapists. As reported earlier a therapist in KZN doing their community service is unique to any other category of health care professional doing community service as 40% of their time in a week is spent doing community outreach. The findings in relation to these will be discussed in detail later. Another relevant difference noted in this study as compared to the studies with doctor's in KZN was that there was no association between collecting a rural allowance and deciding to work in a rural area in future (Reid, 2004) and this will be discussed further. There was a lot of emphasis rather on induction, orientation, mentoring and supervision and support. This needs to be viewed in relation to the influence of contextual factors on the ability to provide adequate support and supervision due to the 50% rate of vacancies of posts in the Province as shown in Table 1. The above findings will be discussed further in the relevant sub-sections in this chapter.

5.2.2 Discussion of the Comparisons of the responses from initial questionnaire & exit questionnaire

It was extremely concerning to note that issues regarding training, supervision, support and safety concerns grew from being positive at onset to being negative at exit. The intention to remain in the public sector also declined. These findings need to be viewed with caution due to the large non-response rate to the exit questionnaire. However these findings were similar to those of other exit studies done in South Africa with doctors in that training and support and supervision needed to be addressed. There was also a decline in the intention of doctors to remain in the public sector after the year of community service. These findings are discussed in detail later in the discussion.

5.2.3 Summary of the differences in attitudes and perceptions from the different occupational categories on the exit questionnaire.

The exit questionnaire had both a quantitative and qualitative component. The qualitative component supported the results obtained in the quantitative analysis and provided additional and useful information that will be discussed. There was not much difference between the occupational catergories in terms of how they experienced community service. A huge difference was noted in the amount of support the community service therapists received through their professional fora and in the issue of coping with language. These will be discussed in detail later in the chapter.

5.2.4 The following are some aspects of the study that will be analysed in detail as it is believed that these will impact greatly on future success of community service programmes as is relevant to therapists:

- **Training**

At onset the perception of most therapists was that their tertiary education did equip them for community service. At exit most felt that they were not so well equipped. In the open - ended questions in the exit questionnaire, therapists felt that their training needed to cover more administrative aspects and involve more practical experience at rural sites. This has implications for the curriculum which needs to be reviewed. They also suggested areas in their clinical training that needed attention in their undergraduate education. Therapists reported that they were better equipped to work optimally at regional and central level. This issue needs to be addressed as most placements are at district level hospitals and the training curriculum needs to address training needs at this level. The findings of this study is concerning as the literature demonstrates that those exposed to rural areas in their training and those whose training needs addressed rural populations were more likely to practice in rural areas.

Therapists were also asked about the orientation to community service received from the university that they attended. There was a significant difference between the universities with regard to this, with UKZN scoring the highest as being the university that best orientated their

CS therapists for community service (p=0.008). These findings can provide useful insight to the training institutions who can learn from each other and make adjustments to their current practices around community service.

Many research findings both internationally and provincially allude to the fact that the training curriculum for rural settings needs to be more appropriate and needs revision (Dhauphinee, 2006). In the Ecuador study, it was found that training oriented health workers to work in an urban as opposed to a rural setting. The World Health Organisation felt that many universities provide inadequate training for placement in rural service (WHO, 2001). Academic institutions need to provide training in rural areas (Sanker, Jinabhai, Munro, 1997). In Australia, it was shown that medical students who have had both undergraduate and post-graduate rural training were more likely to practise in a rural area in the future. Such training must be adapted to meet the needs of the under-served community optimally (Maseka, Ogunbango, Malete, 2002). Others have maintained that the problem is compounded by dispatching the least qualified to perform the most challenging and demanding service. Allocating the least qualified to deficient district and rural services may convert good practitioners into poor professionals since they are unable to practice their skills, knowledge and expertise gained in training (Cameron, Blitz, Durrheim, 2002).

The above findings can be useful for the various role-players involved in the training, education and development of community service therapists.

- **Supervision and mentoring**

At onset of community service, most rehabilitation therapists (66%) believed that they would be furnished with adequate support and supervision to be able to function optimally in the community service year. Sadly, most felt that this was not provided.

Overall there was no significant difference in mean supervision level or mentoring between the occupational categories of therapists. The best supervision was experienced at a central level and in urban areas. Reid (2001) also found that supervision by senior personnel was generally poor, especially in rural settings with a few hospitals with exceptional degrees of support. The study in Mpumulanga (2002) also reported poor support for doctors.

When the mean level of support was compared between the professions with regards to the most satisfactory support from their professional forums, a highly significant overall difference was found ($p<0.001$). This significant difference existed between Audiologists and Physiotherapists, ($p=0.002$). In addition, there was a highly significant difference in support between speech therapists and physiotherapists ($p<0.001$).

The above results are important for various reasons:

- Recently qualified therapists perceived that they would be better supervised and mentored than they actually experienced. Couper (2005) states that a plan for mentoring and support needs to be put in place for community service officers. It would be useful to share ideas, experiences and mistakes in order to strengthen the learning process.
- Support and supervision needs to improve in rural settings in order to retain and capacitate therapists and attract them for rural service.
- Professional fora need to learn from each other's experiences in terms of providing adequate support to their community service therapists such as developing guidelines and mentorship programmes.

- **Availability of resources**

There was no difference between how different occupational categories experienced work space, transport, parking or accommodation. From the qualitative analysis community service therapists felt that it was difficult to access resources, they were obliged to use their own resources, they were allocated no budget, had sponsored equipment, equipment was missing, setting up the department was a very slow process and that they required more resources that were appropriate for Zulu speaking clients. The availability of resources impacts greatly on the quality of service provision and needs to be urgently addressed especially in hospitals that have been allocated community service therapists that have never had a rehabilitation service before.

Dentists in Reid's study (2001), similar to the therapists in the study were concerned that lack of equipment actually impeded their functioning. The study in Ecuador (Cavender, Alban, 1998), also reported that their doctors were not provided with essential equipment and this made it extremely difficult to practise. Other concerns from the above study related to lack of transport, accommodation, institution capacity and infrastructure issues that need to be

urgently addressed. Therapists have suggested that, if their personnel and personal issues are managed more efficiently, they would be more likely to remain.

- **Language**

The fact that most therapists speak English as their first language constitutes an impeding factor in communication with Zulu speaking clients who form the majority of the caseload of therapists. The Speech and Audiology Department at University of KwaZulu Natal-Westville Campus run a module on enabling their therapists to communicate in isiZulu and the other therapy departments might also need to undertake this. This recommendation is made in context of the fact that the Audiologists and Speech therapists were able to cope with language barriers a lot better than the other professional groups. About 50% said that the language barrier impeded their functioning. There was a significant difference between Audiologists and Physiotherapists with the former coping better. Language barriers were also experienced by doctors, dentists and pharmacists in the studies by Reid (2001, 2002). The issue of language needs to be explored further as it is a huge barrier to quality service delivery. The issue of language and cultural aspects was also brought up when community service therapists were asked about how their training could be adapted. Other strategies in addition to having interpreters would need further exploration as many therapists found it difficult to work even with an interpreter present.

- **Community Outreach**

Most therapists reported that they were able to conduct regular clinic visits but this was limited, due to the huge caseloads prevailing at hospitals and low number of clients turning out at the clinic, poor clinic infrastructure and transport problems. This needs attention as KwaZulu-Natal has made a ruling that all therapists complete 40% of their week in working in clinics to ensure expansion of traditionally institution - based services to rural communities. This is unique to therapists only and does not apply to other categories of community service officers in KZN. However this has been identified as one way to strengthen disability and rehabilitation services within Primary Health Care and the District Health System.

