

**EXPERIENCES OF COMMUNITY SERVICE HEALTH PROFESSIONALS WORKING
IN RURAL HOSPITALS OF LIMPOPO PROVINCE, SOUTH AFRICA**

By

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DEDICATION

This study is dedicated to my mother Joyce who sacrificed everything for my upbringing. It is dedicated to your struggles and efforts. I have much love and appreciation for you, mom.

Thank you.

DECLARATION

I declare that EXPERIENCES OF COMMUNITY SERVICE HEALTH PROFESSIONALS WORKING IN RURAL HOSPITALS OF LIMPOPO PROVINCE, SOUTH AFRICA is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

EVANS SHIPALANA

15 April 2019

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I want to thank the following people for their contribution towards this study:

- My wife (Mihloti)...for her love, support and unconditional love.
- My supervisor ...for his guidance and support.
- Community Service Health Professionals ...for participating in the study.
- Department of Health (Limpopo) ...for granting permission to conduct the study.

DEFINITION OF TERMS

Community service

It refers to compulsory service that health professionals perform at public health care facilities after completion of their diploma or degree course (Beyers, 2013). For the purpose of this study, community service is the compulsory one year of remunerated service performed in Limpopo Province public hospitals by newly qualified doctors, dentists, pharmacists, physiotherapists, occupational therapists, speech hearing and audiology therapists, dieticians, psychologists, radiographers and nurses.

Community Service Health Professional

According to the Health Professions Act No 56 of 1974 any person who completed their studies and registering for the first time in the following professions: as a medical doctor, dentist, pharmacist, physiotherapist, occupational therapist, speech hearing and audiology therapist, dietician, clinical psychologist, radiographer or nurse shall perform community service as community service health professional. In the current study, a community service health professional is a person who was performing community service in a Limpopo public hospital in 2015.

Experiences

It refers to the skills and knowledge that a person gains from performing a duty or activity (Beyers, 2013). In the current study experience is knowledge and impression of what community service is as seen from the point of view of health professionals who participated in the community service program in Limpopo rural hospitals in 2015.

Health Professional

It refers to any person who has completed a course of study in the field of health e.g. a nurse (Mosby's dictionary, 2009). In the context of this study, a health professional is an individual who provides preventive, curative, promotional or rehabilitative health care in Limpopo public hospitals.

Rural Hospital

Rural areas are defined as populated areas where local communities farm or depend on natural resources; it includes villages and small towns. In South Africa there is no finite definition of rural. A rural hospital is thus a hospital situated in a defined rural area (Beyers, 2013). In the current study, a rural hospital is a hospital that pays rural allowance to a certain group of health professionals.

ABBREVIATIONS

CS:	Community Service
CSHP:	Community Service Health Professional
HP:	Health Professional
OT:	Occupational Therapist
PT:	Physiotherapist

ABSTRACT

Background: Community service health professionals working in rural areas experience challenges such as poor accommodation, poor supervision, unavailability of equipment and medication. The majority of studies focussed on doctors, with a few including dentists and pharmacists. This study intended to establish the experiences of community service health professionals in all professions.

Objective(s): The objectives of the study were to describe and explore the experiences of community service health professionals.

Methods: A qualitative, exploratory and descriptive study was conducted. Purposive sampling was used to select community service health professionals for the study. Face to face interviews with community service health professionals were conducted to collect data. Community service health professionals were interviewed until data saturation was reached. The Tesch's eight steps were used to analyze data.

Results: The study findings indicated that community service health professionals experienced challenges relating to accommodation, supervision and unavailability of equipment and medication.

Conclusions: Community service health professionals are experiencing challenges regarding working in Limpopo province rural hospitals. It is recommended that the government should allocate more funds to health care services to address the challenges faced by community service health professionals.

Keywords: Community service, Community service health professionals, Experiences and Rural hospitals

CHAPTER 1: INTRODUCTION AND BACKGROUND

1.1 INTRODUCTION

Community service health professionals (CSHPs) are qualified health workers who are fully equipped with the necessary training of their profession. They are deployed to poorly served health institutions to improve the health status of the community. Despite the fact that they often require supervision and guidance from senior professionals, they are capable of handling the majority of health issues on their own. While quality care is made accessible to the communities through this initiative, some recruits report to be benefitting as well. The recruits reported to have grown professionally through independent decision making while making a difference to the community (Reid, 2000).

Health professionals (HPs) that are required to perform community service (CS) after the completion of their studies are Doctors, Dentists, Pharmacists, Nurses, Physiotherapists (PTs), Occupational Therapists (OTs), Speech Language and Hearing Therapists, Radiographers, Dieticians and Clinical Psychologists (Hatcher, Onah, Kornik, Peacocke and Reid, 2014).

Ecuador is one of the international countries that practice the concept of CS for HPs to bolster human resource especially in rural areas. The program also has its challenges and CSHPs in Ecuador were reported to be frustrated by poor accommodation, lack of office space and lack of proper supervision. Despite the frustrations, some recruits felt that doing CS was rewarding as it afforded them an opportunity to understand the state of health services in rural areas (Omole, Marincowitz and Ogubanjo, 2005).

HPs in rural hospitals of Nigeria encounter poor remuneration and lack of equipment as some of their challenges. This contributes towards the exodus of HPs from poor rural areas to more affluent urbanized settings that have better potential for self and professional development. Some of these professionals end up moving to other countries and this puts more strain on the country that is already struggling with other basic human needs (Okeke, 2008).

HPs sponsored by the Umthombo Youth Development Foundations experienced frustration relating to CS while working in rural hospitals (Kwazulu Natal, South Africa). They reported that they didn't feel appreciated or supported by hospital management, district officials and provincial administrators. Some of the frustrations arose from poor accommodation, poor hospital administration and lack of proper equipment. Because of these challenges, they preferred moving to more established urban areas with better resources and thus abandoning their local rural areas (Ross, 2014).

It was observed by the researcher that most of the Community Service Health Professionals in rural hospitals of Limpopo Province prefer to migrate to more urbanised hospitals within the province and out of the province after completion of their one year of compulsory community service year. Some resign from their professions and start new careers. This is despite efforts by government such as payment of variable rural allowance depending on the remoteness of the hospital to some of the Health Professionals in the province as a method to retain them. This trend works against the purpose of community service which is to improve human resource in rural hospitals.

It is the observation of the researcher that rural hospitals in Limpopo Province have limited human resources when compared to hospitals in other provinces or hospitals in urban areas. The movement after community service year by Health Professionals thus compound to the problem of lack of staff. A new group of Community Service Health Professionals is deployed to the hospitals and the one who has served vacate the institution thus limiting continuity of care. In some instances, there may be no new Community Service Health Professional allocated and the hospital has to run without service or with limited service.

It is the view of the researcher that if the experiences of Community Service Health Professionals who work in rural hospitals in Limpopo Province are better understood, hospitals that need to retain them the most will be able to do so easier. This will assist in understanding the plight of community service for health professionals in rural hospitals and thus help to find better solutions to improve the community service program.

