Report of the Community Service for Health Professionals Summit held on the 22nd April 2015.

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1. INTRODUCTION

The Community Service Summit held in the City of Tshwane on the 22nd April 2015 was co-hosted by the Foundation for Professional Development (FPD), the National Department of Health (NDoH), the University of Cape Town (UCT) and the Africa Health Placements (AHP).

The aim of the Summit was to initiate a stakeholder process for the systematic review of the Community Service Policy (CSP) using available evidence from a number of independent studies carried out over the years. The specific objectives were:

- To understand community service in the context of the National Human Resource for Health Strategy 2012-2017 (HRHS),
- To review the last 15 years of experience of community service by doctors and dentists,
- To review the objectives of the CSP in South Africa,
- To review the guidelines and provincial implementation of the CSP in South Africa,
- To make appropriate recommendations.

The summit focused on the medical practitioner and to a lesser extent, on the dentist categories as these are the professions for which most data is available.

The summit was coordinated by a Steering Committee constituted by representatives from the co-hosts and convened by the FPD Lighthouse Project whose aim is to use research, case studies and other evidence based models to systematically review policy, identify policy implementation gaps and to recommend appropriate interventions, including innovative approaches to achieve policy objectives. The Lighthouse Project focuses on priority health issues identified in the NDP 2030 Vision for South Africa, including the strengthening of the Health System through the National Health Insurance, Human Resources for Health and Reducing the burden of Disease. The Lighthouse Project provides technical support in using evidence base policy development as a response to the NDP 2030 vision that calls on all stakeholders to make a contribution. Ultimately the project aims to support effective implementation of policies that advance access to efficient and outcome based quality health care, protect citizens against catastrophic health expenditure and achievement of better health outcomes.

This review of the CSP is largely based on the various studies on the implementation thereof in South Africa and in particular the work by Africa Health Placements in collaboration with the National Department of Health, the Health Professions Council of South Africa, the University of Cape Town and the Foundation for Professional Development.

2. BACKGROUND

The Community Service Policy (CSP) in the health sector was introduced as an important intervention to ensure the availability of human resources in underserviced areas and also to provide an enabling environment for new professionals to acquire experience. The CSP was conceived in the pre-1994 ANC Health Plan and was legislated in 1997 and implemented in 1998. Starting with medical practitioners it was subsequently extended to all health professional groups. In terms of the CSP health professionals are legally required to complete a year of community service (CS) which entails remunerative work in the public sector typified by allocated placement when registering for the first time with their professional council in

South Africa after completion of their studies. Failure to complete the CS period restricts the health care professional from practicing in South Africa. It is however important to note that as CS is not part of the academic curriculum failure to complete CS does not prevent health professionals from practicing outside of South Africa.

Since inception in 1997, the policy on compulsory community service for health professionals has never been systematically reviewed prior to this summit.

Frehywot, et al. (2010), in their study on whether compulsory service programmes as a mechanism for recruiting health workers to remote and rural areas works , found that South Africa is one of 70 countries globally that implement compulsory Community Service [1]. They further found that there were 3 different types of compulsory service in different countries, namely:-

(i) condition of service/state employment programme
(ii) compulsory service with incentives
(iii) compulsory service without incentives

Figure 1: Compulsory Community Service Internationally

Source: (Frehywot, et al., 2010)

Currently around 6500 newly qualified health professionals undertake a year of community service in public health institutions around the country.

Whilst there is a need to evaluate the extent to which the country has achieved the two policy objectives of CS namely to: i) achieve better distribution of human resources for health to underserviced areas and ii) to create an enhanced environment for gaining experience it is acknowledged that CS does not address all the shortages in human resources in the public sector or in rural districts. It is in this context that South Africa has developed a Human Resources for Health Strategy which also take into consideration the WHO recommendations on the recruitment and retention of health professionals in rural and remote areas. Table 1 below outlines these recommended interventions by WHO to Increase access to health workers in remote and rural areas

Table 1: Categories of interventions used to improve attraction, recruitment and retention of health workers in remote and rural areas.

Categories of intervention	Examples
A. Education	Students from rural background Health professional schools outside of major cities Clinical rotations in rural areas during studies Curricula that reflect rural health issues Continuous professional development for rural health workers
B. Regulatory	Enhanced scope of practice Different types of health workers Compulsory service Subsidized education for return of service
C. Financial incentives	Appropriate financial incentives
D. Professional and personal support	Better living conditions Safe and supportive working environment Outreach support Career development programmes Public recognition measures

Source: (World Health Organisation, 2010)

In this content it is clear that CS, is only one of a variety of interventions required to address rural retention and recruitment. In the systematic review of the CSP in South Africa there are two proposed areas of focus namely:

i) To determine whether the policy objectives are still appropriate and if they should be adjusted, especially if evaluated against the Human Resources for Health Strategy (2012/3-2016/7) passed.

Table 2: Applicable components of HRH Strategy for the Health Sector: 2012/13 – 2016 /17 (Department of Health, 2011) that applies to Community Service

Strategic Objective 6	Strategic Objective 7	Strategic Objective 8
Professional Human Resource Management	Quality Professional Care	Access in Rural and Remote Areas
To effectively manage human resources in a manner that attracts, retains and motivates the health workforce to both the public and private sectors in an appropriate balance.	To develop a health workforce that delivers an evidenced based quality service, with competence, care and compassion.	To promote access to health professionals in rural and remote areas.

Source: (Department of Health, 2011)

ii) To deepen the understanding of factors that impact on the implementation of the policy (positively and negatively) at national, provincial and local levels, including guidelines and operational procedures that also need to be reviewed.

3. SUMMIT PROCEEDINGS

The Summit was attended by representatives from the National Department of Health, Provincial Departments of Health, Universities, Researchers, The South African Medical Associations (SAMA), The Junior Doctors Association of South Africa (JUDASA), the Medical Women Association of South Africa (MWASA), the Dental Association (DASA), and Civil Society Organizations whose focus significantly includes the areas of Human Resources for Health.