- **Intention to remain in the public sector**

According to the Department of Health, one of the purposes of community service is to retain

It was interesting to note that an overwhelming number, 93% of therapists indicated that they would recommend the site to which they were allocated as being suitable for future community service placement. This also demonstrates the need for services at these sites. This was very encouraging and alerts the provincial department that the sites being recommended are in need of disability and rehabilitation services. However, what was concerning about this, was that only 16% of therapists indicated that they themselves would consider staying on, at the site where they completed their community service in, the following year. This again has huge implications for the sites where therapists were placed in KZN. This could highlight issues of administration, support, supervision and management received by community service therapists at these sites. In addition 41% stated that perhaps sometime in the future they would consider working at the site they conducted their community service in.

Linked to the issue of retention, Reid (2001; 2002) also recommended that those community service practitioners, who express an interest in long-term service in rural or under-served areas, should be encouraged to do so through contractual agreements with provincial health departments, which include incentives. Preferential selection of therapy students from rural areas, linked to bursaries and academic support programmes, need to be considered in longer-term planning. This has been positively recommended both in Australia (Wilkinson, Laven, Beilby, 2003) and Canada (Chan *et al*, 2005). However, some have questioned whether recruiting from rural backgrounds will ensure that practitioners return to rural service (Moomal & Pick, 1998). Policy makers still need to target urban practitioners as they still remain the major reservoir of human resources for rural communities (Chan *et al*, 2005).

A study was undertaken in South Africa to determine whether medical students of rural origin were more likely to practise in rural areas (de Vries, Reid, 2003). Their findings confirm, as with international studies, that rural origin graduates are more likely to choose rural careers. The Friends of the Mosvold Scholarship scheme in addition hold that support and mentoring through the study process and strategies such as holiday work experience play an important role in ensuring students selected from rural areas are motivated and better prepared to work in rural areas. In addition, policy makers need to encourage training institutions to enrol students from rural areas and review their selection criteria (de Vries, Reid, 2003) and make rural service conditions attractive (Moomal, Pick, 1998). A combination of factors can influence professionals to choose to practise in rural areas such as the exposure to rural

practise during training, an understanding of rural needs and exposure to rural role models (Couper, Hugo, Conradie, Mfenyana, 2007).

A study conducted in the USA, recommended preferential recruitment of applicants from a rural background and encouraging other applicants who had expressed an inclination to become rural family physicians. These were based on their background, career intentions and the need for support during medical school and allowing them to work in rural areas. This would lead to a sustainable, long lasting and an effective and high retention rate (Rabinowitz, Diamond, Markham, Hazelwood, 1999).

However, a public inquiry into the right to access health services by the South African Human Rights Commission (PDOH, 2007), revealed that even if community service therapists desire to remain in the public sector no posts are available at various institutions. It further adds that there needs to be a renewed attempt to encourage the return of skilled health care workers who have emigrated overseas.

According to Hill (2001), international experience has demonstrated that multiple strategy packages were more effective such as those that were adopted by Chile in the 1960's. The package provided increased salary, support for advanced training, annual awards, publication of work undertaken and support from regional hospitals. The success of this programme was dependent on all relevant role-players being involved (Rabinowitz, Diamond, Markham, Hazelwood, 1999).The option of compulsory community service for doctors in South Africa has been identified as one element in a strategy to rectify the urban/rural maldistribution of health professionals (Sanker, Jinabhai, Munro, 1997). South Africa has already commenced with other strategies. These have included the deployment of Cuban doctors to rural hospitals, scarce skills and rural allowance, the pay back of bursary obligations for the year as factors employed as incentives (Reid, 2001). In addition, the Human Resources for Health Plan (2006) and the Service Transformation Plans (2006/2007) that the department has developed will assist in addressing the human resource issues holistically (PDOH, 2007-2010).

- **Attitude to community service**

The overall attitude of therapists in all occupational categories towards community service had changed for the positive (p=0.067). There was no difference between the groups statistically (p=0.903). With regards to attitude and coping in relation to race, the other race groups coped better than Whites and Indians. Regarding **attitude** to community service those who were given **first choice** placement showed the most positive attitude to community service. All groups reported that their **attitude** to community service **changed** for the **better** despite the allocation choice. This is an encouraging aspect.

- **Personal difference and personal and professional gains**

All the occupational categories felt that they had made a difference to service delivery and had gained both personally and professionally from their community service year. This alone is a good internal motivating factor to enhance and improve the programme in future. The majority believed that their attitude was positive and that their clients were very appreciative. Reid (2002) showed similar findings in the study with doctors, dentists and pharmacists where the majority felt that they had both made a difference and had developed as professionals. Most were positive concerning their experiences. The Ecuador study also revealed that community service is of great value in educating professionals of the deplorable health conditions evident in rural areas and promotes the development of such intangible skills as intuition and creativity, which are essential for professional practice.

In the next section some of the above recommended strategies will be considered, that could be adopted in the South African context.

5.3. LIMITATIONS

In the methods section, the attempts made to improve the internal validity of the study were described. How successful the efforts were in improving the reliability of the data is discussed in this section. Some ideas are given as to how to address information and selection bias and confounding in future studies.

5.3.1 Information bias

The basis of the questionnaire used as the data collection tool in this study was developed by Professor S Reid and utilised to evaluate community service for doctors over a number of years. It was assumed that the original questionnaire was reliable, sensitive and specific for assessing doctors. However, information bias could have been introduced through the manner whereby the questionnaire was adapted from the original and also how it was changed between being administered at the onset of compulsory community service for therapists to that which was used at the conclusion of the year of community service. In particular, a series of open-ended questions was added to the questionnaire administered to therapists just before they completed their community service. These were not questions which were part of the questionnaire used to assess doctors. They were however assessed by the Therapy Forums and also by managers in the KwaZulu Natal Rehabilitation and Disability Department and deemed to be important to include for therapists. This process itself could have introduced bias especially if there were challenges with the validation aspects.

At onset the questionnaires were handed out and completed at the induction and orientation meeting whereas at the completion of community service they were mailed electronically to the hospitals to be given to the therapists for them to complete. The difference in the manner of administration of the two questionnaires could have resulted in different information bias. It is possible that under the strict confines of an induction and orientation meeting that a certain social desirability bias could have occurred. For most therapists they may have felt freer to express their true opinion at completion of their community service year and also without being under any duress to complete the questionnaire in a short space of time. There is a possibility that the direction of this bias may have been different at the commencement and the end of the community service year. It is possible that the social desirability element

could be more for the Audiologists and Speech therapists knowing that the principal investigator was from that occupational sub catergory of therapists herself.

In addition therapists could have reported on what they believed the researcher wanted to hear and could have supplied more positive results or experiences than they actually experienced.

A major limitation of the study was that a pilot study was not conducted. It is always desirable to conduct a pilot study in order to improve the internal validity (the rigour with which the study was designed and executed and can the conclusions be relied on), of the questionnaire and assessing it's feasibility for the main study especially in relation to the logistics of data collection. When the onset questionnaire was amended to include fewer questions and designed there was no pilot study conducted and it was not refined or amended until closer to the time of the exit study when the scales and data elements were reviewed and changed. As a result, some of the data field categories were not identical in the initial and exit questionnaire and limited statistical analysis could be done, comparing the initial and exit responses. The scales of measurement were also not standardized. The onset questionnaire employed a "yes", "no" and "neutral" response and the exit used "agree", "disagree" and "neutral". At exit this was standardized with the assistance of the bio-statistician, however this could have introduced bias. The lack of comparability of the onset and exit questionnaires does impact significantly of the validity of the findings.