The researcher has noted that there are few studies that describe and explore the experiences of CSHPs in Limpopo Province rural hospitals. Most of the studies focus on CS for doctors and nurses while omitting other HPs who also play a crucial role on the state of health in Limpopo Province rural hospitals. This study intends to describe and explore the experiences of different HPs who perform CS in Limpopo Province rural hospitals. An in-depth understanding of the experiences of CSHP in Limpopo Province rural hospitals will help guide intervention strategies required for CS during program evaluation and thus assist the program achieve its objectives.

1.2 PROBLEM STATEMENT

It was observed by the researcher that most of the Community Service Health Professionals in rural hospitals of Limpopo Province prefer to migrate to more urbanised hospitals within the province and out of the province after completion of their one year of compulsory community service year. Some resign from their professions and start new careers. This is despite efforts by government such as payment of variable rural allowance depending on the remoteness of the hospital to some of the Health Professionals in the province as a method to retain them. This trend works against the purpose of community service which is to improve human resource in rural hospitals.

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1.3 PURPOSE OF THE STUDY

The study aim was to establish the experiences of Community Service Health Professionals who are working in rural hospitals of Limpopo Province, South Africa.

1.4 OBJECTIVES OF THE STUDY

- To explore the experiences of Community Service Health Professionals working in rural hospitals of Limpopo Province.
- To describe the experiences of Community Service Health Professionals working in rural hospitals of Limpopo Province.

1.5 RESEARCH QUESTION

What are the experiences of Community Service Health Professionals working in rural hospitals of Limpopo Province, South Africa?

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

Compulsory service programs have long existed and in the 1920s the Soviet Union commenced a three year rural service program for their HPs. Other countries that followed are Mexico (1936), Cuba (1960s), Dominican (1960s), Ecuador (1970s) and Nigeria (1970s) (Omole et al, 2005).

The one year South African version of CS for HPs was introduced for doctors, dentists and pharmacists in 1998 and it later included some professionals in the Allied Health Profession in 2003 as a means to retain human resources and to overcome the maldistribution of HP between rural areas and urban areas, between private and public sector as well as between provinces (Maseko, Erasmus, Di Rago, Hooper and O'Reilly, 2014).

2.2 EXPERIENCES OF COMMUNITY SERVICE HEALTH PROFESSIONALS INTERNATIONALLY

Countries such as Ecuador and Thailand require HPs to do a one year compulsory CS program after completion of their studies. They are required to work in rural areas and their incentives combine educational, employment and living provisions. These HPs receive around US\$ 250 if they don't supplement their salaries in private practice and they are required to complete the one year community service program before they could practice their professions independently. Malaysia, Mexico, Venezuela and Iraq require CSHPs to practice for a year without any form of incentive in rural hospitals. Most of the HPs in these countries object to doing CS because of costs, poor facilities, and shortage of equipment as well as unavailability of medication amongst other reasons (Frehywot, Mullan, Payne and Ross, 2010).

In Canada, the number of HPs working in rural settings is very low. Nurses have become the main primary health care providers and they are expected to provide all the health needs of the communities. The nurses are overworked adding to challenges of recruitment, retention, education, recognition and attention. These challenges are in addition to challenges of aboriginal nurses and all these challenges make the experiences of these nurses to be bad (Hanvey, 2005).

The unfavourable working conditions may lead to inferior quality of services by the nurses and has the potential to affect other professionals especially CS personnel who may not have developed adaptive skills to such working conditions. The challenges experienced by the professional nurses in the rural setting may contribute to the nurses moving to urbanized institutions that will have better human resources. This will further weaken the health system (Hanvey, 2005).

In China, the distribution of HPs is dependent on market instead of the government. HPs practice anywhere they wish to. To cater for rural areas, students are provided free medical studies for working in rural areas when they complete their studies. The newly graduates are provided career development opportunities, better compensation and in service training to improve their skills. Partnership with urban hospital centres is also used to improve the HPs skills (Hou and Ke, 2015).

2.3 EXPERIENCES OF COMMUNITY SERVICE HEALTH PROFESSIONALS IN AFRICA.

Countries such as Mozambique and Kenya provide incentives that are family and resource linked such as housing and lower car loan rates to the HPs doing CS in the rural hospitals. Zambia further provides scholarships for the children of HPs in rural hospitals in order to improve retention after completion of the CS year (Frehywot et al, 2010).

In Tanzania, HPs in rural hospitals encounter problems related to under-staffing, lack of supervision and training as well as having to work beyond their scope of practice. HPs felt that because most of their interventions were trial and error, they were gambling with patient's lives (Manongi, Marchant and Bygbjerg, 2006).

2.4 EXPERIENCES OF COMMUNITY SERVICE HEALTH PROFESSIONALS IN SOUTH AFRICA

In a study conducted by the Human Science Research Council (HSRC) for the Health Professions Council Of South Africa (HPCSA) to evaluate the experiences of CS dieticians in all South African Provinces, they reported lack of resources (work space, nutritional supplements and equipment), difficulty for the CSHP to start a new department and poor understanding of the role of dieticians by medical staff as some of their findings (Steyn, 2012).

CS OT's reported less room for personal and professional growth when working in South African rural hospitals and hence they consider moving to urban hospitals that have bigger departments and better supervision by senior OTs (Maseko et al, 2014).

Few CS doctors remain in rural public hospitals in Limpopo Province despite that majority considered that they had made a good impact in the community they served. Reports indicate that CS doctors are overworked and not satisfied with their working conditions (Nemutandani, Maluleke and Rudolf, 2006).

Professional nurses working in primary health care settings in Mopani district of Limpopo Province have been reported to be experiencing burnout due to staff shortages. They are sometimes expected to perform duties of other HPs who are not available in their setting thereby compounding on the problems that stems from nurse shortage. This experience affects CS nurses who are deployed to work in rural hospitals in the region (Mohale and Mulaudzi, 2008).

Hatcher et al (2014) have recommended an emphasis on professional development and supervision for CSHPs in order to retain HPs, improve their skills and distribute HPs equitable. This was an effort to make the experience of community service to be more pleasant and to enable community service professionals to be focus on the objectives of the community service year. With the recommendations applied the community service year is supposed to benefit the both the community and the health professionals involved.

However most of the recommendations have not been partially applied or not applied at all due to various factors. As an example there has not been advertisement of new profession specific senior posts or the filling of senior posts that are vacant in Limpopo Province hospitals such as chief posts and assistant director posts for Allied Health Professions. CSHPs in this field find themselves in dire situation such as having to run a department and to be supervised by professionals not in their health profession.

CHAPTER 3: METHODOLOGY

3.1 INTRODUCTION

This chapter describes the research methods, study site, study population, sampling method, inclusion and exclusion criteria, data collection, data analysis, trustworthiness and ethical considerations that were used to find answers to the objectives of the study.

3.2 RESEARCH METHODS (QUALITATIVE, EXPLORATIVE AND DESCRIPTIVE)

A qualitative, descriptive and exploratory study was conducted to establish the experiences of community service health professionals in Limpopo rural hospitals.

