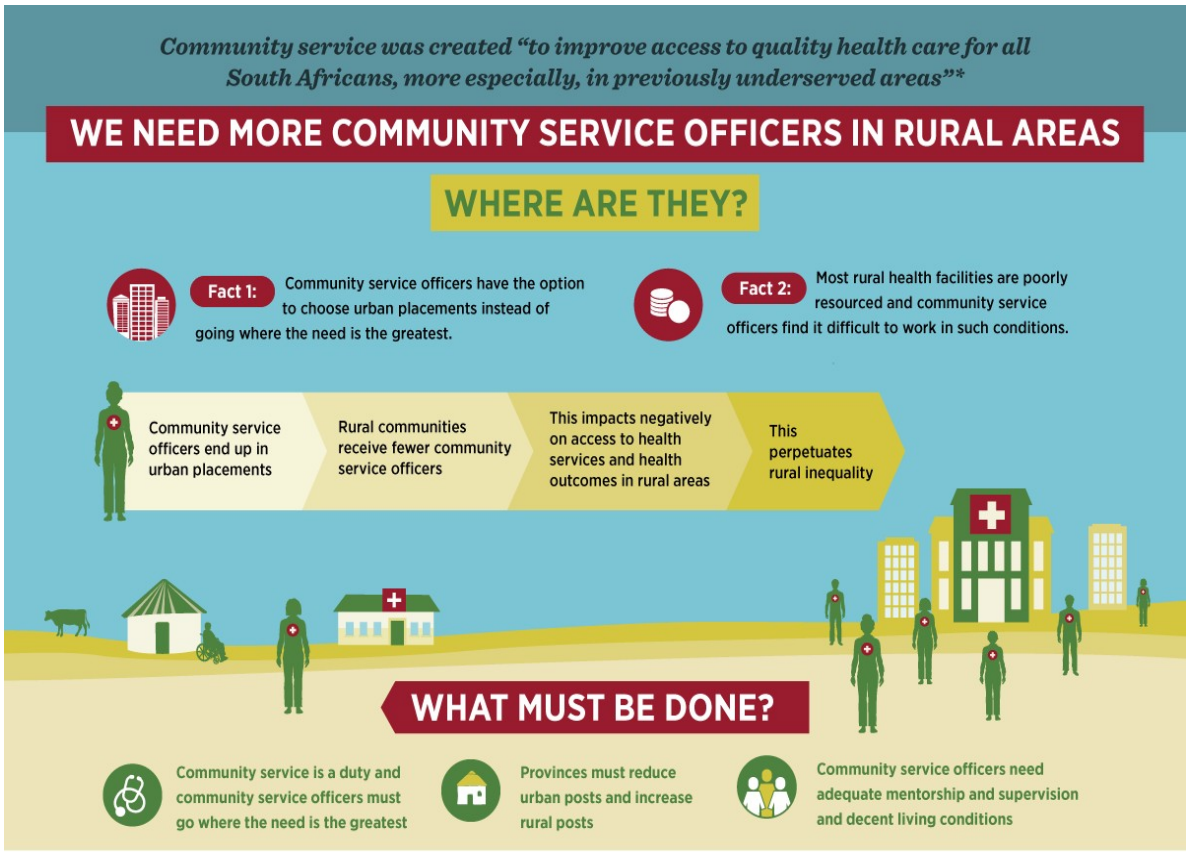
Rural Health Advocacy Project

ANNUAL COMMUNITY SERVICE OFFICER ALLOCATION UPDATE 'ACUTE'

2018



* Department of Health. 2006. Community service to improve access to quality health care to all South Africans. Pretoria: Department of health. http://www.doh.gov.za/docs/pr/2006/pr0105.html

Rural Health Advocacy Project

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ACKNOWLEDGEMENTS

This report was written by Karessa Govender with contributions by Russell Rensburg, Marije Versteeg-Mojanaga and Samantha Khan-Gillmore.

The Annual CSO Allocation Update 'ACUTE'

1. Introduction

With this publication the RHAP launches an Annual Community Service Officer Update 'ACUTE' on the allocation of community service officers in South Africa. The purpose is to monitor whether the country is making progress with regards to meeting the intended purpose of community service which is to address the maldistribution of human resources for health, in particular in rural areas. It follows RHAP's rural health update "Community Service Medical Officer Allocations 2017: Salt in an open wound" which was released in December 2016. This first issue of the Annual Community Service Barometer covers the data that we could access for the North West Province, as of 9 January 2018 and the placements provided to us for the Eastern Cape (unknown round). While the final numbers for the Eastern Cape may have changed after multiple rounds, the distribution data in this update provides an indication of the placement trends.

