Discussion Forum

Perceptions of and attitudes to the compulsory Community Service programme for therapists in KwaZulu-Natal

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Abstract

The success of Community Service programmes initiated globally to recruit health care professionals to provide services in under-served or rural areas depends largely on their attitudes, understanding of the programme's objectives, preparedness for working in these areas and their adaptability. This study assessed rehabilitation therapists' perception and attitude on commencement and completion of their compulsory Community Service programme in KwaZulu-Natal in 2005. Repeat observational cross sectional studies were conducted. A self-administered questionnaire was completed by all therapists on commencement and after completion of their Community Service. The proportion of therapists who indicated that they would work in the public sector in future declined from 50% at onset to 35% by exit and fewer (24%) said they would work in a rural area. Collecting a rural allowance was not associated (p=0.78) with an expressed interest to work in a rural area or remain at the same institution (p=0.32). There were significant differences in support and supervision provided between the professional groups (p<0.001). Particular concerns centred on limited infrastructural support, supervision, training, resources available and language barriers in delivering a better rehabilitation service. Despite the challenges faced, Community Service therapists felt that they had made a difference and that their experience had been personally and professionally rewarding.

Key words: compulsory Community Service, attitudes and perceptions, rehabilitation therapists, financial and non-financial incentives

A major challenge facing South Africa is the provision of basic health care to all citizens and rectifying historical inequities in health service delivery. An increasing burden of disease and disability and the problem of recruiting and retaining health care professionals in rural and under-served areas makes providing equitable and quality health care more difficult to achieve. Some strategies have been developed globally to address the problem (Cavendar & Alban, 1998; Couper, Hugo, Conradie & Mfenya, 2007; Reid, 2001;). These inlcude compulsory Community Service (CS) for physicians and other health care professionals in these areas, where it is assumed that they will improve the health status of rural populations. South Africa adopted legislation for compulsory but remunerated CS in 1998 for medical and allied health professionals, which they have to complete before being permitted to practice in their respective professions (National Department of Health, 1998).The CS policy aims to promote and reinforce the provision of quality health care especially in rural, under-served areas and previously disadvantaged areas of the country. It is intended to redress historical imbalances in health care provision but also to create an opportunity for newly qualified professionals to develop skills, acquire knowledge, behaviour patterns and critical thinking, to help them in their professional development (Reid, 2001). CS for rehabilitation therapists commenced in 2003 in the province of KwaZulu-Natal (KZN) and 142 therapists (69 Physiotherapists, 43 Occupational Therapists and 27 Audiologists and Speech-Language Therapists) have undergone CS in the province. In order that CS programmes are successful and achieve their desired goals continual monitoring and evaluation of their implementation is recommended (Reid & Conco, 1999). Studies in South Africa focussing on CS for medical doctors, dentists and pharmacists (Maseka, Ogunbanjo & Malete, 2002; Omole, Marincowitz & Ogunbanjo, 2005; Reid, 2001, 2002), reported that most of these professionals felt that they had positive experiences and improved peoples' health although supervision, mentoring, logistic and administrative support was inadequate. A successful CS programme needs the supportive attitudes of health professionals, their understanding of the programme's objectives, their preparedness for doing rural service and the ability to adapt to new and challenging experiences (Cavender & Alban, 1998). Health professionals deployed on CS in South Africa constitute a sizeable proportion of human resources in under-served areas. They are important actors in the implementation, monitoring and evaluation of the CS 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, perceptions and happiness may either promote or conflict with

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the objectives, goals and needs of the health service (Lehman & Sanders, 2004; Sanker, Jinabhai & Munro, 1997). The above understanding of the CS therapist's perspective and attitudes is essential and formed the rationale for this study. As key stakeholders in the CS programme these therapists can provide valuable insights into the needs, successes and recommendations for improvement of the CS policy, ensuring sustained and improved distribution and effectiveness of therapists in underserved areas and ultimately in improved health for the community.