In a qualitative research approach, the researcher observes the everyday life of the subject and the point of view of the subject is used to describe and understand the issue under investigation. The researcher investigates the issue about the subject while the subject provides a description to answer why the phenomenon happens in that specific way (De Vos, Strydom, Fouche` and Delpont, 2011). The approach was relevant because the study intended to describe the experiences of Community Service Health Professionals in Limpopo Province rural hospitals as explained by the Community Service Health Professionals. Correct inferences were made from the collected data since the information was solely based on the Community Service Health Professionals perspective and description of their experiences of Community Service.

De Vos et al (2011) explained that exploratory research aims to gather as much information as possible about a person, phenomenon or situation. It could also be used to satisfy the researcher's curiosity or used to get a better understanding of a topic. The study intended to do an in-depth understanding of the experiences of Community Service Health Professionals in Limpopo Province rural hospitals. An exploratory research design was thus used to gather detailed information in order to establish and understand the experiences of the Community Service Health Professionals working in rural hospitals of Limpopo Province. Explorative design is relevant because the study intends to explore the experiences of community service professionals.

Descriptive research depicts the participant in an accurate way in a study. It aims to observe, describe and record aspects of a situation (Babbie and Mouton, 2007). The researcher intended to establish and describe the experiences of the Community Service Health Professionals working in Limpopo Province rural hospitals by doing a survey in Waterberg district. Descriptive design was relevant because the study intended to describe the experiences of community service professionals.

3.3 STUDY SITE

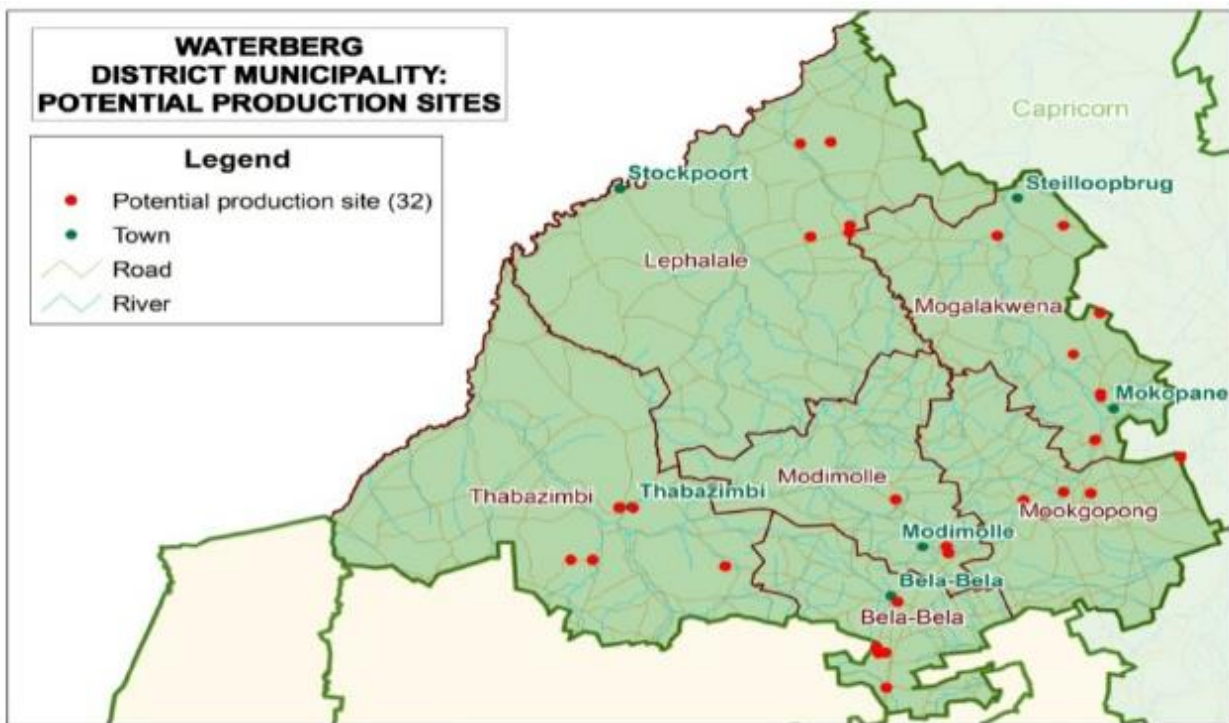


FIGURE 3.1: A map of Waterberg district municipality

There are 43 hospitals in Limpopo Province and they are located within five districts. The study took place in Waterberg district in Limpopo Province. The researcher obtained information from the office of the Waterberg district executive manager that there are 08 hospitals in the Waterberg district. The only provincial hospital in Waterberg district is Mokopane hospital with two hundred and sixty six (266) usable beds. Mokopane hospital provides secondary level hospital care services and specialised care services in the following fields: General surgery, Orthopaedics, Obstetrics and Gynaecology, Psychiatry, Paediatrics, Internal medicine and Family medicine.

The other 07 districts hospitals in Waterberg district have the following usable bed numbers: Voortrekker hospital (96), FH Odendaal hospital (116), George Masebe hospital (143), Belabela hospital (193), Witpoort (59) hospital and Ellisras hospital (108). The district hospitals provide primary level hospital care services and general medical care. The researcher arranged for an appointment with the participants to meet at a venue and time that was convenient for the participants.

3.4 STUDY POPULATION

A population in a study is the entire set of individuals of interest to the researcher (Gravetter and Forzano, 2009). Doctors, Dentists, Pharmacists, Physiotherapists, Dieticians, Clinical Psychologists, Occupational Therapists, Speech language and Hearing Therapists, Radiographers and Nurses who were employed as Community Service employees in 2015 in rural hospitals of Limpopo Province Waterberg district were identified and selected.

Through the Human Resource Development and Planning office of the Limpopo Province Department of Health, the researcher established that in 2015 the total number of Community Service Health Professionals in Limpopo Province hospitals was five hundred and forty (540). Ninety six (96) of these Community Service Health Professionals were placed in Waterberg district. The number allocated for each category of HPs was as follows: Doctors (19), Dentists (05), Nurses (18), Pharmacists (15), Psychologists (03), Speech Language and Hearing Therapists (04), Radiographers (10), Occupational Therapists (09), Physiotherapists (05) and Dieticians (07).

3.5 SAMPLING METHOD

A sample is a subset of the population that is selected for the study (Grove, Gray and Burns, 2013). Purposive sampling method was used to select the participants. This sampling method was used for the identification and selection of information rich cases. Individuals who were willing and available to participate in the study were identified and selected. They also had to be knowledgeable and experienced in community service in order to be selected. The participants should also be able to express and articulate their experiences in a reflective way so that the researcher can gather as much information as possible about the experiences of community service (Cresswell and Plano Clark, 2011). Community Service Health Professionals were randomly selected from different fields of health care for a one on one interview until saturation was reached.

3.6 INCLUSION AND EXCLUSION CRITERIA

- Inclusion criteria

The study included all Health Professionals who were employed as Community Service employees in 2015. The Health Professionals who were part of the study were those who have been employed as Community Service Health Professionals between 01 January 2015 and 31 December 2015. Those that were employed after the 1st of January 2015 were not part of the study.