In future, data for all provinces after each round should be made publicly available for transparency and accountability.

2. Methodology and Definitions

An Excel spreadsheet with the 2017 Eastern Cape and North West placements was made available to RHAP via Health Information Systems Programme. This spreadsheet reported on the final placements in these provinces. The 'applicant allocated' filter was selected as this was interpreted as the facility that the community service officer was allocated to. An Excel spreadsheet with the 2018 North West placements was made available to RHAP via the Human Resources Services Directorate of the North West Department of Health. We were informed that this was the latest round of placements. An Excel spreadsheet with the 2018 Eastern Cape placements was made available to us via the National Department of Health. This provided information on the facilities that had community service posts and the number of posts allocated to each facility.

The community service posts were analysed using two variables. The first was the South African Index of Multiple Deprivation. This index considers income and material deprivation,

employment deprivation, education deprivation and living environment deprivation.[1] The scale was then used to rank districts based on their level of deprivation. The second variable used to analyse the data was rural/urban. No single definition of rurality exists. The most deprived districts are rural but some pockets of deprivation also exist in less deprived urban areas. RHAP classified facilities rural/urban according to our knowledge of the rural/urban geography of provinces and population size. A list of the classification can be accessed via the RHAP website: www.rhap.org.za

3. Definition of terms

The spreadsheets that were made available for analysis used the following terms: posts, allocations, placements. RHAP consulted with senior officials from North West HR and it was found that all three terms referred to *any posts that were available for community service officers to apply.*

HRH: Human resources for health

Allied health professionals: These refer to disciplines distinct from medicine, nursing and pharmacy.[2] They include occupational therapy, speech therapy, physiotherapy, audiology, radiography, amongst other disciplines.

4. Background

In the aftermath of the 2017 community service allocations, the Minister of Health, Dr. Aaron Motsoaledi explicitly stated that rural communities would be prioritised in the placement of health professionals from 2018 and beyond. This was in response to another year of community service allocations where metropolitan areas received the lion's share whilst rural and underserved areas received the leftovers. Health facilities across the nation are in dire need of health care workers – however rural and underserved areas suffer from a more desperate plight – despite rural regions constituting almost half of the country's population, they experience the highest HR shortages. Mpumalanga, Limpopo and Eastern Cape which

[1] Noble M, Zembe W, Wright G, Avenell D. Multiple Deprivation and Income Poverty at Small Area Level in South Africa in 2011. Southern African Social Policy Research Institute and Southern African Social Policy Research Insights. 2013.

[2] Association of Schools of Allied Health Professionals. [Online]. [cited 2018 February 13. Available from: http://www.asahp.org/what-is/.

comprise more than 50% rural people have per capita expenditure which falls below the national average.[3]

Community service health professionals are seen as a much needed asset in rural and underserved areas. In these communities, the addition of a single healthcare worker to an already resource constrained facility makes a significant difference to service delivery. Very often it may be the difference between a service being provided and none at all. Healthcare workers are sparsely distributed in rural areas and the few that exist are required to cover large catchment areas. Health users in rural areas are challenged with few health facilities and healthcare workers. This together with extremely challenging terrain makes it exceptionally difficult for patients to access the limited services that are available. However the presence of health workers in rural areas allows for outreach services into the community. Without this very necessary service, many rural health users may never realise the right to access health.

5. Policy and Legislation in favour of rural and underserved areas

The national department of health is aware of the impact of community service health workers in rural areas and thus both the *Community Service and Internship Placement Guideline 2017-2018* and the National Department of Health Strategy for *Human Resources for Health South Africa, Strategic Priority 8* speak to the prioritization of rural and underserved areas for community service placement. The former document impresses on provincial departments of health to improve funding to district hospitals and primary health care facilities to take on community service officers. The latter document delineates authority to the provincial departments to ensure health facilities in rural and underserved communities are given preference over facilities located in urban areas. It takes it one step further by stating that by 2018/2019 all community service placements will be phased out of central hospitals in metropolitan areas. It must be strongly reinforced that the original intention of the community service programme was to address the inequitable distribution of healthcare workers. The compulsory one year of community service was envisioned to provide health services to priority areas which were historically disadvantaged and present with the greatest need.

[3]Stats SA Census 2011.

