Chapter 17

Monitoring the implementation of community service

Community service for doctors in South Africa was conceived amid controversy, but has emerged as a symbol of the commitment of the health department and the medical establishment to equity in the health services. In terms of the original objectives of the Department of Health, “to distribute health personnel throughout the country in an equitable manner” the scheme has only been partially successful. Two hundred and fifty nine (less than 25%) of community service doctors are placed in rural hospitals (as designated by the rural allowance), while 55% are working in regional, tertiary and specialised hospitals.

The aim of ensuring “improved provision of health services to all the citizens of our country” has most probably been met. All the health facilities that received community service doctors reported positive effects, except for one tertiary hospital that regarded them as a “nuisance”. The interpretation of the policy as meaning that community service doctors should work primarily in the community health services of some districts, has resulted in many of them visiting outlying clinics regularly, with surprisingly beneficial results for the district health system as well as the community service doctors themselves.

The secondary aim of “providing our young professionals with an opportunity to develop skills, acquire knowledge, behaviour patterns and critical thinking that will help them in their professional development”, has been successfully met by some but not all of the community service doctors. This depends on the level of supervision available, as well as the attitude with which the individual approached the year. In general, the response of community service doctors to the challenges and difficulties in public service hospitals around the country has been encouragingly positive, as they have found meaning in “making a difference” in their situations. In the words of one community service doctor placed in a rural hospital: “My perspective has totally changed from the Stellenbosch Afrikaans way of understanding things”.

A comprehensive policy on human resources for medically under-served areas in South Africa is needed, of which obligatory community service for doctors is only a part. Judging by the initial feedback of this first year, and the willingness of all those involved, there is a solid basis to work from. As we proceed to the next round of community service placements, it is imperative that the experiences and lessons of the first year of implementation are taken account of and used as the basis of ongoing planning. Universities need to supply graduates with the appropriate knowledge, skills and attitudes, and provincial health departments need to manage their human resources in an equitable manner.
Introduction

In South Africa, the maldistribution of health manpower in favour of urban areas has been well documented: in essence, the fewest doctors are found in areas where the need is greatest. There are numerous reasons why doctors choose to remain in urban areas, including better incomes, greater opportunities for career advancement, access to services and schools, and more comfortable living environments. In addition, most medical schools are located in urban centres, and graduates tend to remain where they have formed relationships and social networks during their period of study, even if they were originally drawn from rural backgrounds. The issue is not an exclusively rural one. Urban poor also have limited access to primary care, largely because of the lack of capacity of urban primary care facilities to serve the population within their jurisdiction. This is particularly true in South Africa, where informal settlements in peri-urban areas have grown tremendously over the past decade.

To improve the supply of personnel in under-served areas, three major approaches have been used internationally: incentives, coercion, and facilitation. Although this chapter focuses on one coercive intervention, it must be noted that there are a number of other strategies that have been shown to be more successful in recruiting and retaining doctors in areas of need. These include the selection of medical students from rural areas, meaningful community-based experiences during the undergraduate years, support for post-graduate development through distance educational methods, and attractive conditions of service.

Objectives of community service

“The main objective of community service is to ensure improved provision of health services to all the citizens of our country. In the process this also provides our young professionals with an opportunity to develop skills, acquire knowledge, behaviour patterns and critical thinking that will help them in their professional development”.

Although this is the department’s main objective, key informants raised specific issues that they hope this policy will address. These issues include:

- Emigration of qualified doctors to work in other countries
- Lack of public service doctors working in rural or peripheral hospitals
- The urban/rural divide
- Medical training not preparing young doctors for working in rural South Africa
- Private vs. public health service.