- Exclusion criteria

The study did not include Community Service Health Professionals who commenced their employment on a date earlier than the 1st January 2015 or later than 31st December 2015. Community Service Health Professionals who resigned from public service and those that moved to other provinces did not form part of the study.

3.7 DATA COLLECTION

Interviews were used to get an insight to the experiences of working in a rural hospital as a community service health professional (Edwards and Holland, 2013). Unstructured interviews were conducted an interview guide because they allowed the interviewer to be flexible and alter questions depending on the answers provided by the community service health professionals (MacDonald and Headlam, 2009).

An appointment was made with the community service health professionals for an interview. Interviews were conducted in offices organised by the community service health professionals. Upon arrival of the interviewer in the hospital premises, a comfortable place was chosen by the community service health professional where the interview could be conducted.

The purpose of the interview was explained before the interview. The central question for the interviews was: **What are the personal experiences as a community service health professional in a Limpopo Province rural hospital?** Community service health professionals were asked probing questions as a follow up to their responses to the central question in order to guide the interviews and gather as much information about their experiences as possible. This was done to get an in-depth understanding of the experiences of the community service health professionals. A voice recorder was used to record the interviews. Each interview proceeded until no new information about the experiences of community could be provided by the community service health professionals (data saturation).

Data was collected from the following institutions: Mokopane hospital, Voortrekker hospital, George Masebe hospital, Witpoort hospital, Elisras hospital, Bela-Bela hospital, Thabazimbi hospital and Modimolle hospital.

3.8 DATA ANALYSIS

From the interviews, data was first transcribed verbatim. Data was analysed using the eight (8) steps of Tesch method of data analysis described by Theron (2015) as follows:

Step 1

To get a sense of the whole, the researcher carefully read through the thirty transcripts. This gave the researcher the necessary background information. All the ideas that came to mind while reading through the transcripts were written down.

Step 2

The researcher read through the thirty transcripts and he asked himself what individual transcripts were all about. His focus was on the topic of individual transcripts and not the content of the transcripts. The topics were written in the margin of the document.

Step 3

After completing the procedure for all transcripts, the researcher made a list of topics, one column per transcript, placing all the columns in one sheet. The researcher compared the topics and grouped similar topics together. The grouped topics were put in columns with the following headings: major topics, unique topics and leftovers.

Step 4

The researcher then abbreviated the groups as codes. With the list of codes, the researcher went back to the transcripts and wrote the codes next to the appropriate segment of the text. The process was repeated until no new categories and codes emerged.

Step 5

The researcher used the most descriptive words for the topics which had begun to turn into categories. The researcher reduced the number of categories by grouping those that were related to each other. The researcher also looked for subcategories and wrote them down.

Step 6

The researcher made a final decision on the abbreviation for each category and he alphabetized the codes to ensure that duplication does not occur while bearing in mind that a segment of data can fit in two or three categories.

Step 7

The researcher put the data belonging to each category together and performed a preliminary analysis, looking at all the material in one category at a time. The focus of the researcher is now on the content of each category. During this process the researcher kept the research question (What are the experiences of Community Service Health Professionals working in rural hospitals of Limpopo Province, South Africa?) in mind in order to discard irrelevant information.

Step 8

The researcher recoded the existing data to ensure that no new categories and codes emerged.

3.9 TRUSTWORTHINESS

For a qualitative study to be trustworthy, the study's worth should be evaluated. The aspects considered when evaluating a qualitative study's worth are how genuine the study is, how applicable it is to other studies, how consistent the study is and how neutral the researcher is. The four criteria to establish trustworthiness are credibility, transferability, dependability and confirmability (Lincoln and Guba, 1994).

- Credibility

Credibility is established if it can be demonstrated that the research was conducted in a way such that the process was accurately identified and described and the truth of the data and its interpretation is confidently achieved (Mohale and Muladzi 2008). It's a measure of how the results resemble reality.

According to O'Donoghue and Punch (2003), triangulation is a method of cross-checking information from many sources in order to search for regularities in the research data. It is thus a way of ensuring data is credible and valid. The researcher verified the information given by participants by checking on records and confirming with relevant stakeholders as well checking the physical structures where possible (triangulation).

An independent coder experienced in quality research was used to ensure that the results of the study provided by the researcher are a correct interpretation of the interviews on experiences of community service health professionals in Limpopo province rural hospital.

- Transferability

Transferability allows the researcher to describe and present data in such a manner that another researcher can compare them to findings of other studies (Mohale and Mulaudzi, 2008). It ensures that study findings can be used elsewhere. The findings were described within the right context and the study method was explained in detail for those who may need clarity when using the findings of the study.

- Dependability

Dependability is determined by the extent to which the findings of the enquiry could be replicated with the same subjects in the same context (Mohale and Mulaudzi, 2008). The information was gathered until saturation was achieved where possible. Data was continuously analysed to inform further data collection. The researcher was flexible with the data collection and data analysis process.

- Confirmability

To have confirmability, it is vital that the researcher be neutral. The researcher's perspective should not impact the study and there should be no bias (Mohale and Mulaudzi, 2008). The researcher checked if there was information that contradicts what the participants have given during the interview. The research was performed with supervision and guidance from people experienced in public health research. The researcher reflected on his role during the research process from the diary of events he would kept. The voice recorder was be used to verify the correctness of the field notes.

3.10 ETHICAL CONSIDERATIONS

According to the South African Department of Health's Ethics In Health (2015), the ethical principles are described as follows: beneficence and non malificence, justice (equality) and respect for persons (autonomy and dignity).Some of the ethical considerations are informed consent, confidentiality, privacy, risk of harm and likelihood of benefit.

- Beneficence and non malificence

This is ethical obligation to maximize benefit and minimize harm. The results of the study could be used by Limpopo Provincial Health Authorities as a guide for planning of human resources. No information was manipulated to harm the participants and anyone who could be affected by the results including government and non governmental institutions.

- Justice (equality)

This implies that there should be shared balance on the risks and benefits of the study amongst all role players in the study. The results of the study are not intended to benefit one group of Community Service Health Professionals while unfairly denying other groups of Community Service Health Professionals an equal opportunity of benefits.

- Respect for persons (autonomy and dignity)

This implies that persons capable of deliberation about their choices must be treated with respect and permitted to exercise self determination. The participants were allowed to talk about their experiences without intimidation and judgement by the researcher. The information provided by the participants was held in strict confidence and was used for the purpose of the study only.

- Informed consent

Participation in research should be voluntary and guided by informed choices. Before the research starts, participants were informed about the purpose of the study and they were allowed to withdraw from the study at any point during the study or not participate if they opted to do so. An information sheet about the research was given to the participants before the interview could begin. The participants also signed on the consent form to acknowledge that they understand and are willing to participate in the research. Participants were granted permission to ask questions about the research if they wished to do so.