6.1. Summary of Key findings

a. Eastern Cape Province

- For the 2017 placement year, over 50% of rural posts for community service medical officers were not filled.
- The Eastern Cape Province has seen an overall increase in terms of the number of community service posts for 2018 in the majority of cadres reviewed (medical officers, professional nurses, pharmacists, occupational therapists, speech therapists and audiologists). This needs to be applauded. However physiotherapy experienced a decline by 6 community service officers.
- A significant increase was noted with the number of professional nurses increasing from 377 to 507. There has also been an attempt to redirect posts from less deprived districts to more deprived ones. In addition, the number of professional nurses allocated to rural areas outweigh urban.
- Despite these areas of progress, we however continue to see a maldistribution in favour of urban health facilities for medical officers. (Urban: rural = 49: 35).
- In some instances, more deprived districts will be receiving fewer community service officers than in 2017 whilst less deprived districts benefit from an increase. The OR Tambo district which is very deprived district will experience a drop in professional nurses and pharmacist officers whilst the Nelson Mandela Bay Metro, which experiences less deprivation, will benefit from an increase in professional nurses. The Alfred Nzo district will also experience a drop in pharmacist community service officers. Alfred Nzo and Joe Gqabi Districts, which are the most deprived districts in EC, will not be receiving any community speech therapists or audiologist allocations in 2018.
- There is a lack of continuity of care for marginalised rural communities:
    - Isilimela Hospital in OR Tambo District which was allocated a community service occupational therapist (OT) and physiotherapist (PT) last year will not be receiving any in 2018. As it does not have permanent OT and PT posts this means an actual regression in access to healthcare.
    - The same hospital which is currently serviced by two medical officers will not be receiving any community service medical officers for 2018. This, despite Mthatha General Hospital, which is located in an urban area in the same district, receiving 5 community service officers.

Maldistribution between provinces persists. Despite KZN and EC both being rural provinces – the inter-provincial distribution of community service posts strongly favours KZN. KZN was allocated more than double the number of many medical officers than EC and almost twice as many pharmacists as EC. Kwa-Zulu Natal was also allocated 11 more occupational therapists than the Eastern Cape.

b. North West

- Progress in community service allocation in North West Province must be acknowledged. There has been an overall increase in the number of medical officers, professional nurses, pharmacists and physiotherapists. In the case of professional nurses and pharmacists, the number allocated has more than doubled from 2017 to 2018.
- It has been brought to our attention that the North West Province may have created more community service posts than other provinces and have created posts for both bursary holders and non bursary holders. This information however could not be confirmed.
- There has also been a concerted effort to direct posts to more deprived districts and to favour rural areas. This is evidenced in the allocation of professional nurses and pharmacists where the distribution strongly favours rural areas.
- The North West province has ring fenced funding for community service officers. This ensures that funds are available annually for these cadres.
- Despite the progress, there are still areas of concern:
    - Of the 824 posts, 805 have been filled. The unfilled posts in rural areas outweigh those of urban areas. We have been informed that these posts may be filled through the placement of foreign workers. However this has not been finalised yet.
    - The allocation of medical officers strongly favours urban hospitals; urban areas will benefit from almost twice the number of medical officers than rural areas.
    - The least deprived districts (Bojanala and KK) in the North West province have received far more medical officers than the most deprived districts (NMM and Dr. RSM).
    - The overall number of occupational therapists has declined from 2017. The number of occupational therapists allocated to urban areas outweighs that of rural areas.

- The number of speech therapists and audiologists are extremely low when taking into account the level of deprivation and need in the province.
- As stated earlier, NW province has one of the highest prevalence of disability in the country. Adequate staffing for allied health professionals is therefore paramount in addressing the unique needs of this population.

6.2. An overview of the Eastern Cape community service allocation

The Eastern Cape is one of 5 provinces where over half of the population reside in rural areas.[4] This province experiences one of the highest maternal mortality in facility ratio[5] in the country. It is known that overall, rural areas face worse health outcomes compared to urban areas. These outcomes would necessitate more comprehensive health programmes which require adequate staffing with competent health care workers. Historically, this province has been marred with HRH shortages with large inequities between urban and rural districts. An index investigation by the Rural Health Advocacy Project into the 2017 allocation of community service officers revealed that after the first round, more than 50% of medical officer placements were in urban districts such as Nelson Mandela Bay Metro and Buffalo City.[6] Of the 153 medical officer posts available, only 56 were filled. It must be noted that analysis was based on information available at the time. This data was the first round placement of medical officers. New data became available later and this information was used to compare 2017 and 2018 placements.