METHOD

A repeat observational cross sectional study design was used to ascertain the attitudes and perceptions of rehabilitation therapists to their CS experience in hospitals in KZN at two points in time, namely on commencement and after completion of CS. These were then compared amongst the different occupational categories of therapists. All therapists undergoing CS in 2005 were included in the sample and answered a self-administered questionnaire on commencement and again on completion of their CS. The data collection was based on a previously validated questionnaire used to evaluate CS in physicians (Reid, 2004), and adapted with assistance from key stakeholders and piloted for therapists. The questions focussed on issues in CS such as the community outreach component, language difficulties experienced and other topics specifically relevant to therapists in KZN. Some open-ended questions were included in the questionnaire to enhance the validity of the responses. Variables included biographical and demographic details, placement and occupational categories, understanding of the CS policy and objectives, attitudes, perceptions and preparedness of therapists to undertake CS, adaptability to rural experience, benefits of the programme both personally and professionally; and, finally, recommendations for future CS policy and practice.

The commencement questionnaire was distributed at the annual orientation and induction workshop and CS therapists were requested to complete the form immediately. The exit questionnaire and consent form was e-mailed to all the therapists at the end of the year's CS and receipt thereof was confirmed telephonically. Participants were encouraged to contribute to the study in order to improve the number responding and reduce selection bias. Completed questionnaires were returned by post, fax or e-mail. Non-respondents were followed up twice. Responses were made anonymously and data remained confidential. All data was cross-checked for completeness, legibility and consistency and collated in EPI-INFO. After data was cleaned and coded it was processed and analysed using SPSS. Data was summarised using frequency distribution tables and appropriate graphs. The statistical significance of associations between categorical variables was assessed using Chi Squared tests. The attitudes and perceptions of CS therapists were scored on a scale of 1 to 4. Questions were grouped into common themes, weighted and scored by summing across the items to generate a score for each theme. These continuous numeric scales were analyzed quantitatively. Comparisons[1] 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 category) with Bonferroni post hoc multiple comparison tests also being employed. McNemar's Chi Square tests were used to assess the statistical significance of any differences in the proportion of perceptions and attitudes reported from pre- to post- CS (using $p < 0.05$ as the cut off for significance). Ethical approval was granted by the University of KwaZulu-Natal, Biomedical Research Ethics Committee and permission for the study to be conducted by the KZN Department of Health.

RESULTS

The commencement questionnaires were distributed to 142 community service rehabilitation therapists and 126 (89%) completed the initial questionnaire, but only 59 (42%) completed the exit questionnaire. A third (47) of respondents completed both the initial and exit questionnaire. Therapists were placed at 59 gazetted sites in under-served areas[2], of which 32 (54%) were situated in rural[3] areas (Table 1).

[1]*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.*

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

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

Table 1:: *Occupational category, gender and placement site of community service therapists completing both initial and exit questionnaires in Kwazulu Natal in 2005* .

	Total	Physiotherapy	Occupational Therapy	Speech-Language & Audio	Male	Female	Rural	Urban
Questionnaires sent	142	73 -51%	35 -25%	34 -24%	14 10%	128 -90%	67 -47%	75 -53%
Completed Initial questionnaires	126	55 -43%	35 -28%	36 -29%	11 -9%	115 -91%	59 -47%	67 -53%
Completed Exit questionnaires	59	20 -34%	11 -19%	28 -47%	4 -7%	55 -93%	24 -41%	35 -59%
Therapists who completed both initial and exit	47	12 -26%	10 -21%	25 -53%	2 -4%	45 -96%	20 -43%	27 -57%

Changes in attitudes and perceptions of therapists from onset to exit from CS were measured. Four of the attitudes and perceptions of therapists changed from negative or neutral at onset to positive or remained positive from onset to exit of their CS. An improved understanding of the CS policy occurred in 87% (13/15) (p=0.052) and perception of the availability of information on policy, procedures and guidelines occurred in 72% (18/25) of therapists (p=0.036). A significant (p=0.006) proportion (20/31- 65%) of therapists who initially disagreed or were neutral at onset regarding the availability of information about a hospital orientation, reconsidered their perceptions to agree that information on hospital orientation was available to them. At onset, 86% (38/44) of the CS therapists indicated that they were not resentful or upset about the site to which they were allocated and, at exit, 93% (41/44) maintained that they would recommend future placement at the site (p =0.683).