The format of the one day summit was as follows:

The scene was set through an overview presentation that summarized the results of a series of surveys conducted with CS participants from 2001 to 2014. Participants then joined one of three working groups who were tasked to review the results from the following perspectives:

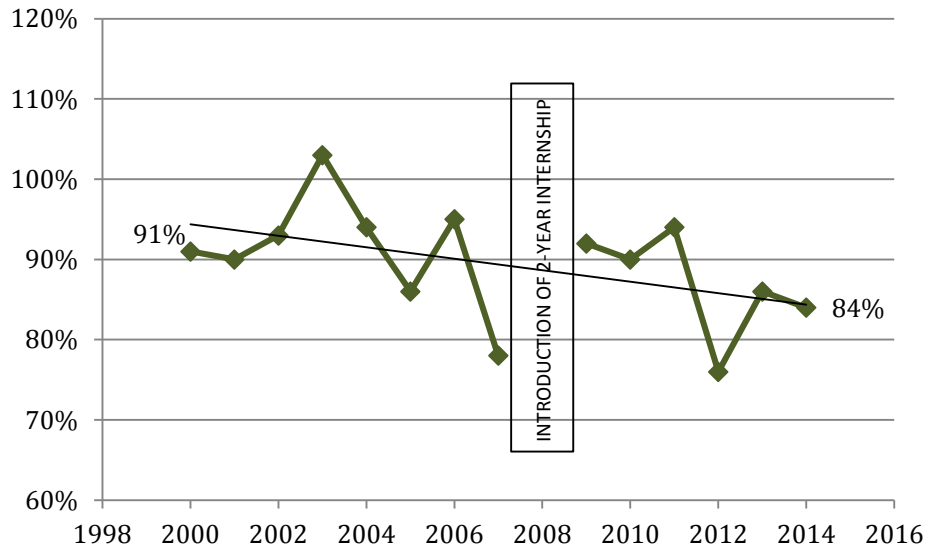
- Implications for policy
- Implications for partnerships, research gaps and priorities
- Implications for public-private partnerships

4. SUMMARY OF RESEARCH FINDINGS SHARED WITH SUMMIT PARTICIPANTS

(i) Turn-up rate

The average turn-up rate for Community Service doctors from 2001-2007 was 89%. The data provides an indication that on average 11 % of doctors are lost to the South African health sector after graduation. The options for this loss proposed included exit from the profession, emigration and career interruption, however no evidence is currently available on the as such *further research is required to identify where these doctors are going, and to define those factors that influence their decision not to engage with the CS programme.*

Figure 2: Turn-up rate for doctors for community service based on comparing the number of CS doctors in a given year with the number of interns from the prior year

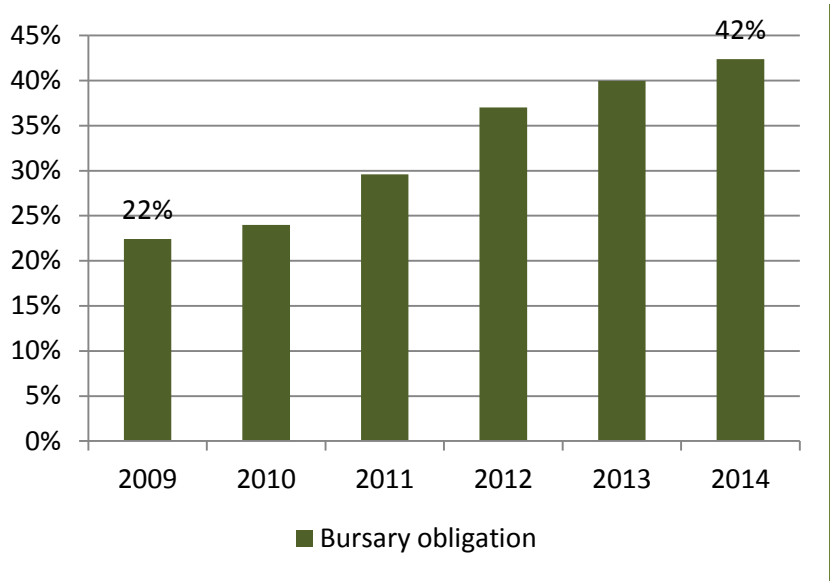


Source: Africa Health Placement 2015 based on information provided by the NDOH

(ii) CS doctors with provincial bursaries

The number of respondents indicating that they had received a provincial bursary has doubled in recent years, from 22% in 2009 to 42% in 2014. As no data is available on what percentage of the doctors who completed their internship but did not show up for CS had provincial bursaries it is not possible to determine if bursary obligations reduces the drop-off rate.

Figure 3: Percentage of CS doctors with provincial bursary obligations

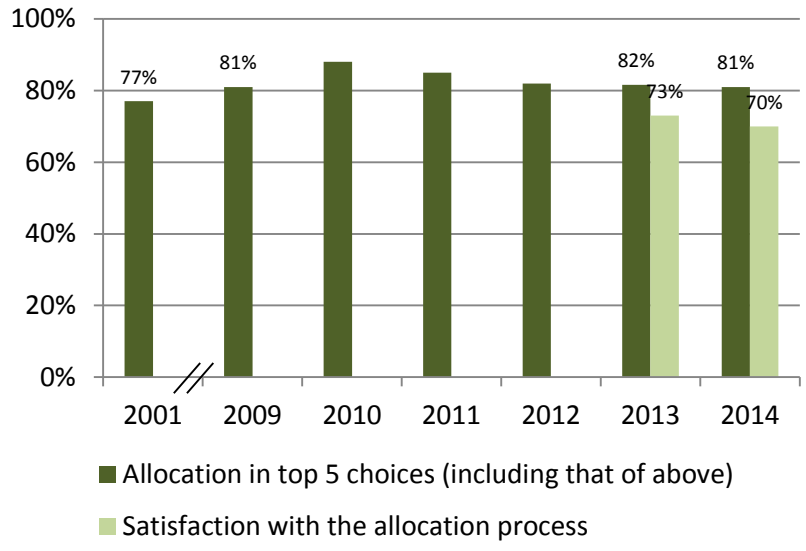


Source: AHP 2015

(iii) Fairness of the allocation process

Allocation of participants within their top 5 choices had increased from 77% in 2001 to 81% in 2009. The figure remained within this range with 81% in 2014. CS doctors satisfaction with the allocation process as measured in in 2013 indicated that 73% of participants were satisfied with the allocation process, and in 2014, this figure dropped to 70%.