[4]Stats SA Census 2011.
[5]Massyn N, Padarath A, Peer N, Day C. District Health Barometer 2016/17. Durban: Health Systems Trust.
[6]RHAP. Rural Health Update: Community Service Medical Officer Allocations: Salt in an open wound. Rural Health Advocacy Project: 2016.

6.3. Medical officers

DISTRICT	MO CS Allocation 2017	MO CS Allocation 2018	Deprivation 1 = Most Deprived 5 = Least deprived
Nelson Mandela Bay Metro	12	14	5
Buffalo City	6	7	4
OR Tambo	19	23	1
Alfred Nzo	5	9	1
Chris Hani	7	14	1
Joe Gqabi	3	6	1
Sarah Baartman	13	8	3
Amatole	10	12	1
	75	93	

Table 1: Comparison of 2017 and 2018 medical officer community service allocation

A positive for the province, there has been an overall increase in the number of medical officers allocated to the Eastern Cape. The increase is significant; 75 in 2017 to 93 in 2018. The most deprived districts (OR Tambo, Alfred Nzo, Chris Hani and Amatole) have all been allocated more medical officers than last year.

Issues with distribution of posts however still persist; despite the gross increase, placements are still favoured towards health facilities in urban areas. Joe Gqabi district which experiences high levels of deprivation has only received 3 more posts than last year.

A closer look at the OR Tambo district reveals further evidence of inequitable distribution. Allocation has been skewed in favour of urban hospitals. Mthatha General Hospital which is located in an urban area has been allocated 5 community service officers whilst a deeply

rural hospital in the same district (Isilimela Hospital) which currently is serviced by two medical officers will not be receiving any community service medical officers for 2018.

6.4. Professional Nurses

DISTRICT	PNs CS Allocation 2017	PNs CS Allocation 2018	Deprivation 1 = Most Deprived 5 = Least deprived
Nelson Mandela Bay Metro	66	78	5
Buffalo City	17	27	4
OR Tambo	97	72	1
Alfred Nzo	50	62	1
Chris Hani	35	84	1
Joe Gqabi	30	60	1
Sarah Baartman	41	48	3
Amatole	41	82	1
	377	507	

Table 2: Comparison of 2017 and 2018 professional nurses' community service allocation

There has been a significant increase in professional nursing posts in the EC. Alfred Nzo, Chris Hani and Amatole districts which all experience high levels of deprivation have gained in the number of posts they will be receiving in 2018. There has also been a strong attempt to direct placements to rural facilities in the province. However some maldistribution still exists. Buffalo City which is one of the least deprived districts will be benefitting from an increase; from 17 to 27 posts whilst OR Tambo district which has a high level of deprivation, has lost 25 posts from last year.

6.5. Pharmacists

DISTRICT	PHARM CS Allocation 2017	PHARM CS Allocation 2018	Deprivation 1 = Most Deprived 5 = Least deprived
Nelson Mandela Bay Metro	8	3	5
Buffalo City	2	1	4
OR Tambo	19	10	1
Alfred Nzo	9	8	1
Chris Hani	3	13	1
Joe Gqabi	3	7	1
Sarah Baartman	7	8	3
Amatole	8	13	1
	59	63	

Table 3: Comparison of 2017 and 2018 pharmacist community service allocation

Similarly to the medical officer allocation, the overall number of pharmacists allocated to the Eastern Cape has increased, albeit minimally from 59 to 63. Despite the increase, the OR Tambo district will be receiving 9 less pharmacists than 2017. The allocation to Alfred Nzo has also dropped. Despite the Joe Gqabi district having the same level of deprivation as Amatole district; it will be receiving approximately half the number of community service pharmacists.

6.6. Rehabilitation

It must be noted that rehabilitation workers often comprise smaller graduating numbers than medicine and nursing. This impacts service delivery as many facilities, especially in rural areas are often completely reliant on community service therapists in the absence of any permanent therapists. Disability is more prevalent in rural and poor areas[7] and therefore rehabilitation services cannot be confined to metropolitan areas at the expense of unmet need in other areas. A comparison of 2017 and 2018 community service allocation for the

[7]RHAP. Rural Health Fact Sheet 2015. Johannesburg : 2015.

following disciplines follows: occupational therapy, physiotherapy, speech therapy and audiology.