A number of attitudes and perceptions of therapists worsened during CS. Training was assessed to determine if therapists felt that their tertiary education equipped them with the necessary skills, competencies and knowledge to be able to perform CS effectively. There was a 36% (17/47) reduction in perception that their academic and professional training had equipped them for CS (p=0.281). Supervision and support were recognized as important requirements for the professional development of young health professionals undergoing CS. Initially, two thirds (31/47 - 66%) of CS therapists anticipated that they would receive good support and supervision from senior peers and mentors. This perception had declined significantly (p=0.002) with only 34% (16) feeling that they had experienced adequate professional, discipline specific supervision during the CS year.

One of the concerns expressed by therapists providing CS involved the question of their personal safety. At exit, more (43% vs. 28% - p=0.239) felt that CS had increased their personal safety risks. The study also compared the therapists' intentions to remain in the public sector at onset to that of working in the public sector in subsequent years, after CS. The intention to work in the pubic sector declined from 50% (24/48) at onset, to only 35% (17/48) at exit. Others expressed interest to work in other sectors with 29%, (14/48) indicating the private sector, 19% (9/48) overseas and 17% seeking alternate work outside the public sector. During the year of CS, the perceptions that therapists made a positive contribution to persons with a disability or those at risk did not vary much from onset to exit with therapists generally remaining positive about their contribution to improving the health status of their clients.

The attitudes and perceptions amongst the different occupational categories were also assessed. 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 and coping, personal safety, personal and professional gains, and future career plans were all investigated and compared. The data for this objective was obtained from 59 therapists who completed the exit questionnaire. A continuous numeric score was devised from categorical variables in order to compare the responses.

Having completed a year of compulsory CS, 56% (33/59) of therapists felt that their undergraduate training was adequate and that they were well equipped to work in an under-served or rural area of KZN. Perceptions of the adequacy of training had deteriorated during the year of CS (3.82, p=0.281). There were no significant differences between the occupational categories in relation to perceptions about the adequacy of training at exit . In the open-ended question analysis therapists indicated that they needed to have acquired more skills and expertise concerning management and administration of health facilities during university training. 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. Therapists were of the opinion that their training needed to cover administrative aspects and involve more practical experience at rural and under-served locations. There were clinical areas that therapists felt they needed additional training on, for example Speech-Language Therapists and Audiologists cited special tests for audiology (Auditory Brainstem Response Testing), dysphagia, pseudohypacusis, cerebral palsy and neonatal intensive care—particularly neonatal feeding.

It is important that young professionals are supported and mentored during their CS in order to develop skills and competencies to enhance their professional and personal development. At the onset of CS, most rehabilitation therapists (66%) believed that they would be furnished with adequate support and supervision to be able to function optimally during their CS 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 therapists working in the public sector are affiliated to the KZN Professional Fora of Speech Therapy and Audiology, Occupational Therapy and Physiotherapy. These 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 and those at risk, in the province. Each forum meets quarterly in the province to discuss issues relating to their particular professional occupational category. 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 between Audiologists and Speech-Language Therapists, and other therapy groups (p=0.002). Analysis of the open-

ended questions supported the contention that CS therapists enjoyed no, poor, or inadequate supervision and that they were the sole therapist in the hospital to which they had been allocated. Perceptions of the adequacy of support and supervision had deteriorated during the year of CS. Overall, the majority of CS therapists 67% (37/58) agreed that senior health professionals at the hospital were not perceived to be of assistance to them or otherwise supportive.

In relation to resource availability there was no difference between the occupational categories of CS 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). In their responses to the open-ended questions, some therapists indicated that they had found it difficult to access resources to perform adequately. Some used their own resources or secured private sponsorships for basic equipment. In many hospitals, there was no specified budget for therapy or basic equipment required to support the practice of each occupational category. When a new therapy service needed to be established in a hospital, it took a very long time to finance the set-up costs. CS therapists also reported that they required more culturally appropriate therapy resources, especially for isiZulu speaking clients.