In order to reduce information bias in the future it is recommended that the questionnaire administration at onset and exit be conducted in the same way. The data elements and scales of the questionnaires need to be identical and validated through a pilot process.

5.3.2. Selection bias

In this study no sampling was undertaken to reduce selection bias however this study remains problematic due to the low response rate and the huge drop-out rates of responses from onset to exit of the community service year. The selection bias caused by members of the study population not responding may have affected the statistical validity of the study. The small sample size was aggravated by the non-response and also affects the precision and internal

validity of the results. Many differences observed require cautious interpretation especially where statistically significant associations were not found.

An attempt to follow up on non-respondents was made through the professional fora and the institutions. In many instances, it was ascertained that the therapists did not receive the questionnaire and it was still in the office of the hospital management. It would have been very useful to observe and assess the characteristics of the non-respondents and ascertain if they differed systematically from the respondents (non-response/refusal bias). Those who responded could include those who had a more positive experience during their compulsory community service year.

Furthermore, the researcher is a Speech Therapist and Audiologist by profession and the best response rate came from this group. This itself could have introduced researcher bias. Occupational Therapists and Physiotherapists should have been included in the discussions to refine the questionnaire not only the Speech therapists and Audiologists. In addition only 14 males were involved in the whole sample and at exit, only 4 males participated. This gender imbalance could have impacted on certain findings due to the very small sample size.

In order to limit selection bias in the future it is recommended that instead of forwarding anonymous questionnaires the researcher could have addressed the questionnaire to individual therapists although still requesting that it be completed anonymously. In addition, an improvement in the response rate might have been achieved by attempting to obtain responses telephonically. This may have increased information bias but decreased selection bias. The exit questionnaire could also be administered at the end of year evaluation meeting held by the Disability and Rehabilitation Programme, thereby improving response rate. Finally all occupational categories should have been consulted in designing the questionnaire.

5.3.3. Confounding

Possible confounding could be related to where therapists studied, placement choice, allocation in urban or rural area, gender and the support given. The following involve some examples of possible confounding. Generally the size of the sample was not big enough to control for confounding so that stratification according to different categories and multi variable analysis was not conducted.

A significant association was noted that Audiologists and Speech Therapists were provided with more supervision and had a more positive overall experience with their community service year. There was also a better response rate from this occupational category. The researcher is a Speech Therapist and Audiologist and attends all Speech Therapy and Audiology Forum meetings and provides information on various issues and this could have confounded some of the results (observer bias).

In addition it was found that therapists working in urban areas were more inclined to say they wanted to work in rural areas than those performing their community service in rural areas. This is somewhat unusual but was found to be significant ($p=0.018$). It would appear to be a worthwhile exercise to check if this was only due to scarce skills or whether their training made them more adept at working in a rural setting or whether they were actually exposed to the rural areas during their training.

The Speech Therapists and Audiologist's also coped better with the language issue. This could indicate that they conduct language therapy as part of their patient management and therefore need to be familiar with isiZulu, in addition to the fact that their curriculum includes 6 months of isiZulu training.

5.4. SUMMARY

Despite the limitations of the study it is evident that therapist's perceptions and attitudes to their community service in this year has provided valuable insight into the strengths, weaknesses and challenges experienced. These discussions assist in formulating the recommendations.

6 CHAPTER 6: RECOMMENDATIONS AND CONCLUSIONS

6.1 INTRODUCTION

Health care for rural populations has become a priority throughout the world and it is therefore important that retention of health care workers remains a priority in under-served areas. Staffing rural and under-served areas can be achieved through various strategies. One such strategy is compulsory community service. However the success and failure of community service depends largely on the attitudes of the professional, their understanding of the programme's objectives, their preparedness for doing rural service and their ability to adapt to such an experience. It is therefore important that a newly implemented community service policy should be evaluated and monitored regularly. The findings and recommendations must also be used to inform policy and assist implementation of the programme. In chapter 6 the conclusions and recommendations based on the findings and discussions made in each important issue explored in the study are presented.

6.2 CONCLUSIONS

Studies, both nationally and internationally, indicated that there was widespread support for compulsory community service as a strategy for the recruitment of health care professionals to under-served areas. However, this needs to be implemented with other financial and non-financial strategies, addressed together with adjustments in the health system such as in the areas of administration, management and logistical support, if health care professionals are to be retained in these areas.

The current study demonstrated that there was support for the idea of community service but problems arose at the point of implementation. If community service is to meet its objectives the conditions under which community service therapists work, such as having the correct equipment to practice professionally, accommodation, tertiary and in service training, regular supervision and other logistical issues must be addressed.

The study also demonstrated that despite therapists collecting a rural allowance this benefit did not of itself motivate them to establish their careers in rural or under-served areas in the

future. It is, therefore, believed that other incentives and strategies need to be developed to ensure retention of health care workers in rural areas especially in the public sector. It also highlighted the fact that therapists need to be well prepared, trained and orientated prior to commencing community service especially in rural areas. They also require to be equipped with basic isiZulu language training to be able to communicate effectively with the heavy case-loads they are exposed to in under-served areas. The support and supervision provided to rehabilitation therapists by more experienced peers during the compulsory community service year demands urgent attention.

This study proved useful in identifying areas of need and success in the implementation of community service for therapists in KwaZulu Natal. It also provides information that can be used by the managers of the programme and other influential key role players to improve future community service for therapists and other healthcare workers in KwaZulu-Natal, drawing from studies locally, nationally and internationally. Areas of future research were also identified.

6.3 RECOMMENDATIONS

General recommendations:

The Community Service Programme needs be continually monitored and evaluated. Ongoing assessment will provide useful information as to whether the policy and programme is being implemented with the expected results. Lessons learned from regular evaluation can be incorporated into the rehabilitation policy and decision making process Disability and Rehabilitation Programme managers in KwaZulu Natal. Ensuring that the policy is effective and implementation efficient is particularly relevant in the health context, which has very limited resources and will help to ensure that available resources are used optimally.

Evaluation can be undertaken at the end of each year in the province and the results can be used to highlight issues and concerns that have been resolved or still need to be considered for improvement. As community service therapists are directly involved in the programme their inputs, perceptions and experiences would be very valuable.

Therapists can also be encouraged to communicate their experiences and challenges to future community service therapists. These presentations could motivate student therapists or at

least alert them to challenges of community service, and give them an opportunity to appreciate the skills they will need for working in under-served areas.

An intersectoral forum needs to be established whereby the Disability and Rehabilitation Programme meets with hospital and district mangers, district disability and rehabilitation co-ordinators and the human resource directorate to investigate options such as bursaries, conditions of service and personnel issues which could also improve the situation for therapists working in difficult conditions.

The issues pertaining to tertiary education and training of therapists can be discussed in the existing meetings held between the Disability and Rehabilitation Programme and the university. However, currently this is restricted to University of KwaZulu-Natal and a national forum needs to be investigated to address many of these issues.

Profession specific concerns need to be communicated to and addressed by the Professional Fora.

District Disability and Rehabilitation meetings occur on a monthly basis and all issues pertaining to community service need to be discussed at these meetings including concerns about space, equipment, and transport for community outreach, safety issues and support and supervision. Furthermore perhaps all provincial co-ordinators of different occupational catergories co-ordinating community service in KwaZulu Natal such as doctors, pharmacists, dentists, dieticians and other categories can meet bi-annually to share best practices. It is envisaged that through this consultation and collaborative process many of the challenges facing community service therapists can be addressed.