6.6.1 Occupational therapists

DISTRICT	OT CS Allocation 2017	OT CS Allocation 2018	Deprivation 1 = Most Deprived 5 = Least deprived
Nelson Mandela Bay Metro	10	5	5
Buffalo City	3	4	4
OR Tambo	9	9	1
Alfred Nzo	0	4	1
Chris Hani	2	6	1
Joe Gqabi	1	3	1
Sarah Baartman	7	3	3
Amatole	3	4	1
	35	38	

Table 4: Comparison of 2017 and 2018 occupational therapy community service allocation

The overall number of occupational therapists allocated to the Eastern Cape has only increased by 3 posts, 35 to 38. Alfred Nzo district benefitted from an increase from 0 OTs in 2017 to 4 in 2018. The Chris Hani district also benefitted, relative to the overall provincial allocation from 2 to 6. Buffalo City, Joe Gqabi and Amatole experiences minimal increases. It must be noted that despite the overall increase for 2018, 38 OTs is far too small a number. Bearing in mind, the large distances therapists would have to traverse to perform outreach in clinics and households. Further, despite the increase, Isilimela Hospital which was allocated a community service OT last year will not be receiving one in 2018. Taking into account that Isilimela also has no permanent posts, this shows a complete disregard for the continuity of care, as patients will not be able to travel out of catchment to the next closest hospital for rehabilitation.

6.6.2. Physiotherapists

DISTRICT	PT CS Allocation 2017	PT CS Allocation 2018	Deprivation 1 = Most Deprived 5 = Least deprived
Nelson Mandela Bay Metro	10	9	5
Buffalo City	5	4	4
OR Tambo	11	11	1
Alfred Nzo	3	3	1
Chris Hani	2	3	1
Joe Gqabi	1	2	1
Sarah Baartman	6	1	3
Amatole	4	3	1
	42	36	

Table 5: Comparison of 2017 and 2018 physiotherapist community service allocation

The overall number of physiotherapists has decreased from 42 to 36. Apart from the OR Tambo district, the other districts have either benefitted minimally or not at all. Similar to the OT allocation; certain facilities will have to forego services that were previously implemented. Case in point, Isilimela Hospital has not been allocated a physiotherapist for this year. Because the service was provided solely by a community service physiotherapist last year and no permanent therapist has been allocated, there will be no physiotherapy services for the hospital and the catchment of approximately 100 000 will not have access to this service.

Every attempt should be made to ensure that services are not discontinued once a need for the service has been established in an area.

6.6.3. Speech therapy

DISTRICT	ST CS Allocation 2017	ST CS Allocation 2018	Deprivation 1 = Most Deprived 5 = Least deprived
Nelson Mandela Bay Metro	0	1	5
Buffalo City	0	2	4
OR Tambo	1	2	1
Alfred Nzo	0	0	1
Chris Hani	0	1	1
Joe Gqabi	0	0	1
Sarah Baartman	0	0	3
Amatole	0	1	1
	1	7	

Table 6: Comparison of 2017 and 2018 speech therapy community service allocation

Speech therapy allocation has increased from 1 to 7. Despite the increase, the overall number is still grossly insufficient and districts with high levels of deprivation such as Alfred Nzo and Joe Gqabi have not been allocated any speech therapists at all.

It must be clarified and strongly reinforced that for a proper rehabilitation service to exist in a facility, all rehabilitation disciplines are required, not just the presence of physiotherapy or occupational therapy. Many patients that require rehabilitation will often need the combined services of occupational therapy, physiotherapy and speech therapy. If only one of these disciplines exists at the hospital, the patient will still have to travel to another facility to access the other services. This is not logical nor does it benefit the patient. Therefore the extremely small number of speech therapists allocated to the province is deeply worrying. Speech therapists play a pivotal role in the management of patients with feeding and swallowing difficulties, often found in individuals with neurological deficits such as cerebral palsy. They are able to offer lifesaving interventions which no other discipline is trained to perform and therefore the dismal figures representing their profession in EC must not be taken lightly.

6.6.4. Audiology

DISTRICT	AUDIO CS Allocation 2017	AUDIO CS Allocation 2018	Deprivation 1 = Most Deprived 5 =Least deprived
Nelson Mandela Bay Metro	1	1	5
Buffalo City	0	0	4
OR Tambo	1	3	1
Alfred Nzo	0	0	1
Chris Hani	0	2	1
Joe Gqabi	0	0	1
Sarah Baartman	0	1	3
Amatole	1	1	1
	3	8	

Table 7: Comparison of 2017 and 2018 audiology community service allocation

The number of audiologist placements increased from 3 in 2017 to 8 in 2017. Some attempts to direct posts to deprived districts are seen in OR Tambo, Chris Hani and Amatole. There has however been a strong preference towards urban facilities with five of the eight posts being in urban. The gross number is insufficient when we consider the burden of TB in the province and the associated risk of hearing impairment stemming from ototoxicity. This would necessitate a far larger number of audiologists than the present.