Most therapists in KZN have English as their first language, with little or no isiZulu which constitutes an impediment in communicating with the majority isiZulu speaking clients. There is a clear need for interpreters, yet these were not always trained in discipline specific translation or interpretation. Even with an interpreter, 33% (19/56) found it difficult to undertake therapy satisfactorily and half claimed that the language barrier impeded their functioning as a therapist in this context. Audiologists experienced the least difficulty (p=0.037) and Occupational Therapists the most difficulties. However, the individual differences between the occupational categories was not statistically significant (p=0.068).

In KZN, 40% of CS therapists' time should involve providing community outreach rehabilitation services in clinics throughout the health district to facilitate improved access to rehabilitation therapy services for disabled people in the community. There was no difference between the occupational categories with regard to the amount of community outreach they were able to perform (p=0.347). More than half the CS therapists (31/57) felt that they had succeeded in their endeavour of providing substantial community outreach. Only a quarter (15/57)) believed that they had failed completely to conduct any community outreach and 20% managed to conduct at least some community-based rehabilitation services. Speech-Language Therapists managed to conduct more community outreach than Occupational Therapists (p=0.450). Analysis of the open-ended questions revealed that many therapists were able to conduct regular clinic visits but that this remained limited due to the huge caseloads prevailing at hospitals, poor clinic infrastructure, transport problems and the poor turnout of clients at the clinics.

Questions on whether therapists believed they coped psychologically were formulated due to the anxiety expressed by some therapists and their relatives prior to commencing CS. There were no occupational specific differences (p=0.678). All the occupational categories felt that they had made a difference to service delivery and had gained both personally and professionally from their CS year, despite initial concerns about the logistics and possibly unrealistic expectations of the compulsory CS year.

Career plans were assessed to determine whether CS had made a difference to participants intentions to become public service employed rehabilitation therapists in the future. No significant difference existed between the categories (p=0.832). However, 56% (n=31/56) of therapists agreed that having completed a year of CS did not change their initial plans to leave the public sector. The analysis of the open-ended questions showed varied responses with some claiming that the experience of CS had negatively influenced their plans to change careers and that the experience was both de-motivating and unpleasant. Other therapists felt that it had changed their work ethic positively. Some reported that they had possessed no choice because of the necessity of fulfilling their bursary obligations to work in the province in their CS year. Overall only 16% (n=9/59) of the CS therapists who completed the exit questionnaire indicated that they would stay on at the same institution during the next year. These therapists had enjoyed the positive working environment, the level of support they received and their exposure to a varied caseload. Approximately 41% (n=24/59) would consider their hospital a place to work in future. Most therapists indicated that they would recommend their allocated hospital as suitable for future CS placement. One of the objectives of CS is to attract and retain therapists in rural areas. Only 24% (n=13) affirmed that they intended to work in a rural area in the future. Another retention strategy adopted by the Department of Health involved the provision of an allowance to health workers if they worked in a rural area. There was no association (p=0.782), between therapists collecting a rural allowance and planning to work in a rural area in future, although those placed in urban areas did indicate that they would be more likely to work in rural areas in the future (p=0.018). There was also no association between collecting a rural allowance and remaining at the same institution in the future (p=0.317). Those (n=31) collecting a rural allowance had a lower mean score (2.10) than those who were not collecting one (n=24; mean= 2.38), indicating that those working in rural areas and concurrently collecting a rural allowance were less likely to stay at the same institution in the future.

DISCUSSION AND RECOMMENDATIONS

The current study confirms both national and international support for compulsory CS as a strategy for the recruitment of health care professionals to under-served and rural areas. However, CS needs to be implemented together with other financial and non-financial strategies if it is to lead to sustained improvements in under-served and rural areas. These should include training, supervision and mentoring, resources, language difficulties, community outreach and other challenges. Numerous factors influence the deployment and retention of health professionals in rural areas including the appropriateness of undergraduate training, curriculum review, exposure to practical training in under-served areas, functional literacy in local languages, preferential selection of therapists from rural backgrounds and granting bursaries to study in health sciences (Couper, Hugo, Conradie & Mfenyana, 2007, 2005; De Vries & Reid, 2003; Hall, 2001; Maseka, Ogunbango & Malete, 2002; Sankar, Jinabhai & Munro, 1997).