- Confidentiality and Privacy

Research participants have a right to confidentiality and privacy. Privacy has to do with who has personal information and records of the participants while confidentiality is about ensuring that measures are in place to prevent disclosure of information that may lead to the identification of the participant. Personal information about the participants was not disclosed without permission of the participants. The participants were not identified by names including those who willingly named themselves. The information collected was used for the study purposes only.

- Risk of harm and likelihood of benefit

The likelihood of benefit should outweigh the risk of harm to the participants, the researcher and the community when conducting research. During the study, no harm was done to anyone and there were no incidences. The research report is truthful and objective about the experiences of Community Service Health Professionals in 2015.

Permission to conduct the study was given by Turfloop Research Ethics Committee (TREC) and permission to conduct the study in the hospitals was as also by the Department of Health (Limpopo Province). Written consent to participate in the study was obtained from the participants and participant's names were not divulged. The information obtained was not used for other purposes except for the study only.

3.11 CONCLUSION

The research methodology that was adopted was relevant for the study because it successfully addressed the aims and objectives that were outlined earlier in the study. The research methodology used was able to bring the results that are outlined and discussed in chapter 4.

CHAPTER 4: DISCUSSION, PRESENTATION AND INTERPRETATION OF FINDINGS

4.1 INTRODUCTION

In chapter 3 the following headings were discussed: research methods, the study site, study population, sampling, inclusion and exclusion criteria, data collection, data analysis, trustworthiness and ethical consideration employed in the study. This chapter focuses on the findings and discussions of the study and the supporting literature.

4.2 DEMOGRAPHIC DATA OF PARTICIPANTS

The sample consisted of 30 participants who were community service health professionals in 2015 in the eight Waterberg district hospitals. Only community service health professionals in the following categories were available to participate in the study: Pharmacists(6), doctors(4), physiotherapists(4), dentists(2), dieticians(4), occupational therapists(3), speech language and audiology(hearing) therapists(2), radiographers(2) and nurses(3). No psychologists were available to participate because they were not retained by the department after community service.

A summary of the demographic data of the participants is given in a table below:

PROFESSION	FREQUENCY
Pharmacists	6
Doctors	4
Physiotherapists	4
Dentists	2
Dieticians	4
Occupational Therapists	3
Speech Language and Audiology(Hearing)	2
Radiographers	2
Nurses	3
Psychologists	0
TOTAL	30

TABLE 4.1: Demographic data of participants

4.3 THEMES AND SUBTHEMES

An analysis of the collected data resulted in 3 themes and 9 subthemes emerging. The sub themes and themes that emerged are summarized in a table below.

THEMES	SUBTHEMES
The general conditions of accommodation were not satisfactory	Debilitated buildings Uncared for environment Unmaintained household goods and appliances Uncoordinated housing arrangements Unavailable houses or rooms
The general quality of supervision was not satisfactory	Unavailability of supervision Inadequate supervision
The availability of equipment and medication was generally unsatisfactory	Shortage of equipment and medication Unmaintained equipment

TABLE 4.2: Themes and subthemes

4.3.1 Theme 1: The general conditions of accommodation were unsatisfactory

In this study, there was a consensus amongst the participants that the accommodation conditions were generally poor because of the debilitated buildings, uncared for environment, unmaintained household goods and appliances as well as uncoordinated housing arrangements.

4.3.1.1 Subtheme 1: Debilitated buildings

Debilitated buildings have weakened structures because they are old and not well maintained. Debilitated buildings pose a danger to the residents and their property because they can crumble and fall down thereby injuring those inside or causing damage to the property inside. Debilitated buildings expose residents to criminals and bad weather conditions hence they are unsafe. According to Kotzee and Couper (2006), unsafe houses that are falling apart are a challenge to community service doctors and the state of the buildings also contributed to poor retention of the doctors. The majority of the CSHPs in this study also emphasised dissatisfaction with the state of the buildings.

The problem of old houses was described in the following statement made by a CS doctor:

“Accommodation was not that bad because they have, for comm serve and MOs and any other staff there but the problem is that some of the houses that were allocated are not in good condition and the hospital budget they don’t have money to fix those things the houses some of them are not in good shape”.

The problem posed by old houses was also supported by the statement made by a CS dietician who said:

“The house I was staying in was a bit too old and some things were not functioning. If I rate out of 10, I would rate where I stayed 5”.

4.3.1.2 Subtheme 2: Uncared for environment

An uncared environment is one that is not well cleaned and not well maintained. It could pose a danger by harbouring creatures that could harm residents. According to Kotzee and Couper (2006), CSHPs experienced challenges of unclean housing environment and this led to some moving away at the end of the year. The CSHPs working in Limpopo rural hospitals also indicated dissatisfaction with the housing environment. They were unhappy because the environment was not well kept and it posed a danger to them.

The problem of uncared for environment was described in the following statement made by a CS occupational therapist:

“.....there was no cleaners and it was old, basically it was not well taken care of, even in the outside it was not clean, you would find there are bushes outside where there are snakes and it was a bit of a challenge and dangerous for us”.

A CS dietician described the problem of uncared environment as follows:

“I started community service in March 2015 and I had a challenge with accommodation because I was given a house that was not clean and the surroundings were not clean as well”.

4.3.1.3 Subtheme 3: Unmaintained household goods and appliances

Unmaintained household goods and appliance are not in good condition because they were not serviced or properly fixed. They are prone to failing when they are in use. Some of the goods and appliances such as geysers and stoves could cause the users harm by electrocution .Kotzee and Couper (2006) indicated that due to budgetary constraints, some of the government properties in the hospital residences were not maintained or serviced. This was a challenge to CSHPs who depended on these goods and appliances.

The CSHPs working in Limpopo rural hospitals experienced challenges due to the household goods and appliances that were not maintained. They were concerned that some of the goods and appliances were unsafe to use.

A CS pharmacist made the following statement about unmaintained household goods and appliances:

“The household appliances were not in good working condition and it was difficult to get them repaired or replaced. The appliances were hazardous and community service health professionals had to buy or fix appliances that were not working”.

The problems of unmaintained household goods and appliances was also mentioned by a CS physiotherapist who said:

“The geysers are sometimes not working, the toilets and maintenance promise to come and fix it and they take two to three weeks and the lights”.

4.3.1.4 Subtheme 4: Uncoordinated housing arrangements

Failure by those who are responsible for allocation of accommodation to ensure that CSHPs have accommodation on time and that the allocation process is above board and satisfactory causes unnecessary anxiety to the CSHPs. The CSHPs working in Limpopo rural hospitals were concerned that those who were responsible for allocation of houses or rooms didn't seem to have a well coordinated or consistent method of allocating houses. They felt that the house allocation policy guidelines were neglected and sometimes abused by those in charge and community service health professionals were treated unfairly.

A CS physiotherapist indicated his dissatisfaction with the uncoordinated housing arrangements in the following statement:

"Today you are sure that you are occupying a certain room and tomorrow you are threatened that a certain doctor is coming to stay or the hospital is hiring more doctors even though you knew that you have the right to stay in the hospital as comm serve in my hospital it was a challenge."