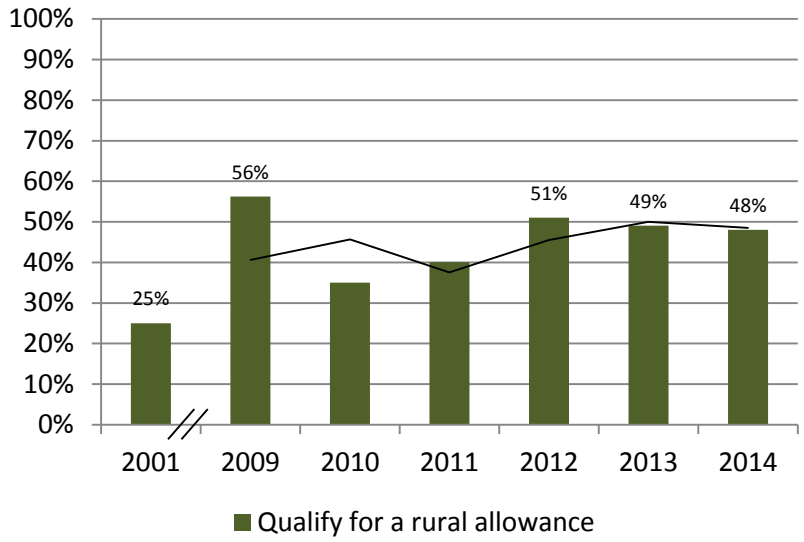
Figure 4: Percentage of CS Doctors placed in their top 5 choices



(iv) Rural placement

The percentage of CS doctors who are placed in rural areas in recent years hovers around 50% but appears to be an improvement from the early years of CS

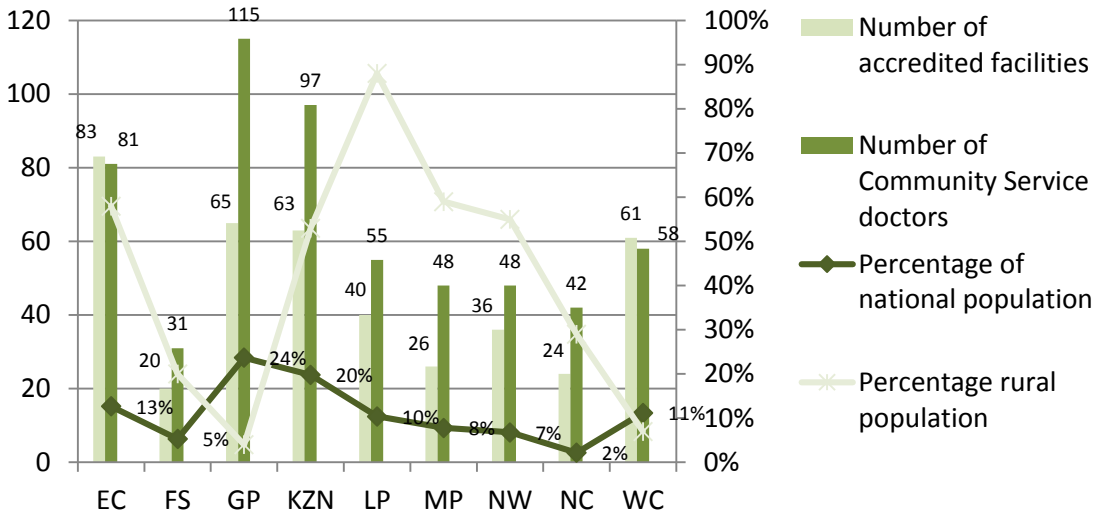
Figure 5: Percentage of CS doctors placed in rural positions based on rural allowances



Source: AHP 2015

The graph below indicates the percentage of the population in each province that is rural, and the relative percentage of the national population (data from StatsSA census conducted for 2011). When observing the number Community Service doctors allocated to each province in 2013, the more populous provinces received more doctors. However, the more rural provinces do not follow this trend. The number of accredited facilities is less than the number of allocated professionals in the Limpopo, Mpumalanga, North West, KwaZulu-Natal, Northern Cape, and Free State – some of the more rural provinces. This suggests a lack of infrastructure in underserved areas, and potentially supervisory support, which remains a barrier to support isolated professionals.

Figure 6: Distribution of CS doctors by province



Source: AHP 2015

v) CS doctors perceptions around CS

To fully understand the experience of Community Service doctors, those factors describing satisfaction, supervision, management and professional development were analysed as a percentage of respondents. It was noted that contribution to the community was a predictable, and possibly conditioned response. A relatively high proportion of respondents indicated that they had experienced professional development.

In terms of practical satisfaction indicators, a high percentage of respondents (94% in 2001, 97% in 2013, and 96% in 2014) indicated performance of overtime duties. For 2013, this response was further categorised by the average number of overtime hours per week. 71% of respondents indicated that greater than 20 hours were performed per week. Other practical measures include accommodation which was reported as satisfactory by 61% of respondents, while relatively high percentage reported a perceived risk to personal safety (64%).

Table 3: CS doctors perceptions around CS experience

	2001	2009	2012	2013	2014	Average since 2009
Contributed to health of community/made a difference	76%	84%	96%	94%	91%	**91%**
Experienced professional development	91%	72%	89%	-	81%	**81%**
Performed overtime duties	94%	94%	95%	97%	96%	**96%**
Satisfied with accommodation	53%	44%	70%	66%	62%	**61%**
No risk to personal safety	45%	33%	45%	36%	31%	**36%**