6.6.5. Dual qualified speech therapy and audiology

DISTRICT	S/AUDIO CS Allocation 2017	S/AUDIO CS Allocation 2018	Deprivation 1 = Most Deprived 5 = Least deprived
Nelson Mandela Bay Metro	5	0	5
Buffalo City	2	0	4
OR Tambo	3	0	1
Alfred Nzo	0	0	1
Chris Hani	1	0	1
Joe Gqabi	0	0	1
Sarah Baartman	1	0	3
Amatole	2	0	1
	14	0	

Table 8: Comparison of 2017 and 2018 speech therapy and audiology (dual qualified) community service allocation

The data available for the 2018 allocation of community service officers in the Eastern Cape did not have any data on dual qualified speech therapists and audiologists. It is uncertain whether this group of cadres were classified incorrectly or no dual qualified speech therapists and audiologists were actually allocated to the Eastern Cape.

7.1. An overview of the North West Province community service allocations

The North West province comprises 4 health districts. Dr Ruth Segomotsi Mompati is the most deprived, followed by Ngaka Modiri Molema, Bojanala and lastly Kenneth Kaunda, which is the least deprived but has pockets of high levels of deprivation. The NW province has the second highest maternal mortality in facility ratio in the country with KK and Dr. RSM districts well above the national average.[8]The HIV testing coverage for NW is below the national average (35.9).[9] It also has among the highest disability prevalence nationally.[10]

[8]Massyn N, Padarath A, Peer N, Day C. District Health Barometer 2016/17, PG 56. Durban: Health Systems Trust.
[9]Massyn N, Padarath A, Peer N, Day C. District Health Barometer 2016/17, PG 176. Durban: Health Systems Trust.
[10]Stats SA Census 2011.

Two out of the four NW districts viz. NMM and Bojanala scored below the national average for percentage of ideal clinics.[11]

7.2. Medical Officers

DISTRICT	MO CS Allocation 2017	MO CS Allocation 2018	Rural	Urban	DEPRIVATION 1 = Most deprivation 5 = Least deprivation
Bojanala	37	46	**59**	**104**	3
NMM	3	28			2
KK	68	69			4
Dr. RSM	0	16			1
	108	**159**			

Table 9: Comparison of 2017 and 2018 medical officer community service allocation

The North West province has benefitted from a significant increase in medical officer community service officer (CSO) allocations. However despite this increase, the least deprived districts (Bojanala and KK) have been allocated the bulk of the CSOs whilst the districts with the highest levels of deprivation have received small figures. The allocation has also strongly favoured urban health facilities; urban areas have received almost twice as many medical officers as rural areas. According to the 2015/16 edition of the DHB, only 50% of residents in Dr. RSM district have access to a medical officer at PHC level. The NMM district fares slightly better at 69.2%. However both districts are below the national average (74.2%).[12] This is concerning. Community service officers placed at district hospitals must have organised outreach programmes to primary health clinics to manage complicated cases.

[11] Massyn N, Padarath A, Peer N, Day C. District Health Barometer 2016/17. PG 28. Durban: Health Systems Trust.

[12] Massyn N, Peer N, English R, Padarath A, Barron P, Day C. District Health Barometer 2015/16. Durban: Health Systems Trust. The most recent version of the District Health Barometer did not report on this outcome and therefore data from the 2015/16 edition was used.

7.3. Professional nurses

DISTRICT	PN CS Allocation 2017	PN CS Allocation 2018	Rural	Urban	DEPRIVATION 1 = Most deprivation 5 = Least deprivation
Bojanala	39	106	**267**	**123**	3
NMM	6	100			2
KK	53	85			4
Dr. RSM	0	99			1
	98	**390**			

Table 10: Comparison of 2017 and 2018 professional nurses community service allocation

The North West province has received a significant increase in professional nurses across all districts; almost 4 times greater than 2017. There has been a strong attempt to direct posts to the most deprived districts (NMM and Dr. RSM). Bojanala district, however, has the highest allocation, despite being one of the least deprived districts in NW. Rural areas will be receiving more than twice the number of professional nurses compared to urban areas. The large number of professional nurses allocated to NW also brings into question whether distribution of PNs to other provinces has been compromised.