The concern about uncoordinated housing arrangements was also indicated in a statement by CS dentist as follows:

"Where I was staying I saw that accommodation was good, but the way people of logistics were dealing with the issue of vacating people from the hospital, I would say it was a bad experience. You know about accommodation they will tell you about their policies that are not implemented like the first in first out if then they want to take you out of the hospital and there are people who have been staying for a long time still remain".

4.3.1.5 Subtheme 5: Unavailable houses or rooms

CSHPs were frustrated when there was no room or house allocated for them when they arrived in the hospital for the first time. Nmutandani et al(2006) found that CS doctors experienced shortages of accommodation when working in Limpopo Province rural hospitals. The CSHPs indicated that they couldn't access rooms or houses and had to make alternative sleeping arrangements elsewhere on their own.

A CS in speech, hearing and audiology described the problem of unavailable houses or rooms as follows:

“When I got here they told me that I will be staying somewhere so when I asked why because most of the comm serves are staying in the hospital premises because it is their first year so they just told me that this hospital you can't be staying here there is not enough accommodation the priority is only given to doctors.”

The problem was also indicated in the following statement made by a CS dietician:

“They said they don't have room for me since they didn't know I was coming so I had to wait for a month and half to get accommodation”.

The CSHPs were unhappy with the kind of accommodation they were allocated, They were unhappy with the quality of the houses they were offered because the structures were old .They were concerned about the unsafe environment around the houses that had been neglected and not cared for. The household goods and appliances were not in good condition and they had to use their own money to repair them. They were also worried by the uncoordinated housing arrangements that were not consistent.

The study are consistent with the findings of Mohale and Mulaudzi (2008) who found that nurses were frustrated by a lack of basic necessities such as accommodation, electricity and running water while working in rural primary health settings in Mopani district. Hatcher et al(2014) indicated that concerns of accommodation was a predictor of whether health professionals will work in rural areas in the future or not and this may encourage health professionals to move to more established areas. This could be amongst the reasons why most of the CSHPs had moved elsewhere after their CS year was over.

4.3.2 Theme 2: The general quality of supervision was unsatisfactory

In this study, there was a consensus that the general quality of supervision was unsatisfactory because there was lack of supervisors and where there was supervision, it was substandard.

4.3.2.1 Subtheme 1: Unavailability of supervisors

When there is no senior member of staff of staff available in their health category to guide them, it will be difficult for the CSHPs to handle some of the advanced challenges. According to Nmutandani et al (2006), CSHP tend to underperform when they have no supervisors available for support. The CSHPs also doesn't develop their clinical skills and confidence fully. The CSHPs working Limpopo rural hospitals faced challenges because they did not have supervisors.

A CS physiotherapist had the following to say about unavailability of supervisors:

“I was thrown into the deep end I had to find innovative ways to assist our patients and treat our patients, but also felt that there were no people employed in the higher posts, because the lack of not necessarily supervision but knowledge from someone to go to”.

A community service doctor made the following statement when describing their experiences about unavailability of supervisors:

“You are allocated to the ward alone there is no senior person to assist you weather you want second opinion from someone there is no one available n the hospital and sometimes it was difficult to get second opinion from level 2 or level 3”.

The findings of the study are consistent with the findings of Beyers(2013), who indicated that community service health professionals in Western Cape were worried about the lack of supervisors when deployed in rural hospitals. They felt that there were more supervisors in urban hospitals than rural facilities.

4.3.2.2 Subtheme 2: Inadequate supervision

When the supervision that is available is not enough or not of good quality, it could be a challenge to the CSHPs because the support provided is less than what is required. Nemutandani et al (2006) indicated that the more specific teachings from the supervisors such as those that are given during ward rounds ensure that CSHPs are able to cope with their clinical duties. The CSHPs in this study experienced challenges due to inadequate supervision.

A CS nurse made the following comment about inadequate supervision:

“When I came here I was working only with the staff nurses, there was no registered nurse and all the registered nurses were taken to maternity and I was the only comm serve.....I was supervised by a staff nurse.”

A community service occupational therapist made the following statement to describe their experience of inadequate supervision:

“We didn’t have guidance about how you do this and how you do that, like how to order equipment I had to go to other departments for assistance.”

Another community service nurse said the following statement about inadequate supervision:

“In the wards it was another issue a comm serve is not supposed to be left alone but with us we were left in that unit alone. Managing conditions on our own with no one correcting you. I was treated as somebody who was experienced already and I was thrown into the deep end and it was not so easy.”

CSHPs were not satisfied with the quality of supervision they received. They were concerned that they didn’t have senior staff that they can report directly to within their field. Some of the CSHPs indicated that they were reporting to senior staff members who were not in their field and had limited knowledge of the complexities outside their field. There were reports of supervisors who expected CSHPs to perform all duties in the section despite limited knowledge. The findings are consistent with those of Nemutandani et al(2006) who found that CS doctors received limited or poor clinical support in Limpopo province. They also found that the CS doctors indicated that patients were likely to die because of system failure resulting from lack of more experienced staff intervention.

4.3.3 Theme 3: The availability of equipment and medication was generally unsatisfactory

In the study, there was a consensus amongst the participants that the availability of equipment and medication was generally unsatisfactory. This is because there was shortage of equipment and medication or the equipment was not well maintained.

4.3.3.1 Subtheme 1: Shortage of equipment and medication

When equipment that is needed to perform day to day duties is not enough, it poses challenges to CSHPs. According to Kotzee and Couper(2006),the shortage of equipment and medication causes stress and impacts negatively towards job satisfaction. The CSHPs experienced challenges due to shortage of equipment and medication.

A CS doctor had the following statement to say about the shortage of equipment and medication:

“I was working in maternity and we use CTGs that are used to monitor foetal heart rate while the mother is still pregnant also there are times when we don’t have those machines and are essential in high risk pregnancies but they will tell you there is no budget. In casualty we don’t have a blood gas machine, we don’t have a ventilator in the whole hospital most of the time you have to transfer your patients out because you cannot manage fully. Even in paed’s we didn’t have a CPAP machine since last year so it is a limitation overall for our practice and you feel like you are not learning those skills because you are not practicing”.

A CS physiotherapist made the following statement about the shortage of equipment and medication:

“Since last year we don’t have TENS or ultrasound so we only have hot packs and we have been struggling since and when we try to buy new equipment they say we don’t have a budget”.

A CS pharmacist made the following comment about the shortage of equipment and medication:

“They will tell you at pharmacy they don’t have it and at depot they don’t have it so you find that there is not even an alternative and you have to write the script for the patients and some of the patients cannot afford. When patients can’t afford their essential medication it is frustrating because they will just come back and complicate and you won’t be able to help them”.

4.3.3.2 Subtheme 2: Unmaintained equipment

When equipment is not performing at its optimum level because it has not been serviced or fixed ,it can cause challenges to the CSHPs. According to Ross and Reid (2009),CSHPs lack reliable equipment in the hospitals that they can work with. The unreliable equipment reduces the quality of work and may even be detrimental to the patients. CSHPs in this study experienced challenges due to unmaintained equipment.