Specific recommendations are made for the following:

- **Training**

  Training institutions should re-examine their curriculum and adapt it in order to ensure that therapists are better equipped to work in rural settings. This study highlighted useful clinical and non-clinical areas where therapists felt that the university needs to expand and integrate into their curriculum. Specific clinical areas for each occupational category are

summarised in Table 6 in the results section. This list reflects the type of caseload mix seen by therapists. The curriculum should then be informed by service delivery needs and realities.

There is a need for more practical experience for therapy students across the board at rural sites. Lessons in practical use of local languages need to be seriously considered in the training of therapists. Additional recruitment of more Zulu speaking under-graduate therapists for training remains a priority. Strategies adopted in other countries and to a limited extent locally can also be considered such as preferential selection of therapists from rural backgrounds who are granted bursaries to study in health sciences and are then recruited to return to practise in the rural areas from whence they came.

Furthermore as therapists are required to conduct 40% of their work week at clinics in order to strengthen primary health care within the district health system, universities need to ensure that disability and rehabilitation services relevant to primary health care is integrated into the curriculum.

These recommendations will be forwarded to the training institutions. In addition, the provincial Department of Health must provide training and development opportunities for the community service officers to assist with addressing their skills gaps.

- **Support and supervision.**

The study has highlighted that rural allowance in itself was not sufficient to attract and retain therapists in under-served areas. Greater emphasis needs to be placed on support, supervision, mentoring, induction and orientation of community service rehabilitation therapists. The study also demonstrated that Audiologists who received all of this had a more positive attitude and experience in their community service year and coped better than other occupational catergories. A system needs to be put in place at district level, including regular meetings of community service therapists with peers and seniors to discuss problems and provide opportunities for support, supervision, mentoring and orientation. Activities for community service therapists could include attending professional forum meetings regularly. Clear guidelines on mentoring should be drawn up using the Health Professionals Council of South Africa recommended guidelines. Support and supervision needs to be strengthened in

rural areas and in district hospitals. Some suggestions include linking community service therapists to senior therapists in the district if there is no senior therapist at the hospital and to the district disability and rehabilitation co-coordinator. In KwaZulu-Natal there is a coordinator from one of the therapy disciplines in each district who cordinates disability and rehabilitation services

Support and supervision visits can be scheduled with therapists from urban areas to conduct on-site visits using the Red Cross Air Mercy Services in KwaZulu-Natal which regularly supports visits of professionals to very rural hospitals. It is also important that a proper induction and orientation programme exists for community service therapists to facilitate their easier integration into the health system. The mentors and supervisors need to be aware that the adjustment to working in under-served areas continues much longer than the time needed to become familiar with the physical and administrative environment. In addition to the provincial induction and orientation programme, districts should conduct their own orientation and induction to familiarize the community service therapists to the local district context and an awareness of existing health priorities.

- **Availability of resources**

Hospitals should provide an adequate budget for the specific resources needed for disability and rehabilitation services. Therapists found it difficult to access resources as shown in 4.4.3 and 5.2.4.

Rural hospitals that do not have residential accommodation in their surrounding area need to upgrade existing accommodation facilities on-site. An official policy on accommodation is essential to ensure that all categories of staff undergoing community service are properly accommodated in a safe environment and adequately subsidized for costs of rentals. Salaries, transfers and rural allowances must be efficiently administered and promptly paid.

Community service therapists must be provided with transport for outreach clinics as well as adequate space and equipment to provide a professional service in their specific discipline.

Provinces can also consider rotating their therapists within a complex of institutions to decrease feelings of isolation and provide them with learning opportunities in different

contexts. This would need to be done in consultation with the therapists as it may be more disruptive than beneficial.

- **Language**

The issue of therapists having limited local language knowledge and practices came up repeatedly as a barrier to service delivery. Audiologists and Speech Therapists coped better with the issue of language during their community service year as they are exposed to a module enabling them to communicate in isiZulu. All tertiary level education therapy departments need to undertake much more extensive language training to equip their therapists for community service but also to work effectively as therapists in this multi-cultural and language society. The KwaZulu Natal Department of Health also needs provide in-service and training opportunities that build capacity for therapists to cope with the language barriers that are synonymous with working in under-served and rural areas of the province.

- **Community outreach**

The resources required to provide an effective and professional community outreach disability and rehabilitation service needs to be addressed by the Department. Some of the issues that need to be addressed include the huge caseloads prevailing at hospitals, poor clinic infrastructure, transport problems and the poor turnout of clients at the clinic. The community outreach strategy for therapists should be pursued by other cadres of health care professionals conducting their community service programmes in KwaZulu Natal as this strategy with therapists has been extremely useful in creating awareness of the service and strengthening the primary health care services for disability and rehabilitation.

- **Retention in rural areas**

The development of a comprehensive human resource policy for the recruitment and retention of all health care personnel in rural and under-served areas in the country is needed. Universities should work more closely with national policy makers to improve existing and possibly create alternative Disability and Rehabilitation curricula that better prepare student therapists to work in rural and under-served areas.

A commitment from Department of Health is necessary to ensure in service capacity building for their staff with continuous development of clinical and management skills. Policies on staff migration need to be in place. The above policies must address disability and rehabilitation service delivery and issues around the provision of quality care for Persons with Disabilities, those at risk and their families.

Multiple strategies need to be devised to retain therapists in rural areas in addition to the financial incentives provided by the Rural and Scarce Skills Allowances. The study showed that this in itself was not an incentive to retain therapists in rural areas. Retention strategies must include improving conditions of service and making infrastructure adjustments to provide adequate work space to conduct quality rehabilitation therapy, reasonable living accommodation and adequate and reliable transport for community outreach services. Other strategies could include providing bursaries to students especially those whose homes are in rural or under-served areas with contracts for them to work in these locations when they qualify.

The Department of Health needs to develop its post structures to retain therapists in rural areas. The crisis in rural areas requires to be viewed in the context of the brain drain affecting the country and consideration given to all conditions that induce therapists to leave the public sector. Senior therapists also need to be offered incentives to remain in under-served areas and assist with orientation of newly qualified therapists. The continual turnover of staff creates a huge burden on the hospital which is aggravated by the 50% vacancy rates. Strategies such as active recruitment of students from rural areas linked to bursaries needs to be explored and the exposure of undergraduates to rural settings during their practical training needs development. Some of these strategies, it is hoped, will encourage recruitment and retention in rural and under-served areas.

Other recommended strategies that could motivate therapists to work in public sector especially in under-served areas include allowing for part-time private practice after hours, increased vacation leave, and improved working conditions, access to post graduate training, preferential recruitment of personnel from rural areas and the enhancement of the status and self esteem of those who serve (Strachan, 2000). Most countries use multiple strategies such as increasing salaries, supporting advanced training, annual awards, part-time private practice, better employment conditions, better rural living conditions, equipment and

administration and technical support (Hall, 2001). Such linking of community service in under-served areas with postgraduate specialization is a potential incentive strategy that requires serious consideration in South Africa and could provide further incentive for young professionals to serve the needy.

Finally, the implementation of the community service rehabilitation programme must be monitored and evaluated continuously in order for it to become a reflective learning organisation.

6.4 RECOMMENDATION FOR FURTHER STUDY

One of the objectives of community service for the Department of Health was to ensure improved provision of health services to all citizens of the country. It is therefore critically important that future research in this area attempts to assess the outcomes on service delivery and the impact on health status in the long term. Internationally, the rationale for the creation of compulsory community service programmes is that the increased presence of professionals will improve the health status of rural and under-served populations, which exhibit higher rates of morbidity and mortality compared with urban populations (Cavender, Alban, 1998). The impact of community service in South Africa in terms of it's improvement of the health status of persons with disabilities in under-served areas will need to be determined and could include issues around improved access to disability and rehabilitation services, access to information for persons with disabilities, access to assistive devices and how this has improved the health status of persons with disabilities.