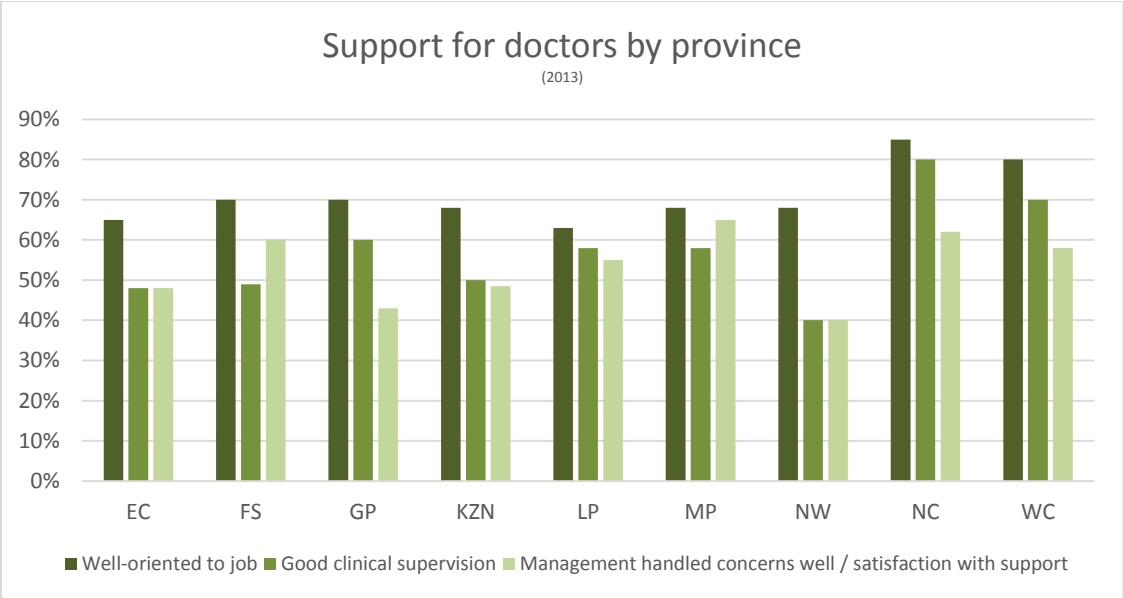
Source: AHP 2015

Community service satisfaction with facility management was investigated per province. A 50% benchmark was used for measurement of majority vs. minority. Those trends observed to have improved from 2001 to recent years were the experience of good clinical supervision, the availability of senior professionals, and that management handled those doctors' concerns well (also reported as satisfaction with support). A decreasing trend was observed from 2012-2014 for orientation satisfaction and management. A suggested reason for this trend is that these Community Service Officers (CSOs) may be becoming 'part of the furniture' and are taken for granted.

In 2012, of the provinces identified as serving rural populations (Eastern Cape, KwaZulu-Natal, Mpumalanga, Limpopo and North West provinces), those respondents from Limpopo were less well-orientated to their job. Good clinical supervision was reported as poor in Limpopo, Mpumalanga and KwaZulu-Natal, with less than 50% of respondents in the province indicating satisfaction with this measure. Both Limpopo and Mpumalanga had less than 50% respondents indicating that management handled their concerns well.

However in 2013 many of the results improved, with the exception of poor management in Gauteng and both poor management and clinical supervision in the North West province.

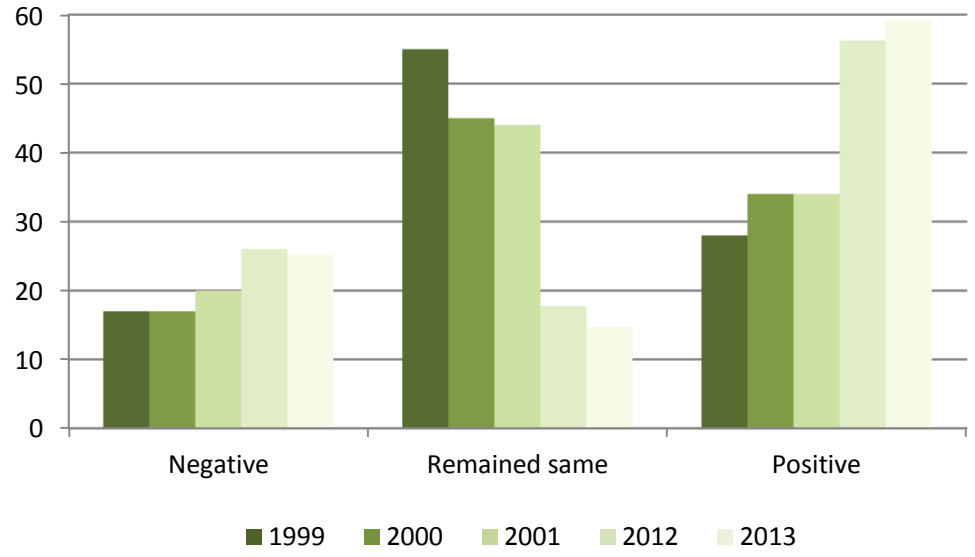
Figure 7: CS doctors perception around managerial and clinical support in by province



Source AHP (2013)

In response to the Likert-scale question: "*My attitude towards community service has become more negative because of my experience this year"* it was observed that overall the Community Service experience has been increasingly perceived as positive when comparing those responses from 2001 to 2013.

Figure 8: Change in attitudes towards CS amongst doctors



vi) Future work intentions

Future work intentions vary on an annual basis. When comparing the average of those respondents for each intention for the past three years, it was noted that the intention to move overseas has decreased substantially. However, the intention to move into the private sector and specialise has increased. The intention to remain at the same facility and the intention to work in rural, underserved communities has remained fairly static.

Preliminary findings suggest that receiving a rural placement was associated with retention of health professionals in rural, underserved areas (2012), and that, in alignment with other research findings, retention in a rural area was associated with the participant's home town being a rural area (2012). For the 2013 survey, the Community Service Officers were questioned about the stage in their education or career that influenced their plans to work in the next year. The responses indicated that of those characteristics the Community Service year was indicated as a major factor (42%) amongst respondents, compared with a figure of 20% for the internship experience, and 18% who made their plans during medical school.