A CS radiographer made the following statement about unmaintained equipment:

“Our equipment is old and does limited things often breaks.”

A community service pharmacist made the following statement to describe their experiences of unmaintained equipment:

“We have a machine that counts tablets and it is difficult when the machine is not working, sometimes we do it manually which takes out our time if the machine is working we do it quicker”.

A community service doctor said:

“For instance since last year we only had working sonar for two months and the entire year it was not fixed.”

The CSHPs were faced with situations where they didn't have the necessary equipment to perform their duties. Nmutandani et al(2006) found that the majority of doctors experienced a lack or shortage of equipment at some point during their work. They had to improvise and limit their interventions. This also reduces their impact. They didn't have the essential medicines for patients and thus the quality of their care was unsatisfactory.

They also were faced with a situation where equipment was not well maintained and thus posing a danger to the patients and themselves. This was consistent with the findings of Mohale and Molaudzi(2008) that nurses generally experienced an inadequate supply of drugs while working in Mopani primary health care settings.

CSHPs also had other negative experiences such as the poor general conditions of infrastructure, very low salaries than what they expected, human resource departments that delayed appointments and payments as well as being worried that they may not find employment after CS. This is supported by the following statements:

“The wheelchairs were here and there was no enough space for the patients and the issue of privacy we even had to swap rooms because people would pass through while we were treating patients to the office and we made the office the treatment room and the treatment room the office”.....(Community service occupational therapist)

“To me it seems like there is no continuation after comm serve you are on your own. You are still going to struggle to find a place where you will be working”..... (Community service pharmacist)

“The first thing is that our appointment was done late so we didn’t get paid the first month and we went the whole month without being paid and we didn’t have money to fall back on”.....(Community service speech, language and audiology therapist)

“The other challenge that we had was with HR people because when you start community service as a comm serve they didn’t pay us our overtime and we had submitted all our things and we had to call district office that’s when they started paying us mid month”.....(Community service radiographer)

“When I open my pay slip I was de motivated. I felt like I have been robbed.....because of the removal of the 37% and besides even if there was the 37% but if you have to compare with other provinces and fellow colleagues that you did the same four year course but they will be earning more than yourself”.....(Community service physiotherapist)

Mohale and Mulaudzi(2008) found that nurses had infrastructure constraints and were not well remunerated when working in Mopani primary health care setting. In this study CSHPs found that the space to work in was very limited and did not have enough rooms to work in or to store their equipment. This has limited their intervention. They were worried that their remuneration was not enough. They experienced difficulty because the process of employment took longer and this led to delayed payments of salaries and benefits. They were also worried that they may not be able to get employment after completion of the CS year. They were concerned that if they were to find work, it would be likely in a new environment.

CHAPTER 5: SUMMARY, RECOMMENDATIONS AND CONCLUSIONS

In chapter 4, the results of the study were discussed and the latest literature was used to support the results. This chapter outlines the conclusion that can be drawn from the study. The chapter also displays the limitations of the study and it also suggests the recommendations that can be employed to deal with the challenges of poor accommodation, Poor supervision, Lack of equipment or medication and other negative work related experiences of the community service health professionals.

5.1 SUMMARY

The issue of poor accommodation, poor supervision, lack of equipment or medication and many other negative experiences by health professionals in South Africa is well documented.

CSHPs are new into the working environment. They are usually sent to unfamiliar environments where they are already exposed to barriers such as language used in the local community. The fact they may not have enough resources to sustain themselves yet because they are new is also key. Hence they require a friendly environment where they can settle and begin their working life. The environment should be conducive for work and outside work in order to help the CSHP thrive in the new place.

It is of great concern to learn that CSHPs experienced neglect in the hospitals because they are supposed to strengthen the Provincial health system and provide a corner stone where quality and accessible health care can be dispensed to the community. The HIV epidemic that is affecting rural communities implies that we need more professional health workers to deal with the disease and its associated health problems. However, negative experiences may deter those who have just finished CS from remaining in the rural areas where they are needed the most.

Improved living conditions and hospital environments that permit personal and professional growth are the key to retaining CSHPs who are critical in the combat against diseases.

5.2 RECOMMENDATIONS

The study was performed in Waterberg district only and it did not cater for the other 4 districts. In some professions such as psychology, they had all moved out of the district and some had only few remaining within the district. The study does not indicate success or failure of the departmental retention.

5.3 CONCLUSION

An active community service committee should be established at district and provincial level with the purpose of guiding newly qualified CSHPs. The committee should be able attend to the needs of CSHPs. There is a need to build accommodation in rural hospitals and to re-establish the old buildings in order to improve quality of accommodation. There is need to allocate more money on the budget for health with the bulk channelled to equipment and medication. Without the proper working tools the health outcomes will be dire. There is need to have senior professionals at each section whom CSHP can learn and gain support from. Sections that are run by inexperienced CSHPs are not an ideal setting for quality health care. Hence senior health professionals should be hired at relevant posts.

REFERENCES

- Babbie, ER & Mouton, J. 2007. *The practice of social research*; 11th edition. Cape Town: Oxford University Press.
- Beyers, B. 2013. Experiences of community service practitioners who are deployed at a rural health facility in the Western Cape. M Cur dissertation. University of Western Cape, Cape Town.
- Cresswell, JW & Plano Clark, VL. 2011. *Designing and conducting mixed method research*. 2nd edition. CA: Sage.
- De Vos, AS, Strydom, H, Fouche', CB & Delport, CSL. 2011. *Research at grass roots for social sciences and human service professions*. Pretoria: Van Schaik.
- Edwards,R & Holland,J.2013.What is qualitative interviewing? London: Bloomsbury.
- Journal Special Issues, Applied Linguistics (2011).Ed Richards
- Frehywot, S, Mullan, F, Payne, PW & Ross, H. 2010. *Bulletin of World Health Organisation*. Compulsory programmes for recruiting health workers in remote and rural areas.do they work? 88:364-370.
- Gravetter, F.J., & Farzano, L.A B. (2009). *Research methods for the behavioral sciences*. Belmont, CA, Wadsworth Cenage Learning.
- Grove,S.K.,Gray J.R.,Burns N.(2013). Understanding nursing research. E- book :Building an evidence based practice. Elsevier Health Sciences.
- Hanvey, L. 2005. Rural Nursing Practice in Canada. A Discussion Paper prepared for the Canadian Nursing Association: Draft 3, September 2005. CNA:Ottawa.
- Hatcher, AM, Onah, M, Kornik, S.Peacocke, J & Reid, S. 2014. Placement, support and retention of health professionals. *Human Resource for Health* 12(14):1-3.
- Hou, J & Ke, Y. 2015. Addressing the shortage of health professionals in rural China: issues and progress. *International Journal of Health Policy Management* 4(5):327-328.

Kotzee, T & Couper, ID.2006.What interventions do South African qualified doctors think will retain them in rural hospitals of the Limpopo Province of South Africa? *International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy* 6:581.

Lincoln,YS & Guba,EG.1994.Competing paradigms in qualitative research. Handbook of qualitative research.pp 105-117.London :Sage.