7.4. Pharmacists

DISTRICT	PHARM CS Allocation 2017	PHARM CS Allocation 2018	Rural	Urban	Deprivation 1 = Most Deprived 5 = Least deprived
Bojanala	8	27	**52**	**28**	3
NMM	10	23			2
KK	14	19			4
Dr. RSM	0	11			1
	32	**80**			

Table 11: Comparison of 2017 and 2018 pharmacists community service allocation

The pharmacist allocation has more than doubled from 2017 to 2018. There has been an attempt to direct posts to the most deprived districts (NMM and Dr. RSM). Bojanala district however has the highest allocation, despite being one of the two least deprived districts in the province. The two less deprived districts (Bojanala and KK) were allocated 12 more pharmacists than the two most deprived districts (NMM and Dr. KK). This still shows a preference for the less deprived districts in the province. However from the rural/urban allocation, there has been a strong attempt to place community service pharmacists in rural areas; rural areas will be receiving double the number of pharmacists than urban areas.

7.5. Occupational therapists

DISTRICT	OT CS Allocation 2017	OT CS Allocation 2018	Rural	Urban	Deprivation (1 = Most Deprived; 5 = Least deprived)
Bojanala	10	7	**12**	**14**	3
NMM	0	6			2
KK	17	9			4
Dr. RSM	0	4			1
	27	**26**			

Table 12: Comparison of 2017 and 2018 occupational therapists community service allocation

The overall allocation for occupational therapy in the province this year is poor. Not only has North West province received fewer therapists than last year but the least deprived districts will be receiving the highest allocation (Bojanala and KK). Allocation to urban has also been favoured over rural. It must be acknowledged that NMM and Dr. RSM were not allocated any occupational therapists in 2017 and thus the current allocation of 6 and 4 respectively will be a great benefit to these districts. However these numbers are nowhere close to being able to address the need in these districts, taking into account the high disability prevalence in the province.

7.6. Physiotherapists

DISTRICT	PT CS Allocation 2017	PT CS Allocation 2018	Rural	Urban	Deprivation (1 = Most Deprived; 5 = Least deprived)
Bojanala	12	10	**19**	**15**	3
NMM	2	8			2
KK	14	10			4
Dr. RSM	0	6			1
	28	**34**			

Table 13: Comparison of 2017 and 2018 physiotherapists' community service allocation

Physiotherapy has benefitted from a minimal increase of 4 physiotherapy community service placements. The least deprived districts have received the highest number of physiotherapists (Bojanala and KK). There has been an attempt to direct posts to rural areas; rural outnumbers urban by 4 community service officers. It has been noted that a large number of physiotherapists have been allocated to district hospitals rather than clinics. Community service therapists are often placed at district level hospitals because of the direct supervision they will receive. However it is still strongly recommended that these therapists conduct outreach services in the community. Roving teams of therapists overseen by an experienced therapist is one such strategy of providing rehabilitation services to rural and underserved communities.

7.7. Speech therapists

DISTRICT	ST CS Allocation 2017	ST CS Allocation 2018	Rural	Urban	Deprivation (1 = Least Deprived; 5 = Most deprived)
Bojanala	4	4	**6**	**5**	3
NMM	1	4			2
KK	8	2			4
Dr. RSM	0	1			1
	13	**11**			

Table 14: Comparison of 2017 and 2018 speech therapists community service allocation

The province has experienced a decline in speech therapy posts from 2017. The overall number is extremely poor and insufficient in addressing the needs of the province. The most deprived district (Dr. RSM) has received the smallest allocation of only a single speech therapist. It must also be noted that rural health facilities typically have fewer permanent therapists and it could very well be that the single speech therapist in Dr. RSM may be responsible for servicing a very large catchment. Healthcare workers rely heavily on peer support in the early stages of their career and therefore it is counterproductive to place a single community service speech therapist in a district. Similar to the physiotherapy allocation, we find the majority of speech therapy allocations have been to hospitals.

7.8. Audiologists

DISTRICT	Audio CS Allocation 2017	Audio CS Allocation 2018	Rural	Urban	Deprivation 1 = Most Deprived 5 = Least deprived
Bojanala	6	1	**5**	**5**	3
NMM	0	3			2
KK	4	4			4
Dr. RSM	0	2			1
	10	**10**			

Table 14: Comparison of 2017 and 2018 audiologists community service allocation

The 2018 audiologist figures are not a true reflection of the actual number placed. According to a reliable source from the NW Human Resources, 7 audiologists were placed. This shows a decline in placements from 2017. Similar to the speech therapy allocations, the overall number of audiologists is insufficient in addressing the need within the province. It was also found that audiologists were also predominantly placed in hospital facilities and not clinics.