Another objective for instituting community service was to allow young professionals the opportunity to develop skills, acquire knowledge, behaviour patterns and critical thinking to help them to develop their professional experience. Measuring the extent to which this has been achieved requires more research.

The community service policy was also directed at attracting and retaining health care professionals in the public sector. Of concern in this study was the fact that the intention to remain and work in the public sector in the future declined from 50% at onset to only 35% at exit. Even financial incentives with scare skills allowances and rural allowances were not sufficient inducement to support the retention of therapists in rural and under-served areas. It

is important that in South Africa, where the majority of the population still reside in rural areas, other innovative strategies are instituted and effected to retain rehabilitation therapists in areas of need. A case control study that looks at therapists that remain in the public sector (cases) and those that leave (controls) could be conducted to determine factors that contribute to therapists leaving or staying in the public sector. Factors found to induce doctors to remain in the public sector such as a sense of vocation (a calling to serve the poor), a sense of adventure, nature–enjoying the natural surroundings, acquiring experience – the development of hands-on experience, acquiring a wide range of skills, an escape from stress and a focus on the family could be investigated for therapists. (Couper, 1999).

It is also important to determine the reasons that some newly qualified rehabilitation therapists avoid rural service. These may prove to be very complex, and involve the inability to practice and regard oneself as a professional, the lack of contact and the required support from higher levels of the health system. Ideally, certain exposures could be assigned to therapists such as supervision and support to determine their experiences and how they differ from groups not assigned the exposures. This could be done using a randomised controlled study design. In the process of conducting this research there was an observation that many therapists do not turn up for their community year and this differed among different professionals. Future research could explore reasons why therapists and other health care professional do not turn up for their community service year, the reasons for this and what they do instead.

The impact on service delivery, to the client and the health system, with the introduction of community service must be assessed. A more far-reaching attitude and perception study, involving therapists from all provinces, could be undertaken with a larger sample size and adopting strategies to reduce selection bias by improving the response rate. This would ensure improved internal and external validity. Comparison between training institutions must be conducted and monitored, to determine exactly how they are equipping therapists for community service. Therapists could be followed up long tem to determine if the way they were trained had an impact on their experiences. This could be done using a cohort study design.

6.5 SUMMARY

It is important that recommendations by therapists and other health care professionals undergoing community service inform the implementation of this programme. Further studies, need to be undertaken, as there are many unanswered questions about how best to implement community service with therapists in KwaZulu-Natal and the optimal strategy to staff under-served areas with healthcare workers in order to improve the health status of the population.

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8 APPENDICES

8.1 ONSET QUESTIONNAIRE

Appendix 1 Onset Questionnaire
Pre commencement questionnaire

COMPULSORY COMMUNITY SERVICE: Department of Health

Section one

Biographical information

Name:
_____

Address:
_____
_____
_____

Contact Details:
(T)
_____
_____

(F)
_____
_____

(CELL)
_____
_____

E-MAIL
_____

1. Your status: ☐ Male ☐ Female ☐ Black ☐ Indian

☐ Female ☐ Unmarried ☐ White ☐ Coloured

2. At which tertiary institution did you qualify?

☐ Cape town ☐ Free state ☐ Kwazulu Natal ☐ Medunsa ☐ Port Elizabeth

☐ Potchefstroon ☐ Pretoria/Tswane ☐ Rau ☐ Rhodes ☐ Stellenbosch/UWC

☐ Transkei ☐ Wits ☐ University of North Outside SA

3. In the allocation process last year, what was the number of your choice, of the health facility that you were finally allocated to?

4.

☐ 1 choice ☐ 2 to 5 choice ☐ 6 to 10 choice ☐ >10 choice

Section B

5. My understanding of the objectives of community service is very good.

☐ Disagree ☐ Neutral ☐ Agree

6. My source of information from the university has been good in orientating me with information.

☐ Disagree ☐ Neutral ☐ Agree

7. There is a lot more information that I still require about my community service.

☐ Disagree ☐ Neutral ☐ Agree

8. I was able to easily access information about the hospital and location.

☐ Yes ☐ No

Section C

9. I believe community service is a good policy.

☐ Disagree ☐ Neutral ☐ Agree

10. I am really looking forward to my year of community service.

☐ Disagree ☐ Neutral ☐ Agree

11. I feel resentful about my placement.

☐ Disagree ☐ Neutral ☐ Agree

Section D

12. I feel my training has equipped me for community service.

☐ Disagree ☐ Neutral ☐ Agree

13. I believe that I will be given adequate support and supervision.

☐ Disagree ☐ Neutral ☐ Agree

14. My attitude towards community service is very positive.

☐ Disagree ☐ Neutral ☐ Agree

15. I intend working in the public sector after my community service year.

☐ Disagree ☐ Neutral ☐ Agree

16. Intend working in a rural area after my community service.

☐ Yes ☐ No

17. I will be pursuing my postgraduate studies during my community service year.

☐ Yes ☐ No

Section E

18. I will be able to adapt to language and cultural differences

☐ Disagree ☐ Neutral ☐ Agree

19. I am concerned with my safety

☐ Disagree ☐ Neutral ☐ Agree

Section F

20. I believe that I will be able to make positive contribution to the service.

☐ Disagree ☐ Neutral ☐ Agree

8.2 EXIT QUESTIONNAIRE

Appendix 2 Exit Questionnaire

EXIT QUESTIONNAIRE TO COMMUNICY SERVICE OFFICERS:2005

Please indicate tour choice with an X in the appropriate square

1. Your status: ☐ Male ☐ Married ☐ Black ☐ Indian
   ☐ Female ☐ Unmarried ☐ White ☐ Colored

2. Your Profession:

☐ Occupational therapist ☐ Physiotherapist ☐ Speech therapist

☐ Audiologist

3. At which tertiary institution did you qualify?

☐ Cape Town ☐ Free State

☐ KwaZulu- Natal ☐ Medunsa ☐ Port Elizabeth ☐ Potchefstroom

☐ Pretoria/Tswane ☐ RAU ☐ Rhodes ☐ Stellenbosch/UWC

☐ Transkei ☐ Wits ☐ University of North ☐ Outside SA

4. What level of health facility have you spent the most time working at this year?

☐ Specialized Hospital ☐ Central/Tertiary Hospital ☐ Regional Hospital

☐ District Hospital ☐ Community Health Centre ☐ Military sick bay

5. In the allocation process last year, what was the number of your choice, of the health facility that you were finally allocated to ?

☐ 1st choice ☐ 2nd to 5th choice ☐ 6th to 10th choice ☐ > 10th choice

6. Do you receive rural allowance?

☐ Yes ☐ No ☐ Don't know

7. Do you receive a scarce skills allowance?

☐ Yes ☐ No ☐ Don't know

8. The compulsory community service policy is a good one to retain health personnel in rural areas.

☐ Yes ☐ No ☐ Don't know

9. I understand the objectives if the community service policy.

☐ Yes ☐ No ☐ Don't know

10. My tertiary education equipped me well for this year.

☐ Disagree strongly ☐ Disagree ☐ Neutral ☐ Agree

11. My tertiary education needs to cover more practicals at rural sites.

☐ Disagree strongly ☐ Disagree ☐ Neutral ☐ Agree

Comments

_____

_____

_____

11. There were clinical areas that were needed more training on.

☐ Yes ☐ No

Comments

13. I was well orientated to my job by the hospital staff when I arrived:

☐ Disagree strongly ☐ Disagree ☐ Neutral ☐ Agree

14. Information on policies and procedures were readily available to me.

☐ Disagree strongly ☐ Disagree ☐ Neutral ☐ Agree

15. The induction and orientation program by the rehabilitation program, Department of Health has been very useful.

☐ Disagree strongly ☐ Disagree ☐ Neutral ☐ Agree

16 . The professional forums were a good source of support.