Community service was clearly declared as “service and not training” which was further explained to mean that “community service is different from internship and vocational training in that it is an attempt aimed at redressing the inequalities of the past”. However key informants from Department of Health also highlighted this scheme as a learning experience for newly qualified doctors. They said the aim is for the doctors to gain confidence, and develop their skills and ability to deal with the challenges of working in the most needy areas with minimal resources. It is hoped that community service will address the fear of working without necessary support in the peripheral structures and that therefore in future, more doctors will choose to work there.
**Policy formation process**

One of the recommendations of the 1994 Ministerial Committee on Human Resource Development (MCHRD) was the introduction of remunerated vocational training for health personnel, starting with medical doctors. The MCHRD then drafted a policy on Post-graduate Vocational Training (PGVT) for medical doctors in consultation with the Medical and Dental Council. This was made available for public comment in late 1995 to interested stakeholders, including the Junior Doctors’ Association of SA (JUDASA), the SA Medical Association, the National Interns Association and University representatives. The majority of stakeholders came out strongly against PGVT for various reasons, one of which was that the 6-year medical training was adequate to make graduates competent to practice. The Portfolio Committee on Health held public hearings, and after consultation with the Minister it was ruled that the option of one year of remunerated community service was the way to go. The Ministry of Health then drafted the policy on community service in consultation with the Council, and also prepared the necessary legislation for inclusion in the Health Professions Amendment Bill in late 1996. The Bill was finally passed by the National Council of Provinces in November 1997, and the President signed it into law on 12 December 1997. Regulations were then published and discussed, with a list of approved health facilities and a date of commencement of 29 May 1998. Stakeholders also gave input to the plan for the allocation process. Given the strong human rights constitution in South Africa, it was argued that community service doctors must be given some choice of where to serve. The first cohort of 26 doctors started their community service in July 1998, followed by the larger cohort of 1 088 in January 1999. It is anticipated that dentists and pharmacists will begin their community service in the years 2000 and 2001 respectively.

**Possible indicators**

Key informants from the Department of Health put forward possible indicators that could be used to assess the effectiveness of this policy. These are:

- **Redistribution of doctors to peripheral areas**
  
  The success of the community service policy will be indicated by the number of doctors, who are South African graduates, working in the more peripheral areas. Institutions designated for the rural allowance should give a clearer picture of the coverage of the most remote areas. It is important to note that many peri-urban areas are also under-served areas.

- **Health systems related indicators**
  
  Indicators related to health systems were suggested as means of determining the success of this policy, such as the degree to which community service doctors contribute to a well-functioning health district, or hospital.

- **Acceptance of community service doctors by the staff and the community**
  
  It would be important to ascertain communities’ perceptions about the effect of having community service doctors in their areas. The acceptability of community service doctors to other doctors, nurses and other members of the health team is an issue, as is their ability to work in a multi-disciplinary health care system.

- **Extension of community service to other professionals**
  
  Five years from now, to what extent will community service have been extended to other professions?
Personal development for community service doctors. Some gains may be:
- Growth in terms of knowledge, skills, professional values and confidence. Critical thinking in terms of decision making, dealing with emergencies, and using available resources. Sensitivity to the needs of this country as a result of this experience and exposure.
- Health indicators
  - Take into consideration the impact of HIV/AIDS.
  - Long term goal is to improve the health status of all South Africans.
  - Compare this year’s health indicators with 5 years later.
- Emigration rates
  - Improvement on the emigration rates: more doctors deciding to remain in SA.

**Methodology**

A formal study monitoring compulsory community service for doctors in its first year of implementation is currently under way. The results of the first part, which is qualitative, are presented here. Two basic issues were investigated: the experiences of the doctors themselves, and the effect of the scheme on the hospitals and the health service as a whole.

Interviews with key informants and focus group discussions were held with managers and community service doctors in 3 provinces: KwaZulu-Natal, the Eastern Cape and the Northern Province. These provinces were chosen as they contain the largest proportions of their populations in rural areas, which was the initial focus of the scheme. District, regional and central hospitals were chosen in each province for this study. Hospital managers and senior nurses were interviewed in addition to the community service doctors themselves and their colleagues, in order to gain as comprehensive a picture of the situation in each hospital as possible.