Table 4: Future plans of CS doctors

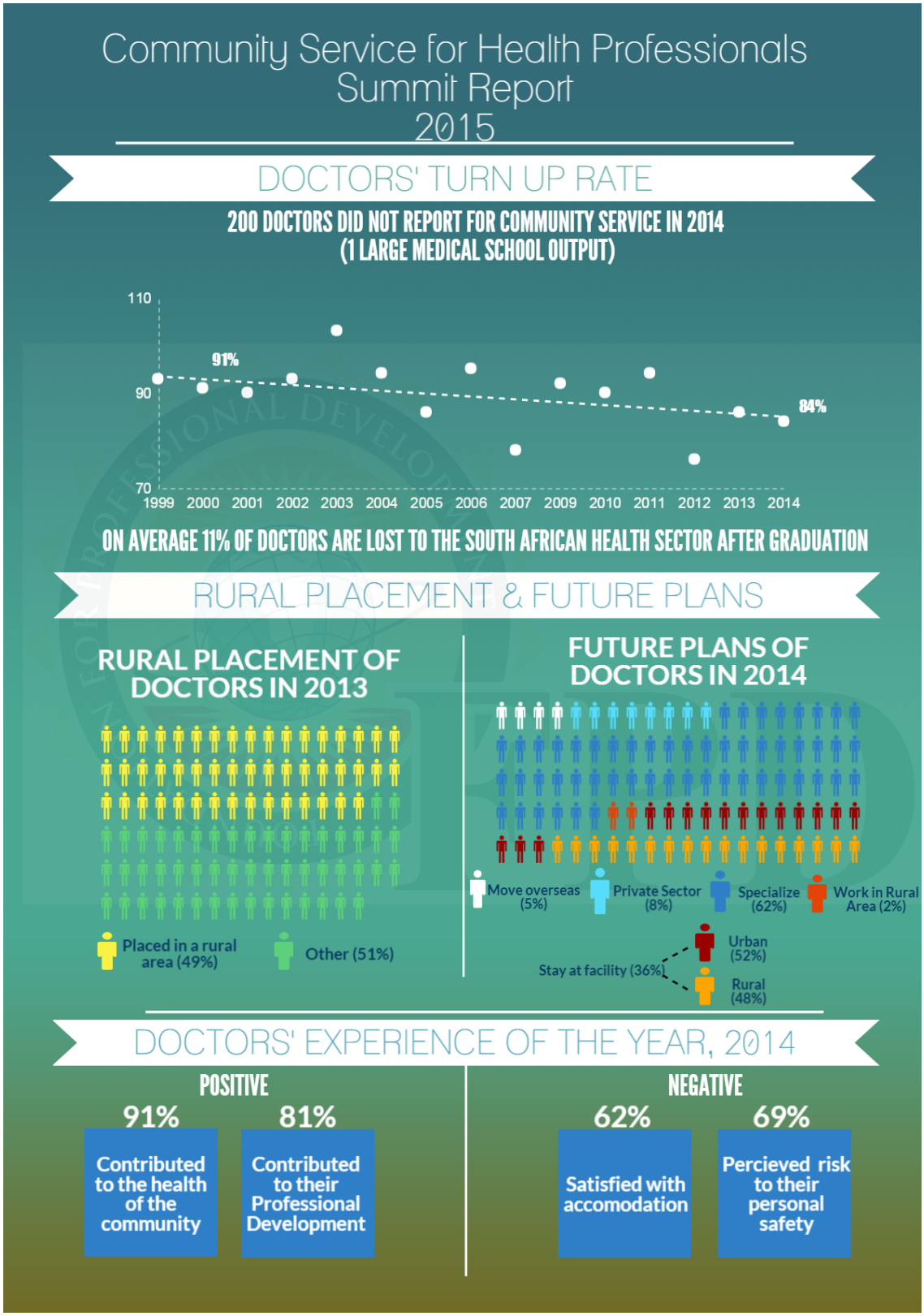
	2001	2009	2012	2013	2014	Average since 2009
Specialise	34%	64%	34%	38%	62%	**50%**
Stay at same facility	-	30%	19%	31%	36%	**29%**
Work in rural, underserved communities	19%	22%	27%	11%	2%	**16%**
Private sector (SA)	7%	16%	27%	4%	8%	**14%**
Move overseas	43%	7%	2%	0%	5%	**4%**

Source: (AHP 2015)

The 2014 survey indicated that 36% of the CS practitioners intended to stay at the same facility the next year. Of interest is that 48% of these respondents were based at the rural facilities as indicated by receiving rural allowance. Of the CS practitioners who would continue at the same rural facility, 43% had no bursary obligations and presumably made a voluntary chose based on the experience during the community service.

5. SUMMIT DISCUSSION GROUPS

Participants were then divided into three discussion groups focusing on Policy, Research and Partnerships respectively. The table below summarizes the research findings and or identified problem area and the consensus on recommendations to address these, reached at the summit.


Community Service for Health Professionals Summit Report 2015
DOCTORS' TURN UP RATE
200 DOCTORS DID NOT REPORT FOR COMMUNITY SERVICE IN 2014
(1 LARGE MEDICAL SCHOOL OUTPUT)
110
90
70
91%
84%
1999 2000 2001 2002 2003 2004 2005 2006 2007 2009 2010 2011 2012 2013 2014
ON AVERAGE 11% OF DOCTORS ARE LOST TO THE SOUTH AFRICAN HEALTH SECTOR AFTER GRADUATION
RURAL PLACEMENT & FUTURE PLANS
RURAL PLACEMENT OF DOCTORS IN 2013
Placed in a rural area (49%)
Other (51%)
FUTURE PLANS OF DOCTORS IN 2014
Move overseas (5%)
Private Sector (8%)
Specialize (62%)
Work in Rural Area (2%)
Stay at facility (36%)
Urban (52%)
Rural (48%)
DOCTORS' EXPERIENCE OF THE YEAR, 2014
POSITIVE
91%
Contributed to the health of the community
81%
Contributed to their Professional Development
NEGATIVE
62%
Satisfied with accomodation
69%
Percieved risk to their personal safety

6. RECOMMENDATIONS

i) Policy review

The summit reached consensus on the continued relevance of the Community Service Policy and the appropriateness of its objectives in the strengthening of the health system and in particular the successful implementation of the Human Resources for Health Strategy, the NHI and the NDP vision 20130 goals for health. There were areas identified for strengthening based on the findings of various studies and discussions held. Table 5 below outlines recommendations and actions to address deficiencies in the CS policy identified at the summit.

Table 5: Problem area and measures to strengthen CS policy

	Findings / Problem area	Recommendations	Actions	Responsibility
1	**Standards and support** Health facilities often do not meet minimum standards around creating a safe and adequately equipped working environment while adequate clinical and managerial support is often lacking.	The CS policy should make provision for: • A Facility Accreditation System (FAS) for facilities designated for Community Service needs to be developed. Minimum norms and standards should be established for: o orientation, o clinical supervision o management support o availability of equipment, o pharmaceuticals • Measures to ensure compliance with these standards should be put in place i.e. a hotline should be established at the NDOH where Community Service professionals can report case of deviations. • Safety and security concerns need to be addressed	• Develop a FAS • Develop norms and standards around : • Clinical infrastructure • Clinical support • Managerial support • Establish a reporting hotline • Survey conducted and recommendations made to PDOHs	NDoH and PD'sOH. NDOH NDOH

2	**Retention in rural areas after CS** The CS policy does not directly address how to improve retention of professionals in rural, underserved areas after completion of CS. As a result retention is low resulting in a high turnover of staff at facilities.	• The CS policy should be amended to create incentives to improve the experience of CSOs during rural placements and could include: o Supported professional development opportunities, o Study leave o Job security through multiyear employment contracts that extend beyond CS year. • Addressing issues mentioned under *Standards and support above* • Create through partnership with other stakeholders incentives to promote rural and remote service i.e. o FPD would provide free online CPD programmes. o Universities to prioritise CSOs from rural service for specialisation posts.	• Update policy • Establish MOUs with interested stakeholders	NDoH and PD'sOH NDOH

ii) Policy Implementation

It was noted that there are variations in how the CSP is implemented in different provinces. Provinces shared their experience, including how they have overcome some of the challenges they face. There are many undocumented good practices and lessons learnt in provinces that are not shared amongst each other. Through case studies some of the provincial innovations can strengthen implementation capacity and ability in other provinces. Table 6 below outlines some of the initiatives proposed to close the implementation gaps identified in the various studies and during discussions.