It was found that multiple community service officers were placed in the same urban health facility in the least deprived districts in the province; in the case of Job Shimankana Tabane Hospital in Rustenburg in Bojanala district and Klerksdorp Provincial Hospital in Kenneth Kaunda district. This reflects maldistribution as it is very likely that these larger hospitals in urban areas would already have permanent therapists.

8. Conclusion

Community service posts are not a long term solution to the ongoing and persistent HRH shortages. Community service officers only fulfil a one year contract and therefore the creation and filling of permanent posts for healthcare workers must be done.

There is a strong preference for health science students to apply to urban facilities. After round 1, it was found that most of the facilities in urban areas had been filled. This is contradictory to the ethos of community service, which was envisioned to supplement staff shortages in rural and underserved areas.

There is a low baseline of healthcare workers produced every year. This small figure is then rationed across 9 provinces. This is particularly evident in the allied health professions (occupational therapy, physiotherapy, speech therapy and audiology).

It has come to our attention that community service officers are declining placements because of inadequate/absent accommodation. Ganyesa Hospital in the North West has lost two community service pharmacists because of a lack of suitable accommodation.

The imminent return of Cuban trained South African doctors into the SA public health system has triggered speculation that funding allocated for allied health workers will be used to pay the doctors' salaries. Rehabilitation workers are already a scarce skill in South Africa and this move will only lead to the further decline of health in the country.

9. Recommendations

It must be reiterated that the goal of community service is to supplement HRH in rural and underserved areas. There has been an attempt to allocate community service officers to these areas. However this is not done consistently across all cadres.

Despite clear policy on community service allocations and support from the minister of health, Dr. Aaron Motsoaledi, on the urgent need to prioritise rural and underserved areas, there has been a lack of enforcement, where allocation is in favour of urban and less deprived districts. In addition, many urban hospitals are benefitting from numerous community service officers.

There has been a trend for applicants to choose employment in urban areas and their decision cannot be faulted if these placements have available posts. However this outcome is contrary to the community service allocation policies and the directive from national department of health to prioritise rural facilities. To ensure that applicants are not choosing urban facilities at the expense of service delivery in rural areas, urban placements must not be listed on the ICSP system unless a need has been identified in these areas. In essence, the provision of equitable access to health services must not be dependent on the preference of an individual to decide whether they would like to serve in a certain community. A realistic goal to work towards would be a 90/10 split in favour of rural communities. The 10% can be allocated to underserved communities within urban areas.

It must be reinforced that a well functioning health system is dependent on all levels of care being appropriately resourced. Higher levels of care depend on lower levels for up-referrals. Ensuring strong capacity at PHC level prevents district hospitals from being overwhelmed with patients and more importantly, ensures patients can access health services conveniently.

THE CURRENT SITUATION

Gross maldistribution of community service officers in favour of urban and less deprived districts

Evidence of regression of health services in rural health facilities

THE WAY FORWARD

Strict and urgent compliance to NDoH to allocate CSOs in rural areas

Provincial departments must reduce community service posts in urban areas and increase posts in rural areas. Provincial departments must provide funding for these posts

Resource prioritization must occur in a manner that favours rural and underserved areas

Mindshift change: Community service officers must realise community service is a duty and should not be granted the privilege to decide where they would like to be placed

As is the case with NW, ringfencing of funds for community service officers is strongly encouraged to ensure sufficient funding for the placement of community service officers.

Supportive environments are necessary to attract healthcare workers. Healthcare workers need suitable accommodation as well as mentorship to guide them in the early years of their career. In our work in rural health, we have found those health facilities which offer good mentorship, opportunities for career progression and specialisation, suitable accommodation and a social environment that is appealing to healthcare workers fare much better in recruiting healthcare workers. These factors must be strongly considered because failure to do so will only further enlarge the gap in HRH inequities across rural and urban areas. This is especially relevant to healthcare workers who have completed their community service and who are not obligated to return to the public sector.

The allocation of community service officers must be done based on need. Resource prioritization must be done in a manner that favours rural and underserved areas.

A clear strategy for HRH acquisition and retention must be defined. This strategy must not rely solely on community service officers for a quality service to exist. The allocation of allied health professionals requires serious and urgent attention.

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