**Table 1: Hospitals visited**

<table>
<thead>
<tr>
<th>Name of hospital</th>
<th>Number of beds</th>
<th>MO posts</th>
<th>CS posts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>KwaZulu-Natal</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emmaus hospital</td>
<td>141</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Ladysmith hospital</td>
<td>591</td>
<td>12</td>
<td>7</td>
</tr>
<tr>
<td>Madadeni hospital</td>
<td>608</td>
<td>33</td>
<td>8</td>
</tr>
<tr>
<td><strong>Eastern Cape</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Holy Cross</td>
<td>352</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>Nessie Knight</td>
<td>180</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>Northern Province</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Botlokwa</td>
<td>40</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>WF Knobel</td>
<td>259</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Pietersburg/Mankweng complex</td>
<td>970</td>
<td>95</td>
<td>20</td>
</tr>
</tbody>
</table>

Note: MD = Medical Officer  
CS = Community service
The framework that arose from analysis of the data gathered in the current study, is represented in Figure 1.

The policy decision to implement compulsory community service was taken at national level amid some controversy. Clear guidelines were not formulated to support the policy of compulsory community service before the first large group of post-interns was allocated to their community service posts in January 1999. This has lead to some confusion and creative interpretations of what was originally intended.
by the concept “community service”. The implementation of the scheme was devolved to institutional level, where managerial capacity is extremely variable. Some hospital managers and superintendents capitalised on the opportunities afforded by extra medical staff, and went out of their way to accommodate the community service doctors by incorporating them into an existing team. However, in other situations, particularly smaller hospitals and health centres where there is a lack of leadership, the medical services are poorly co-ordinated and the community service doctors found themselves forced to find their own place in the hospital system. From the community service doctors’ point of view, the allocation process that allowed for 5 options in order of choice, was based on insufficient information for most to make informed choices.

Distribution of community service doctors

Of the 1 182 interns in the country in 1998, almost all actually applied for community service: 56 decided to either delay their community service year, go to another country or not to register at all. These 1 088 doctors were distributed amongst the provinces as shown in Table 2, amongst community health centres, district hospitals, regional hospitals, and tertiary or specialist hospitals according to Table 3. Thirty-four doctors were attached to the SA military health services.

Table 2: Distribution of community service doctors by province in 1999, excluding doctors attached to SANDF

<table>
<thead>
<tr>
<th>Province</th>
<th>Number of CS doctors 1999</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Cape</td>
<td>126</td>
<td>11.6</td>
</tr>
<tr>
<td>Free State</td>
<td>98</td>
<td>9.0</td>
</tr>
<tr>
<td>Gauteng</td>
<td>169</td>
<td>15.6</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>237</td>
<td>21.9</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>79</td>
<td>7.3</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>17</td>
<td>1.6</td>
</tr>
<tr>
<td>Northern Province</td>
<td>160</td>
<td>14.8</td>
</tr>
<tr>
<td>North West</td>
<td>79</td>
<td>7.3</td>
</tr>
<tr>
<td>Western Cape</td>
<td>119</td>
<td>10.9</td>
</tr>
<tr>
<td>Total</td>
<td>1 084</td>
<td>100</td>
</tr>
</tbody>
</table>

Sources for Tables 2 and 3 were different, and is the reason for the small difference in the total number of doctors.
Table 3: Distribution of community service doctors by facility in 1999

<table>
<thead>
<tr>
<th>Site of allocation</th>
<th>Number of CS doctors</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community health centres</td>
<td>22</td>
<td>45</td>
</tr>
<tr>
<td>District hospitals</td>
<td>479</td>
<td></td>
</tr>
<tr>
<td>Regional hospitals</td>
<td>401</td>
<td></td>
</tr>
<tr>
<td>Tertiary &amp; specialized hospitals</td>
<td>186</td>
<td>55</td>
</tr>
<tr>
<td>SA Military Health Services</td>
<td>34</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1122</td>
<td>100</td>
</tr>
</tbody>
</table>

It is important to note that, of the 1,122 community service doctors who reported for duty in 1999, only 259 (24%) were placed in facilities that qualify for the rural allowance. Thus less than a quarter were placed in “inhospitable” rural situations. As Table 3 shows, 45% were placed in community health centres or district hospitals, and the rest (55%) were accommodated in regional, tertiary and specialised hospitals.

**Experiences of community service doctors**

Analysis of the qualitative data gathered from the focus groups of community service doctors revealed three major themes, and some secondary ones. The attitudes and morale of the community service doctors was generally positive, largely as a result of feeling that they were making a difference, even though they felt that their supervision and support was generally poor. The learning that they described was largely that of developing self-confidence and independent decision-making, rather than clinical skills. The allocation procedure was felt to be less than fair by most community service doctors. Other issues such as conditions of service and social factors were highly dependent on the situation: they were major problems for some, and no issue at all for others.