☐ Disagree strongly ☐ Disagree ☐ Neutral ☐ Agree

Comment

17. I was not given enough resources and equipment to work productively

☐ Yes ☐ No

Comments

18. I was provided with adequate:

Space for therapy	☐ Yes	☐ No
Transport	☐ Yes	☐ No
Parking	☐ Yes	☐ No
Accommodation facilities	☐ Yes	☐ No

Comments

_____

_____

_____

19. I did not manage to do a lot of community outreach at the various clinics.

☐ Disagree strongly ☐ Disagree ☐ Neutral ☐ Agree

Comments

_____

_____

_____

20. I found it difficult to do therapy via an interpreter

☐ Disagree strongly ☐ Disagree ☐ Neutral ☐ Agree

21. I did not experience significance professional development this year

☐ Disagree strongly ☐ Disagree ☐ Neutral ☐ Agree

22. I found it difficult to work within multidisciplinary team.

☐ Disagree strongly ☐ Disagree ☐ Neutral ☐ Agree

23. The disability sector was very valuable to me.

☐ Disagree strongly ☐ Disagree ☐ Neutral ☐ Agree

24. I was exposed to many culturally diverse issues.

☐ Disagree strongly ☐ Disagree ☐ Neutral ☐ Agree

Comments

_____

_____

_____

25. I did not experience significant professional development this year.

☐ Disagree strongly ☐ Disagree ☐ Neutral ☐ Agree

26. I have experienced good supervision this year.

☐ Disagree strongly ☐ Disagree ☐ Neutral ☐ Agree

Comments

_____

_____

_____

27. I believe that mentors should come from the same professional group as my Myself.

☐ Disagree strongly ☐ Disagree ☐ Neutral ☐ Agree

28. My seniors have not always been available when I needed help:

☐ Disagree strongly ☐ Disagree ☐ Neutral ☐ Agree

29. I have coped well psychologically this year:

☐ Disagree strongly ☐ Disagree ☐ Neutral ☐ Agree

30. I don't have a positive attitude to community service at this stage:

☐ Disagree strongly ☐ Disagree ☐ Neutral ☐ Agree

31. My attitude has changed for the positive over the course of the year.

☐ Disagree strongly ☐ Disagree ☐ Neutral ☐ Agree

32. The experience of this year has not changed my long-term career plans:

☐ Disagree strongly ☐ Disagree ☐ Neutral ☐ Agree

Comments

_____

_____

_____

33. I feel that I have personally made a difference to my patients this year.

☐ Disagree strongly ☐ Disagree ☐ Neutral ☐ Agree

Comment

_____

_____

_____

34. I have gained personally and professionally

☐ Disagree strongly ☐ Disagree ☐ Neutral ☐ Agree

35. I intend to stay on working at the same institution next year:

☐ Disagree strongly ☐ Disagree ☐ Neutral ☐ Agree

36. Where are you planning to work next year?

☐ Private sector SA ☐ Public sector SA ☐ Overseas ☐ Other

37. What is the most important factor to you in deciding where to work next year?

☐ Finances ☐ Career ☐ Experiences ☐ Travel ☐ Family ☐ Other

38. If you go to work overseas, are you intending to return to work in SA

☐ Definitely not ☐ No ☐ Not sure ☐ Yes ☐ Definitely

39. If remaining in public service in SA, do you plan to undertake further training?

☐ No ☐ Neutral ☐ Yes

40. Are you considering working in a rural or underserved area in SA in the future?

☐ No ☐ Neutral ☐ Yes

41. I would recommend this site for future placements for community service.

☐ Definitely not ☐ No ☐ Yes ☐ Definitely yes

42. Has community service increased the risk to your personal safety this year?

☐ No ☐ Neutral ☐ Yes

43. Were you satisfied with the way the hospital management handled any concerns a problem of yours.

☐ No ☐ Neutral ☐ Yes

44. Were you able to make friends easily?

☐ No ☐ Neutral ☐ Yes

45. Please write any further feedback on a separate sheet of paper including your Recommendations for the improvement of community service.

8.3 GAZETTED SITES FOR COMMUNITY SERVICE 2005

KWAZULU-NATAL DEPARTMENT OF HEALTH

APPROVED FACILITIES FOR COMMUNITY SERVICE FOR OCCUPATIONAL THERAPIST FOR 2005

Each complex and/or institution includes rotation through Community Health Centres and Clinics in District Health Services, identified by the Department

DISTRICT	FACILITY
Ugu (DC 21)	1. Murchison /Port Shepstone Complex • Port Shepstone Hospital* • Murchison Hospital* 2. G J Crookes Hospital* 3. St Andrews Hospital*
Umgungundlovu (DC 22)	1. Midlands Complex • Grey's Hospital • Fort Napier Hospital • Townhill Hospital • Umgeni Hospital 2. Pietermaritzburg Complex • Edendale Hospital • Northdale Hospital • PMB Assessment and Therapy Centre 3. Appelsbosch Hospital*
Uthukela (DC 23)	Uthukela Complex 1. Emmaus Hospital* 2. Estcourt Hospital 3. Ladysmith Hospital
Umzinyathi (DC 24)	Umzinyathi Complex 1. Charles Johnson Memorial Hospital* 2. Church of Scotland Hospital* 3 Dundee Hospital* 4. Greytown Hospital*
Amajuba (DC 25)	Amajuba Complex 1. Madadeni Hospital 2. Newcastle Hospital 3. Niemeyer Memorial Hospital*
Zululand (DC 26)	Zululand Complex 1. Benedictine Hospital* 2. Ceza/Thulasizwe Hospital* 3. Itshelejuba Hospital* 4. Nkonjeni/ St Francis Hospital*

	5. Vryheid Hospital
Umkhanyakude (DC 27)	Umkhanyakude Complex 1. Bethesda Hospital* 2. Hlabisa Hospital* 3. Manguzi Hospital* 4. Mosvold Hospital* 5. Mseleni Hospital*
Uthungulu (DC 28)	1. Eshowe Complex Catherine Booth Hospital* Eshowe Hospital Nkandla Hospital* KwaMagwaza Hospital* 2. Ngwelezana Complex Ngwelezana Hospital Ekhombe Hospital* Mbongolwane Hospital*
Ilembe (DC 29)	Ilembe Complex 1. Stanger Hospital 2. Umphumulo Hospital* 3. Untunjambili Hospital* 4. Montebello Hospital*
Sisonke (DC 43)	Sisonke Complex 1. Christ the King Hospital* 2. East Griqualand and Usher Memorial* Hospital 3. St Appolinaris Hospital* 4. Tayler Bequest Hospital*
Ethekweni	1 Ethekweni North Complex 1. Mahatma Gandhi Memorial Hospital 2. Phoenix Assessment and Therapy Centre 3. Provincial Rehab Centre 4. Osindisweni Hospital 2. Ethekweni Central Complex 1. Addington Hospital 2. Clairwood Hospital 3. King Edward VIII Hospital. 4. King George V Hospital 5. R K Khan Hospital 3. Ethekweni South Complex