Table 6: Implementation gaps and recommended interventions

	Findings/Problem area	Recommendations	Actions	Responsibility
1	**Guidelines and Standard Operating Procedures** There is no standardized approach by provinces in implementation of the policy and there is no system for shared learning of best practices.	• National implementation guidelines and standard operating procedures (SOPs) should be comprehensive, and developed from bench marking of good practices and an assessment of community and programmatic needs. A systematic case study approach should be adopted as a method of operational research.	• Develop guidelines and SOPs	NDoH with support of academic institutions
2	**Rural and underserved area allocation** Some Community Service professionals prefer not to work in rural and underserved areas and manage to negotiate/or are allocated to work in urban areas that have relatively good HRH	• The policy should clearly articulate a strict focus on underserved areas in both rural and urban areas where Community Service Officers are allocated and enabled to meet community needs. • **Comment:** Careful attention should be given to impact of greater emphasis on rural placement on the CS show-up rate. If it has a detrimental effect it needs to be rapidly identified and corrected.	• Update policy and track implementation and • Design placement lists with the objective of increasing allocation to rural and underserved areas in mind	NDoH
3	**Conflicting policies** Real and or perceived non alignment of policies and policy clashes impede effective implementation, especially HR, Finance and Higher Education Policies.	• An interrogation of the possible lack of alignment of policies and/or policy clashes should be undertaken, with a priority focus on HR, Finance (including Provincial Bursary administration), and Training and Development areas.	• Assessment of potential policy conflict	NDoH
4	**CS Allocation process** There is no transparency in the allocation of CS posts and the criteria for declining or approval of special requests for alternative placement are not generally known.	• There should be a clear policy and transparent standardized guidelines on the allocation of CS posts. Requests for alternative placements should not compromise the policy objectives, particularly placement in rural, underserved areas, and a system to monitor abuse should be established.		NDoH and PD'sOH
5	**Lack of CSO positions** In some provinces even doctors who have government bursaries cannot be appointed due to unavailable posts for Community Service while a number of recent health inspectors are effectively unemployed due to CSO post shortages	• Forward planning to ensure post availability needs to be done urgently. • **Comment:** If it is impossible to place CSOs due to budget constraints these CSOs need to be exempted from CS	• Reconciliation of anticipated CS placements with funded position	NDoH and PD'sOH

6	**Retention in the public sector** Although CS is designed to encourage retention in the public sector there are no guaranteed post in areas where CS takes place despite these areas being designated as needy.	• Full time positions in the public sector should be marketed to CSOs well before the end of their CS	• Identify vacancies and advertise to CSOs 4 months before their term is completed	NDoH and PD'sOH
7	**Communication** Communication with potential candidates for CS is poor and information of allocated areas not provided ahead of time.	• Communication platforms should be created to allow better communication with CS candidates and to promote benefits of specific posts	• Establish a communication strategy and mechanisms	NDoH and PD'soH
8	**Clinical support** There is a need to attract and retain senior professionals and specialists for clinical support to Community Service and junior professionals in general.	• More peripheral sites should be accredited for academic rotations to ensure increased access to senior professionals for clinical support and exposure to specialties of interest	• Accredit positions for academic rotation	NDoH , Academic institutions and HPCSA
9	**M&E systems** There is no M & E system to monitor up-take of the programme and retention of these health professionals, and no systematic review of the policy to identify and close implementation gaps.	• There should be routine monitoring and evaluation to ensure that the objectives are being met and implementation fulfils policy objectives. Surveys of medical graduates and interns should be supported.	• Implement a M&E system	NDoH and PD'sOH in partnership with Professional Associations
10	**Increasing the role of CS members in facility governance** There is a need to ensure that CSOs voice be heard in governance structures	• Include a position for CSO representative on hospital boards	• Modify guidance around composition of hospital board	NDoH and PD'sOH

iii) Partnerships for Implementation

The NDP Vision 2030 for South Africa calls for all to make a contribution towards the achievement of the identified priority areas, including in HRH. Partnerships include other government departments, community based organizations, non-governmental organizations, regulatory bodies, private sector and other civil society organizations. The areas in the table 7 below were identified where partnership between stakeholders can improve the CS experience.

Table 7: Problem areas that can be resolved through partnerships

	Findings/ problem area	Recommendations	Actions	Responsibility
1	**Accommodation** There is a need for quality dedicated accommodation in underserviced areas for CSOs that will be reserved exclusively for their use	• Developing such dedicated accommodation potentially through PPP's should be investigated. Consideration should be given to models where government provides land, financial guarantees and rentals. Alternatively accessing CSI funding sources should be explored	• Develop a concept document on such a PPP	FPD
2	**Continuing Professional Development** To address professional development concerns consideration should be given to ensuring access to CPD programmes	• Training institutions can be engaged to provide training that is (1) accessible to CS professionals in rural areas and underserved areas (2) relevant to their work and level of experience in and (3) cost effective for either government and/or themselves.	• Provide access to free CPD	Professional Associations, Academic Institutions
3	**Isolation** There is a need to reduce the feeling of isolation by the CS HWs	• Sponsorship for CSOs to attend national conferences would reduce their personal isolation during CS and provide them with professional development • Finding a mechanism through which to link CS-hosting hospitals with Wi-Fi would improve access to training via online portals, as well as allow professional support and training via tele-medicine and video conferencing. • Local senior professionals in the area should be approached for support, including the District Specialist Teams.	• Lobby conference organizers and owners to provide earmarked scholarships • Wi-Fi access should be a minimum criteria for a facility to be accredited for CS	Professional Associations NDOH
4	**Community support** There is a need for local communities to take greater responsibility for ensuring an environment that encourages CS applications and to support the CS professionals.	• The role of communities around rural and underserved facilities should be defined and promoted including community awareness of the services and involvement in providing support. Structures such as clinic committees, hospital boards and ward committees should be involved. • Community members should be included in orientation programmes	• Develop a community engagement and communication strategy	PD'sOH
6	**Automation of application and placement**	• A web based system should be created allowing prospective CS candidates access to potential postings , access information on facilities and apply online	• Secure donor funding	NDoH