**Major issues**

**Supervision and support**

The level of supervision available to community service doctors was variable. In teaching hospitals, first-year medical officers are given very little opportunity for independent decision-making. In isolated rural hospitals community service doctors were often the only full time medical staff. In some hospitals, other doctors were hesitant to supervise the community service doctors, as they did not feel sufficiently qualified themselves: “We are not specialists, we just have experience”.

Most community service doctors reported that they could at least get help over the telephone when they needed it. But even this was a problem in the more remote hospitals in the Eastern Cape, where telephone access was limited.

Community service doctors in the group of hospitals in northern KwaZulu-Natal reported extraordinarily positive experiences of receiving support from committed seniors, citing this experience as a reason to stay on for the next year. However, a number of community service doctors felt that they could
not rely on the advice of their nearest referral centre. These doctors preferred to phone their academic teaching hospital consultants for help, even if their teaching hospital was far away.

Some doctors received no senior supervision:

“The community is gaining but we are suffering: we expected to gain more, or have more input”.

“I am not learning anything new here: my clinical skills are stagnating”.

“At least we have each other”.

Community service doctors did not use email or the Internet as a source of information. Most preferred to ask one another or a senior colleague in the first instance.

**Learning**

Most community service doctors reported that they had learned to make independent decisions for the first time. Most learning was in the area of gaining confidence and insight into themselves as practitioners, as opposed to formal learning of clinical skills from supervisors. Where supervision was available, new skills were learnt.

“I have not learnt anything new medically, but I have gained an enormous amount of confidence”.

A minority found themselves in a situation where they felt under-utilised.

The location of community service doctors’ internship was a significant factor in determining their expectations and level of skills. Those who had completed their internships in academic hospitals were at a distinct disadvantage in rural hospitals, whereas those who had been interns at regional hospitals had confidence and felt that they could contribute appropriately.

Formal post-graduate education was an issue of great contention when the notion of post-graduate vocational training was first mooted. JUDASA felt that the clinical supervision available in most rural situations would be insufficient to justify the year as training. JUDASA accepted that the primary goal of community service was to meet a need. However, in the process of policy formation, the issue of how doctors would require the necessary clinical skills to cope in a rural hospital was overlooked. The attitude of a number of community service doctors has therefore become one of “we are here to serve but not to learn”. This has meant that they have missed the learning opportunities presented to them through their clinical experiences in any context, through lack of guiding supervision by more experienced clinicians. As one community service doctor said, “I am not sure of some things and there is no-one to help me learn from these experiences”.

A disturbing finding in a few hospitals in the Northern Province was the fact that despite the great need, community service doctors were not doing Caesarean sections, resulting in unnecessary overloading of the referral hospitals. Lack of a clear definition of the role of community service doctors, and their relationship to the other doctors in the hospital, all of whom are foreign-qualified, was cited as the reason in one hospital. In another, it was due to the lack of management capacity to open the theatre.

One community service doctor, alone in an Eastern Cape hospital with 8 Cuban colleagues, chose to make the most of the year’s experience: “This is a life experience which I’m not in a hurry to repeat. But at least I’ve learnt how to do a Caesar – in Spanish!”
Box 1: A Woman Doctor’s story

A young woman, who completed her internship in a tertiary hospital around Durban, decided to choose a hospital that was in the township, not far from a big town and she got her first choice. She is now based in a large regional hospital.

She only had positive things to say about her community service experience. She enjoys working in this hospital that is neither big nor small. She feels she is getting all the exposure she needs. “You get the feeling that you are not an intern anymore but yet still have people at your door when you need help”.

“It’s been excellent on my side, a perfect inversion”. She felt that this exposure has given her an opportunity to know how much she knows. She thinks that she is in a better position compared to her colleagues who left internship for private sector or specialization. Talking to her one got a sense that she was feeling a little bit guilty about opposing this policy that has worked out more for her benefit.