	1. Prince Mshiyeni Memorial Hospital 2. Wentworth Hospital 4. Hilcrest Hospital

2004/02/13

* ISRDS NODES

* NON PENSIONABLE AREA ALLOWANCE

KWAZULU-NATAL DEPARTMENT OF HEALTH

APPROVED FACILITIES FOR COMMUNITY SERVICE FOR PHYSIOTHERAPIST FOR 2005

Each complex and/or institution includes rotation through Community Health Centres and Clinics in District Health Services, identified by the Department

DISTRICT	FACILITY	NO OF POSTS
Ugu (DC 21)	1. Murchison/Port Shepstone Complex	4
	Port Shepstone Hospital*	
	Murchison Hospital*	
	2. G J Crookes Hospital*	2
	3. St Andrews Hospital*	2
Umgungundlovu (DC 22)	1. Midlands Complex	2
	Grey's Hospital	
	Town Hill Hospital	
	Fort Napier Hospital	
	Umgeni Hospital	
	2. Pietermaritzburg Complex	2
	Edendale Hospital	
	Northdale Hospital	
	PMB Assessment and Therapy Centre	
	3. Appelsbosch Hospital*	1
Uthukela (DC 23	Uthukela Complex	
	1. Emmaus Hospital*	2
	2. Estcourt Hospital	2
	3. Ladysmith Hospital	2
Umzinyathi (DC 24)	Umzinyathi Complex	
	1. Charles Johnson Memorial Hospital*	1
	2. Church of Scotland Hospital*	3
	3. Dundee Hospital*	2
	4. Greytown Hospital*	1
Amajuba (DC 25)	Amajuba Complex	
	1. Madadeni Hospital	2
	2. Newcastle Hospital	1

Zululand (DC 26)	Zululand Complex 1. Benedictine Hospital* 2. Ceza/Thulasizwe Hospital* 3. Itshelejuba Hospital* 4. Nkonjeni/St Francis Hospital* 5. Vryheid Hospital*	 2 2 2 2 2
Umkhanyakude (DC 27)	Umkhanyakude Complex 1. Bethesda Hospital* 2. Hlabisa Hospital* 3. Manguzi Hospital* 4. Mosvold Hospital* 5. Mseleni Hospital*	 2 2 2 2 2
Uthungulu (DC 28)	1. Eshowe Complex Catherine Booth Hospital* Eshowe Hospital Nkandla Hospital* KwaMagwaza Hospital* 2. Ngwelezana Complex Ngwelezana Hospital Ekombe Hospital* Mbomgolwane Hospital*	 1 2 1 1 3
Ilembe (DC 29)	Ilembe Complex 1. Stanger Hospital 2. Umphumulo Hospital* 3. Untunjambili Hospital* 4. Montebello Hospital*	 2 1 1 1
Sisonke (DC 43)	Sisonke Complex 1. Christ the King Hospital* 2. East Griqualand and Usher Memorial Hospital* 3. St Appolinaris Hospital* 4. Tayler Bequest Hospital*	 2 2 2 2
Ethekweni	1. Ethekweni North Complex Mahatma Gandhi Memorial Hospital Phoenix Assessment and Therapy Provincial Rehab Centre Osindisweni Hospital 2. Ethekweni Central Complex	4 2

	Addington Hospital Clairwood Hospital King Edward VIII Hospital King George V Hospital R K Khan Hospital 3. Ethekweni South Complex Prince Mshiyeni Memorial hospital Wentworth Hospital 4. Hillcrest Hospital	3 2
		81

2004/02/13

* ISRDS NODES

* NON PENSIONABLE RURAL ALLOWANCE

KWAZULU NATAL COMPULSORY COMMUNITY SERVICE 2005 ALLOCATION FOR SPEECH THERAPY AND AUDIOLOGY

	ST	A	Reporting Institution
DC 21			
COMPLEX			
Murchison	1	1	Murchison
Port Shepstone			
G.J.Crookes Hospital	1		G.J.Crookes Hospital
St. Andrews	1		
DC 22			
COMPLEX			
Fort Napier			
Greys	1		
Townhill			
Umngeni			
COMPLEX			
Edendale	1	1	Northdale
Northdale Pietermaritzburg Assessment and Therapy Centre			
Applesbosch			
DC 23			
COMPLEX			
Emmaus	1		Emmaus
Escourt	1	1	Escourt
Ladysmith	1	1	Ladysmith

	ST	A	Reporting institution
DC 24			
COMPLEX			
Charles Johnson Memorial	1		Charles Johnson Memorial
COSH	2		COSH
Dundee	1	1	Dundee
Greytown	1		Greytown
DC 25			
COMPLEX			
Madadeni	1	1	Madadeni
Newcastle			
Niemeyer			
DC 26			
COMPLEX			
Benedictine	2		Benedictine
Ceza			
Itshelejube			
Nkonjeni	1		Nkonjeni
St. Francis			
Thulasizwe			
Vryheid			
DC 27			
COMPLEX			
Bethesda			
Hlabisa	1		Hlabisa
Manguzi	1		Manguzi
Mosvold	1		Mosvold
Mseleni			
DC 28			
COMPLEX			
Catherine Booth			
Eshowe	1		Eshowe
Nkandla			
St Marys			

	ST	A	Reporting Institution
COMPLEX			
Ekhombe			
Mbongolwane			
Ngwelezane	1	1	
DC 29			
COMPLEX			
Stanger	1	1	Stanger
Umphumulo			
Untunjambili			
Montobello	1		Montobello
DC 43			
COMPLEX			
Christ the King	1		Christ the King
E.G. Usher Memorial	1		E.G. Usher Memorial
St. Apollinaries			
Tayler Bequest			
ETHEKWINI			
COMPLEX			
Mahatma Gandhi + P.A.T.C. +Provincial	1		Mahatma Gandhi
Osindisweni			
COMPLEX			
Prince Mshiyeni Memorial Hospital	1	1	Prince Mshiyeni Memorial Hospital
Wentworth			
Hillcrest	1		Hillcrest
COMPLEX			
Clairwood			
Addington	1	1	Addington
R.K.K			
King Edward Hospital			
King George Hospital			

8.4 ETHICS CLEARANCE

UNIVERSITY OF
KWAZULU-NATAL

21 February 2006

Ms N B Khan
Community Health
Nelson R Mandela School of Medicine

Dear Ms Khan

PROTOCOL : Perceptions of and attitudes to the compulsory community service programme by Rehabilitation Therapists in KZN, 2005. NB Khan, Public Health. Ref.: H317/05

The Postgraduate Education Committee considered the abovementioned application and the protocol is approved for your MPH degree.

Please note that the study may not begin without ethics approval.

May I take this opportunity to wish you every success with your study.