	Greater automation of CS applications , selection and post CS placements would improve efficiency and increase transparency			
7	**Orientation** Orientation program are not always available for CS professionals.	• Training and support partners should be engaged to design and implement orientation for CS professionals (cultural, logistical and clinical) based on existing programs.	• Develop and implement programme	AHP
8	**Expand potential clinical supervisors** Facilitate involvement and support of professionals especially in private practice for support to CS HWs	• Private sector professionals should be encouraged to become involved as clinical mentors to CSOs	• Develop database of local health professionals • Develop a twinning programme	Professional Associations
9	**Improved recognition**	• A recognition system for CS professionals should be developed in partnership with the NDoH and PD'sOH which include 1) annual recognition awards 2) Forums for engaging with leadership	• Develop recognition system	Professional Associations in partnership with NDOH and PD'sOH
10	**Technical Assistance** Facility management often does not have the capacity to deal with shortages of equipment, pharmaceuticals and other essentials for providing services.	• Management to be capacitated on supply chain management In addition to adhering to norms and standards like essential drug list and essential equipment list, the option of leasing equipment with maintenance contracts should be considered.	• Prioritise facility based technical assistance to facilities that host CSOs	NDOH and PEPFAR implementation partners
11	**Feedback from CSO participants** With the exception of a series of annual community service surveys , for which the funding is coming to an end, there are no mechanisms to receive feedback from CSOs	• A website could be established which (1) profiles facilities that are available to host CS officers, (2) allows interns to contact facilities or current facility staff to discuss the potential CS opportunities, (3) • A web and App based system should be established allowing rating of facilities by CS participants similar to TripAdvisor	• Develop and website and mobile app	Professional Associations
12	**Documentation of CS completion** Incoherence of the NDoH and HPCSA processes make it difficult for CS in applications and sign off after completion of term	A seamless platform should be introduced whilst acknowledging independence of institutions.	• Integrate this interaction with Professional Councils into the automation system previously discussed	NDOH

iv) RESEARCH GAPS AND PRIORITIES

After noting a number of research gaps and the need to systematically review policy on an evidence based approach, the summit recommended that the Community Service Policy objectives and the HRH Strategy should direct the research questions. Based on findings of available studies and discussions, recommendations in table 8 were made.

	Findings/ Problem area	Recommendations	Actions	Responsibility
1	**Lack of opportunities to promote research and discussion of CS** Systematic review of the CS policy has not been done since inception	• Community service research must be driven by the human resource needs of the country, each province, district and facility, as determined by the HRH Strategy and also WISN.	• Create a platform for regular showcasing of CS research and for discussion	FPD to facilitate inclusion of this subject in relevant conferences
2	**Alignment of research with HRH policy** National HRH Policy and Strategy needs to guide the CS Policy which was promulgated prior to the HRH Policy.	• Research into the Community service program must be framed in terms of the National HRH Strategy, and should both strengthen the strategy as well as be supported by other parts of the strategy	• Identify a research agenda	Research institutions guided by NDoH
4	**Operational research** Operational / Action research should also be an integrated into the CS implementation process	• Qualitative information about community service should also be collected and analysed on an ongoing basis. This is one form of giving the participants voice in their work.	• Promote CS operational research in academic institutions	Research institutions
5	**Cost effectiveness studies** Proving the cost effectiveness of the CS programme and related budgetary issues are key in achieving the objectives and aims of the policy	• Budgeting for posts, the cost-effectiveness of community service, and the follow-up of provincial bursary-holders, are important issues that significantly affect the implementation of community service. Cost effectiveness and efficiency studies should be undertaken	• Promote cost effectiveness studies	Research institutions guided by NDoH
6.	**Understanding drop-off rates** Greater understanding needs to be developed of why there is such a substantial drop-off rate between completion of studies and reporting for CS	• A study needs to be designed to examine this issue	• Implement study	Research institutions guided by NDoH

7. CONCLUSION

Although the National Human Resource for Health Strategy 2012-2017 (HRHS) was not examined in detail, it is clear that the Community Service Policy is still relevant and appropriate in advancing the objectives of the strategy. In essence the data available for doctors show that the CS programme meets the two stated objectives of this programme namely to increase skilled human resources in rural and underserviced areas with around 50% of CD doctors receiving rural allowances, while 80 5 plus of CS doctors report professional growth during their CS year. An unstated objective of CS has been the hope that exposure to a rural practice environment would increase interest of CSOs to practice in such an environment, for doctors this seem to be not the case with only an average of 16% of CS doctors reporting an intention to work in rural and underserved communities over the past 14 years but the percentage expressing this preference has reduced substantially in the last two year to 11% in 2013 and only 2% in 2014.

The review of the last 15 years of experience of community service by doctors and dentists, although not systematic and comprehensive, presents invaluable evidence and lessons including from the various interventions made by provinces to ensure that the policy objectives are achieved. This review identified a need for periodic reviews going forward.

As the countries public health system is dependent on this source of skilled professionals the summit has made a number of recommendations that rely heavily on the concept of multi-stakeholder partnerships to address the weakness and challenges linked to the CS programme. The participants believe that these recommendations need to be implemented and as a matter of urgency to not only ensure the success of this programme but also to improve the acceptability of this programme to the participants. Although the data is not available for all categories of CSOs the trend observed amongst doctors of an increasing number not showing up for CS (16% in 2014) is of concern and should be a major motivation for implementing these recommendations.

8. REFERENCES

Department of Health, 2011. HRH Strategy for the Health Sector: 2012/13-2016/17, Pretoria: Department of Health.

Frehywot, S., Mullan, F., Payne, P. W. & Ross, H., 2010. Frehywot, S., Compulsory service programmes for recruiting health workers in remote and rural areas: do they work? Bulletin of the World Health Organization, 5(88), pp. 364-370.

World Health Organisation, 2010. Global Policy Recommendations: Increasing access to health workers in remote and rural areas through improved retention, Geneva: World Health Organisation 2010.

Annexure A: Summit Programme and Presenters

Community Service for Health Professionals Summit

22 April 2015

The Summit is hosted in partnership by the National Department of Health , the Foundation for Professional Development , the University of Cape Town and the African Health Placements . It is co-ordinated by the FPD Lighthouse Project whose aim is to use research, case studies and other evidence based models to systematically assess Policy Implementation and Impact Gaps that adversely affect achievement of objectives of health policy reforms , and to recommended interventions based on globally benchmarked and locally responsive solutions.