She feels she has got all the support she needs from the seniors in the hospital. She said she has got very few contacts with the seniors but they are there when she needs them.

After 6 months in the wards, she is now working as an anaesthetist and hoping to write a sub-diploma in anaesthesia at the end of her community service year. She said that she has always wanted to specialise in anaesthesia and was planning to do that immediately after her internship. She is grateful for this exposure because it would have been premature for her to specialise then. Now she has gained experience from other departments like paediatrics and obstetrics which have “complimented my future plans”.

Attitudes and coping skills

The realisation of many community service doctors that they are actually making a difference is a huge motivation for them. This is particularly so for those who visit outlying clinics, some which have never been visited by a doctor. Patients and staff at the clinics appreciated their visits, and this made rural placements worthwhile, in spite of all the difficulties and disadvantages.

“Even the way that patients greet you (when visiting a clinic), makes you feel that it is worthwhile”.

“I am very glad that I came here (to a rural hospital). It is not what I expected but it is still a good experience”.

The development of self-confidence was a critical factor in maintaining a positive attitude to the year. In the context of taking progressively more responsibility for clinical decisions, community service doctors run the risk of emotional stress when things go wrong and they feel guilty. Here again, their internships prepared many of them:

“Our internships prepared us for this: we were hardened, emotionally, and just learned how to cope”.

On the other hand, a minority of community service doctors are experiencing insurmountable difficulties in isolated circumstances, and feel demoralised by the situation. Despite their initial enthusiasm and attempts to introduce positive changes, they have been drained by the experience, and now feel frustrated and powerless to make an impact on their situation.

“We have run out of ways of handling the frustrations of working out here”.

“It’s like hitting your head against a brick wall when you try to get something done here”.

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“This year has completely disrupted my life, since all my connections are in Gauteng”.

Interestingly, the senior nurses who worked with these same doctors were full of praise for their work. “They really try and they work hard: I can say that they are 100%”

**Box 2: A Rural Health Centre story**

Two young male community service doctors end up against their choices, in a rural 32-bed district hospital with two Cuban doctors and a superintendent. This is a health centre that is currently being upgraded to a district hospital, seeing approximately 100 deliveries per month, and 4,000 outpatients per month. Of the latter, the 4 doctors see an average of 30 patients in the OPD per day; the PHC nurses screen the rest. The doctors also share the responsibility of the 4 departments namely the 8-bedded female and male sections, maternity and paediatrics (empty at the time of our visit).

The hospital also has two modern fully equipped operating theatres that had never been used since they were built in 1994. The reason given for not operating is because they do not have a ward for post-operative care. Yet there is an 8-bed ward that is used as a storeroom for pharmaceutical products, and there is a theatre-trained nurse working full time in this hospital. As a result, all patients needing Caesarean section are transferred to the large hospital 55km away.

These young men feel grossly under-utilised. They have gone through different emotions from anger and depression to accepting the situation. They were very unhappy with the situation. They had made suggestions on how to change the situation but there hasn’t been any response from the management. They cannot wait to finish their year and leave. What keeps them sane are the clinic visits, where at least they feel needed. Otherwise they feel that this year has been a total waste for them.

They feel that this hospital is not an ideal place for community service in its present state, but has got great potential that is not being realised. Lack of leadership has not helped the situation.

**Secondary issues**

**Allocations: fairness and equity**

The allocation process was widely felt to be grossly unfair. The allocations of community service doctors according to their five choices left a minority whose choices could not be accommodated. Those allocated to urban hospitals raised no objections to their placements, whereas those in isolated rural situations felt resentful of their colleagues in central hospitals who are able to proceed with specialities of their choice. Objectively, the allocations are indeed unfair to those who do not receive a placement in one of their first five sites of choice. The suggestion was made repeatedly that community service should only be offered in rural hospitals, not in urban hospitals at all. Alternatively, rotations of six months through one regional and one district hospital could be arranged regionally.