In KZN, training must be relevant to CS delivery needs where most therapists serve district hospitals and are required to provide a substantial time serving the community at primary health care clinics. This study, like other South African studies, revealed poor support and supervision for CS therapists by peers, more senior therapists and hospital management especially in rural areas and district hospitals where problems may be more complex and intractable. Ongoing support needs to be available for induction, orientation, mentoring, support and supervision of CS therapists. Regular Professional Forum meetings were found to offer good support and opportunities for mentoring.

Appropriate resources are needed to provide a quality service, and this is especially so at sites where a new therapy service is being established. The barrier to service delivery afforded by the lack of resources has been identified in similar studies (Reid, 2001; Cavender & Alban, 1998). Occupation specific essential equipment, adequate space to work, transport for community outreach and the provision of living accommodation should be non-negotiables in a CS programme and should be linked to improved conditions of service and budgeting for the service. The language and cultural challenges limited the ability of CS therapists and other health professionals to provide a quality service in under-served areas. (Reid, 2001; 2002). In addition to having appropriately trained and resourced interpreters, all therapy training institutions and the health department need to undertake extensive language training to equip therapists for CS and to work effectively in this multi-cultural and multilingual society. An expectation that CS therapists expand their service to clinics and to the community is unique to this category of health care worker in KZN. It has been identified as a way to strengthen disability and rehabilitation services at district level. Although a relatively resource intensive policy, it has the potential to provide an effective and professional community outreach disability and rehabilitation service and also should be pursued by other cadres of health care professionals conducting their CS programmes.

A major challenge is the proportion of therapists who, having indicated that they would remain or intended to become public sector employees and work in a rural area, declined following the experience of compulsory CS. A rural allowance did not prove an incentive to work or remain in a rural area, a finding confirmed by other similar exit-interview studies done with South African doctors. (De Vries & Reid, 2003). In addition to improving training, support and supervision, resource allocation, language and resources for community outreach, other recommended strategies that could motivate therapists to work in the public sector, especially in under-served areas (Hall, 2001; Reid, 2004) include being granted approval to conduct private practice outside public service hours, increased vacation leave, improved working conditions, opportunities for post-graduate training, better rural living conditions, creating more posts in rural areas and financial incentives other than rural allowances. An inter-sectoral forum needs to be created to effectively address challenges impacting on CS programme implementation. The CS rehabilitation programme should be sensitive to needs which are identified in continuous monitoring and evaluation in order for it to be more responsive to changes required in policy and practice.

This study proved useful in identifying areas of need and success in the implementation of CS for therapists in KZN. It also provides information that can be used by the managers of the programme and other key role players to improve future CS for therapists and other healthcare workers in KZN.

CONCLUSION AND IMPLICATIONS

Therapists found the CS experience both personally and professionally rewarding. However, if community service therapists and health care professional are to be retained in rural and under-served areas, there need to be substantial structural adjustments in the health system including improved administration, management, supervision, mentoring and logistical support. CS policy should be evaluated and monitored regularly and the findings and recommendations used to inform policy development and assist implementation of the programme.

The study has some substantial methodological limitations which could affect the validity of the findings. Certain questions in the onset and exit questionnaire were not comparable. All CS therapists in 2005 were included in the sample in order to reduce selection bias, however the low response rate for the questionnaire and the large drop-out rate of respondents from onset to exit of the CS year introduced a selection bias. The resulting small sample size also affects the accuracy of the results. Many differences observed require cautious interpretation especially where statistically significant associations were not found. A social desirability bias could explain more favourable outcomes for

the Audiologists and Speech-Language Therapists - knowing that the principal investigator was from that occupational category.

Ultimately the question is, whether compulsory CS, which increases the presence of health professionals in rural and under-served populations, impacts on the quality of life of persons with disabilities and those at risk. Further investigation, that ensures internal and external validity comparing therapists that remain in the public sector and/or in under-served areas and those that leave after the completion of CS is required. This would contribute to understanding why therapists remain or leave. Issues related to training (undergraduate and in-service), supervision and ongoing support of junior therapists also need further investigation and discussion.

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