The project predominantly focuses on the implementation of NHI related programs and interventions , including in the pilot districts announced by the Minister of Health. The Lighthouse project provides technical support to the National Health System in identifying as a response to the NDP 2030 vision that commits all stakeholders to make a contribution towards achieving the agreed goals . Ultimately the project aims to support efforts to improve the health care and outcomes, protect citizens against catastrophic health expenditure and achieve significant efficiency gains.

The endorsement of the Lighthouse Project by FPD is also inspired by the experience of FPD and other partners that had to deal with addressing Policy Implementation Gaps in the absence of structures that allow systematic feedback to policy makers. In partnership with the Department of Health , Knowledge-based Institutions and other development partners, the Lighthouse Project will use the Health Observatory as an innovation hub to provide a continuous learning and innovation environment that supports evidence based Policy Research and Development and to close the policy implementation feedback loop.

Reason for the Summit on Community Service

Community Service for Health Professionals Policy was introduces as an important intervention to ensure the availability of Human Resources for Health for underserviced areas. Since its legislation in 1997 and its inception in 1998 with the first group of doctors, the policy of compulsory community service for health professionals has never been systematically reviewed. Originally conceived before 1994as an important part of the ANC Health Plan, its implementation proved to be challenging, but Health Minister saw it through parliament eventually and it was successively extended to all health professional groups. Currently around 6500 newly qualified health professionals undertake a year of community service in public health institutions around the country. The objectives of the programme, to ensure better distribution of health professionals across the country as well as to contribute to their professional development, need to be evaluated. We need to know to what extent they have been achieved or not, whether they are still appropriate and whether they should be adjusted, specifically in the light of the Human Resources for Health Strategy (2012-2017). Secondly the guidelines and operational procedures for implementing community service at national, provincial and local levels, also need to be reviewed accordingly.

Aim and Objectives of the summit

The aim of the summit is use evidence regarding South Africa's community service programme for doctors to raise policy-makers' and programme-implementers' understanding of the implications for policy, for future research, andfor partnerships to support the programme.

This objective will be achieved through the following objectives:

- To understand the Human Resource for Health Strategy 2012-2017
- To review the last 15 years of experience of community service by doctors and dentists
- To review the objectives of the programme
- To review the guidelines and provincial implementationof the programme
- To make appropriate recommendations

Note that while the focus of this summit will be on doctors and dentists, for which the greatest amount of data exists, it is anticipated that the review process will extend to other professional groups in a similar fashion.

The Evidence

A number of independent studies of community service have been carried out over the years, and a significant evidence base exists. This summit initiates a process for reviewing the policy systematically with stakeholders, including the strategic as well as the operational issues before distilling the key findings and options for presentation to the policy-makers. A review of the experience with medical doctors and dentists will be presented, but with the aim of extending this to all health professions in due course. Information on the demographics and throughput data for each professional group, the application and turn-up rates, the allocation process, the experience of the year, as well as the future career plans of community service doctors and dentists will be presented.


NDoH
FPD
Policy Implementation Observatory
University of Cape Town Primary Health Care
AHP
Programme Community Service for Health Professionals Summit:
22 April 2015
Programme Director: Dr Gwen Ramokgopa
Registration 08:00 - 09:00
Opening & Welcome Dr Gustaaf Wolvaardt 09:00 - 10:00
Presentation on Lighthouse Project Dr Gwen Ramokgopa
Presentation on Community Service Policy Dr Terence Carter
Presentation on Research on Community Service Prof Steve Reid
TEA BREAK: 10:00 – 10:15
Discussions 10:15 - 11:00
Commissions 11:00 - 12:00
Policy Issues for review
Partnership for Implementation
Research gaps and priorities
LUNCH BREAK: 12:00 – 13:00
Report Back 13:00 - 14:00
Summary & Way Forward Dr Terence Carter 14:00 - 14:30
Dr Gustaaf Wolvaardt
TEA BREAK: 14:30 -15:00
Supported in part
USAID
FPD

Annexure B: List of summit participants

Title	First	Surname	Organisation
Dr	Mzwandile	Banda	Department of Health Eastern Cape
Ms	Gunile	Buthelezi	National Department of Health
Ms	Annamarie	Cilliers	National Department of Health
Dr	Mlekeleli	Gambu	Department of Health Gauteng
Mr	Nkhetheni	Gelebe	FPD Fellowship Program
Mr	Hennie	Groenewald	National Department of Health (standing-in for Dr Terence Carter)
Dr	Mathabo	Hlahane	Private Practice
Dr	Waleed	Ikram	Kimberley Hospital
Mr	Saul	Kornik	Africa Health Placements
Mrs	Retha	Langa	Africa Health Placements
Dr	Diale	Maepa	Department of Health Gauteng
Dr	Virginia	Makgoba	Medical Women Association of SA
Dr	Khanyi	Makwakwa	South African Dental Association
Dr	Malebo	Maponyane	Medical Women Association of SA
Dr	Matsontso	Mathebula	Sefako Makgatho Health Sciences University (standing-in for Prof Ayo-Yusuf)
Mrs	Wonder	Matlhahlane	Retired – National Department of Health Program Manager
Mrs	Lillian	Mnisi	FPD
Dr	Confidence	Moloko	Chairperson Health & Welfare SETA
Dr	Solly	Motuba	South African Medical Association
Dr	Honjiswa	Mpateni	South African Medical Association
Dr	Jimmy	Mthethwa	Department of Health KZN
Dr	Ntodeni	Ndwamato	Department of Health Limpopo
Dr	Simon	Nemutandani	Department of Health Limpopo
Prof	Yusuf	Osman	Oral Health Centre
Mrs	Julia	Peacocke	Africa Health Placements
Dr	Prinitha	Pillay	Rural Health Advocate
Dr	Mpho	Pooe	Medical Women Association of SA
Dr	Gwen	Ramokgopa	FPD (Consultant)
Prof	Steve	Reid	University of Cape Town
Dr	Johan	Smit	National Department of Health
Mr	Gert	Steyn	South African Medical Association
Mr	Luthando	Tobo	Department of Health Eastern Cape
Dr	Anatjie	van der Wath	University of Pretoria
Dr	Sinah	Vlug	Medical Women Association of SA
Dr	Gustaaf	Wolvaardt	FPD
Mrs	Thembeka	Zondo	Department of Health Mpumalanga