Allocations also did not seem to take account of the institutions’ actual need for doctors. Thus at one rural hospital, all medical officer posts were filled already, and additional community service posts were added to make a total of 14 doctors for 300 beds. By contrast, at a nearby hospital of a similar size, they were extremely short-staffed, and three community service doctors were supported by only two other medical officers. Information on the situation at each hospital was not available at the time that interns were requested to submit their choices, and many had no idea of their options, particularly outside their provinces. It was stated that married couples were not given preference in the allocation procedure, but this was not substantiated.
**Conditions of service**

Some community service doctors had major problems with their conditions of service. Accommodation and communication were identified as problems, but these were confined to individual hospitals. One hospital in the Eastern Cape has only one telephone line for the hospital, and it was only possible to phone during daylight hours. Generally some plans had been made with regard to accommodation, sometimes at the expense of other staff at rural hospitals. Some doctors had problems with obtaining official transport to visit clinics, while others were concerned about safety when travelling alone. This led to some refusing to visit certain clinics in one area because of the high risk of hijacking. A number of individuals reported specific problems concerning their salaries and transfers, but these were isolated cases.

**Social factors**

The support of a social network which is taken for granted in urban areas, becomes essential in isolated rural situations, (see “The story of three friends”) but is not always attainable.

“There is nothing else for us to do here after hours except speak to each other and watch TV”.

“Maintaining a relationship (with a girlfriend) while you are out here is impossible”.

It is certainly imperative that married couples are not split up. The distance from family and friends is something that most community service doctors had to come to terms with, but this kind of support is vital when there is a crisis, or when things go wrong.

**Box 3: A Story of Three Friends**

Three Stellenbosch University friends worked out that if they chose a remote hospital where no one else wanted to go, as their first choice for community service, the chances were that they would end up together. According to them, “It does not matter where you are working, what is important is who you are working with”. Sure enough, after their internships in regional hospitals, they ended up in one of the most remote hospitals in the Eastern Cape, staffed by 4 Cuban doctors and an Ugandan superintendent.

They share a house next to the hospital, and are together most of the time. They even help each other to do calls after hours. They are seen by hospital staff as “the young ones” who are “happy, free, liked by people, who make things easier for the hospital, who practice the Xhosa language, help nurses in history taking, do clinic visits and drive the vehicles themselves”. Nurses, administration staff and management had only good things to say about having these community service doctors.

In terms of support they rely on their previous experience and each other. They sometimes phone their medical school for advice and they have found the superintendent of the hospital very helpful. They felt that their internship at the medium/large hospitals exposed them to skills like performing Caesarean sections that they had to do when they got to this hospital. They also said that they have read more.

Amongst things that have made their life easier is the good leadership in the hospital, which ensures the maintenance of good interpersonal relations amongst staff. An effort has been made to upgrade facilities and equipment in the hospital and there are also excellent laboratory services on the hospital grounds.
The impact on the health system

In terms of impact, the smaller hospitals felt the impact of the community service doctors more than the bigger hospitals. In the smaller hospitals, the presence of community service doctors was more needed, more welcome and appreciated by the staff and community. This was not the case with the bigger hospitals where sometimes the hospital staff did not even know there were community service doctors at the hospital – they had thought that they were just new doctors. In the bigger hospitals, the impact was most noticed by management and other doctors. Most of the information below applied to smaller hospitals.

Stress relief for team members

The stress relief was experienced not only by doctors who were now doing fewer calls in the hospitals, but also by the nurses.

“All the work used to be just for nurses, ordinary nurses using (their) own experience to screen patients. Now there is (a) doctor in OPD all the time”.

Well staffed hospitals

In some hospitals, superintendents felt that for the first time they had a reasonable complement of medical staff. Posts that used to be difficult to fill were filled, and this made the running of the hospital easier.

Less crowding in the outpatients department

As a result of having more doctors available in the hospitals, some institutions had less crowded OPDs. Some hospitals attributed this to the impact of clinic visits by the community service doctors.

Fewer lodgers in the wards

“We used to have lodger patients crowding the wards, people who were stranded (and) had no transport to go home, but that is not the case anymore, there is always a doctor in OPD”.

Faster turnover of patients in the wards

Nurses felt that with the doctors around, patients were getting appropriate investigations, accurate diagnoses and correct treatment, leading to the patients healing faster and therefore leaving the hospital faster.
Outlying clinic visits

Institutions that had previously had difficulty in visiting outlying clinics were able to do regular clinic visits. Clinic visits were being done by community service doctors, either weekly, fortnightly or monthly.