Yours sincerely

PROFESSOR M ADHIKARI
Chair : Postgraduate Education Committee

c.c. Dr S Knight, Community Health
Mr S Siboto, Postgraduate Education

Nelson R Mandela School of Medicine, Faculty of Health Sciences,
Medical Research Administration

Postal Address: Private Bag 7, Congella 4013, South Africa

Telephone: +27 (0)31 260 4495 Facsimile: +27 (0)31 260 4529 Email: borresen@ukzn.ac.za Website: www.ukzn.ac.za

Founding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

→ forward to Nunia please

UNIVERSITY OF
KWAZULU-NATAL

RESEARCH OFFICE (GOVAN MBEKI CENTRE)
WESTVILLE CAMPUS
TELEPHONE NO.: 031 – 2603587
EMAIL: ximbap@ukzn.ac.za

23 FEBRUARY 2006

MS. NB KHAN (203513736)
SPEECH THERAPY AND AUDIOLOGY

Dear Ms. Khan

ETHICAL CLEARANCE APPROVAL NUMBER : HSS/06028A

I wish to confirm that ethical clearance has been granted for the following project:

"Perceptions of and attitudes to the compulsory community service experience by Rehabilitation Therapists in KwaZulu-Natal"

Yours faithfully

Ximba

MS. PHUMELELE XIMBA
RESEARCH OFFICE

PS: The following general condition is applicable to all projects that have been granted ethical clearance:

THE RELEVANT AUTHORITIES SHOULD BE CONTACTED IN ORDER TO OBTAIN THE NECESSARY APPROVAL SHOULD THE RESEARCH INVOLVE UTILIZATION OF SPACE AND/OR FACILITIES AT OTHER INSTITUTIONS/ORGANISATIONS. WHERE QUESTIONNAIRES ARE USED IN THE PROJECT, THE RESEARCHER SHOULD ENSURE THAT THE QUESTIONNAIRE INCLUDES A SECTION AT THE END WHICH SHOULD BE COMPLETED BY THE PARTICIPANT (PRIOR TO THE COMPLETION OF THE QUESTIONNAIRE) INDICATING THAT HE/SHE WAS INFORMED OF THE NATURE AND PURPOSE OF THE PROJECT AND THAT THE INFORMATION GIVEN WILL BE KEPT CONFIDENTIAL.

cc. Supervisor (Dr. S Knight)

8.5 LETTERS OF PERMISSION FROM THE DEPARTMENT OF HEALTH

MEMORANDUM
Department of Health

SANDHYA SINGH: DISABILITY AND REHABILITATION PROGRAMME

Tel: 033 – 395 2260
Fax: 033 – 3940105
Cell: 083 457 11 64
E-mail: singhsa@dohho.kznt.gov.za

Private Bag X9051
Pietermaritzburg
3200

TO: The Ethics Review Committee
Nelson R Mandela School of Medicine

FROM: Ms. S. A. Singh

DATE: 24 October 2005

RE: Motivation: Expidited Review
Masters in Public Health: Dissertation: N.B.Khan

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1. The Disability and Rehabilitation, received and approved an application by Ms N.B.Khan, an MPH student to undertake a study on Compulsory Community Service for Therapists in KwaZulu-Natal.
2. The Programme acknowledges the importance of monitoring and evaluating the community service for therapists programme which was introduced for the first time in 2003.
3. While attempts have been made by the Rehabilitation Programme since 2003, to "informally" institute monitoring and evaluation procedures, the methodology lacked validity and the response rate which was low made analysis difficult.
4. The Programme firmly believes that Ms Khan's proposal will significantly contribute towards establishing a credible knowledge base to further enhance implementation of the community service programme.
5. It is envisaged that the study will impact on key processes including:
   - 5.1. Curriculae review and development in order to align training to service needs.
   - 5.2. Review of service systems in order to enhance appropriateness of and access to service delivery.
6. The Rehabilitation Programme, Department of Health, strongly recommends utilization of the tool developed by Ms Khan to monitor and evaluate the community service for therapists in KZN 2005.
7. In this regard the Expedited Review process is supported.

Thank you

Ms S.A. Singh
Deputy Director: Rehabilitation Programme

SUPPORTED ☑

NOT SUPPORTED ☐

comments

Ms N.Phillips
General Manager
Public Health Service Cluster

SUPPORTED ☑

NOT SUPPORTED ☐

Comments

Letter of Support: Head of Section – Disability and Rehabilitation

The Deputy Director
Disability and Rehabilitation Programme

04/10/05

ATTENTION: Ms SA Singh

RE: Masters in Public Health: Research dissertation

1. Permission is hereby sought to conduct research as a requirement for my MPH.
2. My topic is the "Perceptions of and attitudes to the compulsory community service experience: perspectives of community service occupational therapists, audiologists, physiotherapists and speech therapists in KZN"
3. The objective of the study is to identify the areas of need and success in the implementation of the program and make recommendations to the relevant stakeholders to enhance the implementation, monitoring and evaluation of the process.
4. All therapists will be included in the study to reduce selection bias.
5. This entails therapists filling a questionnaire that they would send back.
6. The detailed proposal for the study is attached for more information.

Thank you

N.B.Khan
Assistant Manager
Disability and Rehabilitation Programme.

Ms S A Singh
Deputy Director : Rehabilitation Programme

Supported ☑

Not supported ☐

COMMENTS:

The Programme strongly supports the initiative which addresses monitoring and evaluation of an essential HR process.

DECLARATION AND APPROVAL BY HEAD OF DEPARTMENT

The General Manager
Public Health Services

04/10/05

Attention: Ms N Phillips

RE: Masters in Public Health: Research Dissertation

1. Permission is hereby sought to conduct research as a requirement for my MPH.
2. My topic is the "Perceptions of and attitudes to the compulsory community service experience: perspectives of community service occupational therapists, audiologists, physiotherapists and speech therapists in KZN"
3. The objective of the study is to identify the areas of need and success in the implementation of the program and make recommendations to the relevant stakeholders to enhance the implementation, monitoring and evaluation of the process.
4. The study will be conducted at all hospitals where community service therapists are placed and all therapists will be approached to participate.
5. This entails completion of a Questionnaire.

Kindly refer to the attached draft protocol for more information.

Thank you

N.B.Khan
Assistant Manager: speech Therapy and Audiology
Rehabilitation Programme
CELL: 0845486350

Ms N Phillips
General Manager
Public Health Services

Approved ☑

Not Approved ☐

Comments:

_____

_____

_____

8.6 INFORMED CONSENT INFORMATION SHEET

INFORMED CONSENT INFORMATION SHEET

Kindly complete and return with the questionnaire in the enclosed envelope.

You are requested to participate in a research study, on the "Perceptions of and Attitudes to the Compulsory Community Service Programme for Therapists in KZN, 2005". This study is being conducted as part of a dissertation for my Masters in Public Health that is being done through UKZN -Medical School. This is the study that was introduced to all of you at your orientation and induction at the Royal Hotel on 20-21 Januaiy 2005.

Your participation although voluntary would be extremely valuable in ensuring that future programmes are successfully implemented in KZN and throughout the country. The Department of Health strongly supports the ongoing monitoring and evaluation of the programme and will be using the results and reccmmendations from this study as a guide to key roleplayers in the Province. As you are directly involved in the community service programme your input is greatly desired and appreciated.

The research entails completion of a questionnaire that will be mailed to all community service therapists (occupational therapists, audiologists, speech therapists and physiotherapists) doing community service for 2005. The Questionnaire will go via the Rehabilitation Programme to all Institutions Heads to you. You will be required to complete the questionaire and return it the enclosed envelope. The information you provide will be stored and kept confidential. Furthermore the questionnaires are anonymous.

Copies of the completed study can be mailed to you on request. For more information you may contact the following persons:

Researcher: N.B.Khan, telephone (033-3953130) fhx (033-3940105) e-mail khan@dohho.kzntl.govn.

Supervisor: Dr Knight telephone (031-2604287) e-mail knights1@ukzn.ac.za.

Head of Rehabilitation Section, Department of Health, KZN
Ms SA. Singh telephone (033-3952260) singhsa@dohho.kzntl.gov.za.

You may contact the Medical Research Office at the Nelson R Mandela Medical School at 031- 260 4604 if you have any questions about your rights as a research participant.

Thank you for your co-operation.

_____ _____

Researcher: N.B.Khan Date

_____ _____

Participant signature Date