“There are less patients coming to the hospital because of the doctors’ visits to the clinics”.

Development of skills

Other doctors have found having the “young ones” quite enriching in terms of being involved in discussions or responding to their questions. Training that had been impossible because of work pressure was now possible. Nurses also said that they were gaining from working with these newly trained doctors who had updated information to share with them.

Transfers to other hospitals

“They are very patient with patients, they investigate, they treat, they transfer to other hospitals”.

In some hospitals, there was an increase in the number of transfers because the doctors were doing more thorough investigations. In other situations there were fewer transfers because operations were performed in the smaller hospitals.

Communication

An important advantage of having more South African doctors working in public hospitals was easier communication with other hospital staff. This was appreciated even more after the experience of working with doctors from foreign countries like Cuba. Where doctors were able to speak local languages it was an additional bonus for patients and nurses who no longer had to interpret. African community service doctors were trusted by African patients because they understood cultural beliefs and rituals. This helped patients to comply with treatment.

Enthusiasm

“They are still very fresh and new, they bring a refreshing atmosphere”.

“They are always available”.

“…maybe it is because of their age, they are always willing to help, and they come with the smile”.

“These ‘young ones’ are happy, free, liked by people, they make things easier for the hospital, they practice the Xhosa language, help nurses in history taking, do clinic visits and drive the vehicles themselves, they are very nice to our patients”.
Conclusions

Community service for doctors in South Africa was conceived amid controversy, but has emerged as a symbol of the commitment of the health department and the medical establishment to equity in the health system. Unclear policy guidelines in this first year of implementation (not unexpected in the light of the pressure to start) lead to the highly variable community service placements. Only 259 (less than 25%) of the community service doctors are placed in rural hospitals (as designated by the rural allowance), while 55% are working in regional, tertiary and specialised hospitals. Thus, the aim “to distribute health personnel throughout the country in an equitable manner” has only been partially addressed by this policy so far.

Preliminary findings indicate that the aim of ensuring “improved provision of health services to all the citizens of our country” has probably been met. All the health facilities that received community service doctors reported positive impacts, except for one tertiary hospital that regarded them as a “nuisance”. The interpretation of the policy as meaning that community service doctors should work primarily in the community health services of districts, has resulted in many of them visiting outlying clinics regularly, with surprisingly beneficial results for the district health system as well as the community service doctors themselves.

The secondary aim of “providing our young professionals with an opportunity to develop skills, acquire knowledge, behaviour patterns and critical thinking that will help them in their professional development”, has been successfully met by some but not all of the community service placements. This depends on the level of supervision available, as well as the attitude with which the individual approached the year. In general, the response of community service doctors to the challenges and difficulties in public service hospitals around the country has been encouragingly positive, as they have found meaning in “making a difference” in their situations. In the words of one community service doctor placed in a rural hospital: “My perspective has totally changed from the Stellenbosch Afrikaans way of understanding things”

A minority found the environment demoralising, and felt resentful at the unfairness of the allocation process that placed them there. The exact proportion of negative and positive experiences will be determined in the quantitative survey planned for the end of 1999. This will also give an indication of the number of community service doctors who are prepared to remain in the public service in areas of need in the longer term.

It is important to remember that “health manpower planning is an integral part of comprehensive health planning and should not become an independent activity”, and that “planning, production and management of human resources must be brought into closer and more functional relationship with each other”. As we proceed to the next round of community service placements, it is imperative that the experiences and lessons of the first year of implementation are taken into account, and used as the basis of ongoing planning. Universities need to supply graduates with the appropriate knowledge, skills and attitudes, and provincial health departments need to manage their human resources in an equitable manner.

A comprehensive policy on human resources for medically under-served areas in South Africa is needed, of which obligatory community service for doctors is only a part. Judging by the initial feedback of this first year, and the willingness of all those involved, there is a solid basis from which to work.
**Recommendations**

**Policy related recommendations**

- The development of a comprehensive human resource policy for the distribution of medical personnel, and an explicit strategy for meeting medical needs in rural and under-served areas in the country are vital.

- The definition of a medically under-served district, or health personnel shortage area needs to be developed.

- A clear definition of community service, in order to ensure more standardisation and equity across the country should be developed.

- Clear guidelines that will serve as job descriptions will ensure that community service doctors are involved in areas of need in districts, and not just used as additional medical officers in hospitals which are already adequately staffed. These guidelines should be developed in relation to norms for services offered by district and regional hospitals.

- Clear criteria for health facilities that should be allocated must be defined. For example, health facilities should be able to sustain a ratio of senior doctors to community service doctors of not less than 1:1, for the purposes of adequate supervision. The criteria should also clarify the type of services rendered by the facility, so that the doctors can be fully utilised.

- Discussions should be held with stakeholders with respect to the suggestion of excluding the tertiary and central hospitals from receiving community service doctors. This would enable the scheme to address the original aim of maldistribution, and would be fairer to those who are currently allocated to peripheral hospitals who do not have access to specialist departments. Community service doctors with genuine reasons to stay in urban areas could be placed at regional hospitals rather than central hospitals.

- Preference for allocation to a large hospital could be given to community service applicants who are committed to serve for a further year in the public sector in an under-served area. Preference for registrar posts for specialist training could be given to those who have served their community service year and an additional year in an under-served area.

- Universities should work more closely with national policy makers to develop a medical curriculum that better prepares students to work in rural and under-served areas.

**Conditions of service**

- Accommodation: Rural hospitals with no alternative accommodation need to upgrade existing accommodation facilities, ensuring that places are available for married people or families. An official policy on accommodation is needed in some provinces.

- Salaries, transfers and rural allowances must be administered without delay.

- There must be a formal induction process for all community service doctors during their first week.

**Supervision and Support**

- A training component to community service must be acknowledged by all stakeholders. At a minimum this would amount to in-service training in order for community service doctors to fulfil their duties adequately in the institutions in which they are placed. Ideally this should form the framework for a more comprehensive plan of post-graduate vocational training.
The support, development and retention of senior medical staff are issues that need urgent attention if standards of care are to be maintained, particularly in rural hospitals. These include academic support, incentives and a career structure. The development of trainers for the envisaged postgraduate vocational training is also dependent on this level of worker.

A localised support system needs to be put in place, including regular meetings of community service doctors with seniors to discuss problems, in order to provide opportunities for mentoring.

Undergraduate training and internship need to be reviewed in the light of the demands made on community service doctors.

Allocation process

Information: More detailed information about each of the approved health facilities for community service needs to be made available. An effective way of doing this could be by means of a web page.

Choices: Interns need adequate time to deliberate on their choice of health facility for the year of community service. At least a month should be given to accommodate this.

Family considerations: The allocation process should double the effort in placing people with families. Although the policy prioritises married people, unmarried parents should also be accommodated.

Superintendents' role: The community service doctors suggested that the process of application should involve the hospital superintendent, who is well suited to select appropriate candidates according to the needs of the hospital.

Internship experience: Community service doctors allocated to rural hospitals with no specialist support should ideally be chosen from the pool of interns who gain experience in the regional and smaller hospitals, rather than from those who complete their internships at central and academic hospitals.

Regional rotations: Community service doctors should be rotated from the medium/large hospitals to small hospitals. Community service doctors should be released for in-service training courses in specific skills (e.g. anaesthetics, obstetrics) at regional or central hospitals, for short periods of time providing the needs of the hospital at which they are placed are not compromised.

Management

Leadership and management of the hospitals: There is an urgent need to develop leadership and management skills in public hospitals. This is key to retaining doctors in the rural and remote areas, as well as strengthening the quality of service delivery.

Provincial Co-ordinators: There is a need for a provincial officer who will take responsibility for all issues related to community service.

Retention of community service doctors in the public sector

Most of the doctors who were keen to remain in the public sector were uncertain about their future prospects because of frozen posts in the public service. Many of the community service doctors who were in the remote or most peripheral areas expressed a preference to work in the medium/large hospitals where there is a possibility to learn, develop or specialise. A plan is needed on the part of the government to enable this, such as a number of “buffer” posts.