MacDonald,S & Headlan, N.2009.Introductory guide to research methods for social research. Research Methods Handbook. Manchester: Centre for local economic strategies (CLES).

Manongi, RN, Marchant, TC & Bygbjerg, IC. 2006. Improving motivation among primary health care workers in Tanzania: a health worker perspective. *Human Resource for Health* 4:6.

Maseko, LJ, Erasmus, A, Di Rago, T, Hooper, J & O'Reilly, J. 2014. Factors that influence choice of placement for community service among occupational therapists in South Africa. *South African Journal of Occupational Therapy* 44(1).

Mohale, MP & Mulaudzi, FM. 2008. Experiences of nurses working in a rural primary health care setting in Mopani district, Limpopo Province. *Curationis* 31(2): 60-66.

Mosby's Medical Dictionary. 2009. Sv "context". 9th edition. New York: Elsevier.

Nemutandani, MS, Maluleka, FRS & Rudolf, MJ. 2006. Community service doctors in Limpopo. *South African Medicine Journal* 96(3).

Okeke, JO. 2008. Shortage of Health Professionals: A study of recruitment and retention factors that impact rural hospitals in Lagos State, Nigeria. Doctor of Health Administration dissertation. University of Phoenix. Phoenix.

Omole, OB, Marincowitz, G & Ogubanjo, GA. 2005. Perceptions of hospital managers regarding doctor's community service. *South African Family Practice* 47(8):55-59.

O'Donoghue, T & Punch, K 2003, *Qualitative Educational Research in Action: Doing and Reflecting*. Falmer Press, London.

Theron, P.M., 2015, 'Coding and data analysis during qualitative empirical research in Practical Theology', *In die Skriflig* 49(3).

Reid S. 2000. Community Service for Health Professionals. Department of Health letter addressed "Dear Intern" Public Service (Community Service). University of Natal, Kwazulu Natal.

Ross, AJ. 2014. Working in rural areas-the experiences of Umthombo Youth Development Foundation. *African Journal of Primary Care and Family Medicine* 6(1).

Ross,A & Reid, S. 2009.The retention of community service officers for an additional year at district hospitals in Kwazulu-Natal and Eastern Cape and Limpopo Provinces.*South African Family Practice* 51(3):249-253.

South Africa. 2015. Department of Health Ethics in research: principles, processes and structures. 2nd edition. Pretoria: Government printer.

South Africa. 1974. Health Professions Act (56 of 1974). Pretoria: Government Printer.

Steyn, NP. 2012. Community service dieticians delivering an effective nutrition: what are the policy options? *Human Science Research Council*. www.hsrc.ac.za.

APPENDICES

APPENDIX 1: BUDGET

ITEM	AMOUNT
Printing	R2000
Telephone	R1000
Travelling	R20000
Assistant fee	R15000
Food and Tools	R 8000
Miscellaneous	R10000
Data Analysis	R10000
Editing	R5000
Total	R 71000

APPENDIX 2: TIME FRAME

ITEM	FINAL DATE
1.Power point presentation of proposal to staff at department	29 January 2016
2.Power point presentation of proposal to staff of the school	29 February 2016
3.Submission to the School Research Committee	31 March 2016
4.Proposal serves at the Faculty Higher Degrees Committee	29 April 2016
5.Submission of proposal to TREC	31 May 2016
6.Collection of data	30 June 2016
7.Data analysis	31 August 2017
8.Submission of finalised research report	31 October 2017

APPENDIX 3: CONSENT FORM

EXPERINCES OF COMMUNITY SERVICE HEALTH PROFFESIONALS WORKING
IN RURAL HOSPITALS OF LIMPOPO PROVINCE, SOUTH AFRICA

SHIPALANA EVANS

MASTERS IN PUBLIC HEALTH (STUDENT)

UNIVERSITY OF LIMPOPO SCHOOL OF PUBLIC HEALTH

Tick the appropriate box

Y=YES N=NO

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions. Y N

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reasons. Y N

3. I agree to take part in the above study. Y N

4. I agree to the interview being audio recorded. Y N

Name of Participant	Date	Signature
-----	-----	-----
 Name of Researcher	 Date	 Signature
-----	-----	-----

APPENDIX 4: INFORMATION SHEET

EXPERINCES OF COMMUNITY SERVICE HEALTH PROFFESIONALS WORKING IN RURAL HOSPITALS OF LIMPOPO PROVINCE, SOUTH AFRICA

The study above is conducted by Shipalana Evans as the main researcher. The study is conducted under supervision as required for the partial fulfilment of requirements for the degree Masters in Public Health at the University of Limpopo (Department of Public Health).

The study is conducted on community service health professionals who were working in Limpopo Province rural hospitals in 2015. All research guidelines and requirements will be adhered to in this study. The study intends to give an honest, truthful and scientifically correct report on the experiences of community service health professionals in Limpopo Province rural hospitals.

For more information about the study, the researcher could be contacted telephonically on 0787346032 or contact the University of Limpopo (Department of Public Health) on 0152684614.

APPENDIX 5: DATA COLLECTION TOOL

Open-ended interview question:

How did you experience community service as a health professional in _____
(specific profession e.g. medicine, dentistry etc) at _____(name of rural hospital)?

Probing Question:

The question will be asked to probe deeper during the interview.

Tell me more.....

Then what happened.....

What do you mean by that?

How did you feel?

What did you do?

What were your thoughts then?

APPENDIX 6: INDEPENDENT CODER CONFIRMATION



SEFAKO MKGATHO
HEALTH SCIENCES UNIVERSITY
PHYSIOTHERAPY DEPARTMENT
SCHOOL OF HEALTHCARE SCIENCES
Letter of Confirmation

The Postgraduate Officer
Private Bag X1106
Sovenga
0727

Dear Sir/ Madam

TO WHOM IT MAY CONCERN

Re: Assistance with data analysis as an independent coder

I hereby confirm that **Mr. E. Shipalana, student no: 200602518**, has been assisted by myself as an independent coder for Qualitative Data analysis of a study titled: **"EXPERIENCES OF COMMUNITY SERVICE HEALTH PROFESSIONALS WORKING IN RURAL HOSPITALS OF LIMPOPO PROVINCE, SOUTH AFRICA"**.

Name & Status: Muziwakhe Daniel Tshabalala, Senior Lecturer (Physiotherapy)

Qualifications: BSc Physio (UCT); MSc Physio (Wits)

Date & Signature: 28 September 2018

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APPENDIX 7: TREC CLEARANCE CERTIFICATE



University of Limpopo
Department of Research Administration and Development
Private Bag X1106, Sovenga, 0727, South Africa
Tel: (015) 268 2212, Fax: (015) 268 2306, Email:noko.monene@ul.ac.za

**TURFLOOP RESEARCH ETHICS
COMMITTEE CLEARANCE CERTIFICATE**

MEETING: 08 September 2016

PROJECT NUMBER: TREC/132/2016: PG

PROJECT:

Title: Experiences of community services health professionals working in rural Hospitals of Limpopo Province, South Africa
Researcher: Mr E Shipalana
Supervisor: Mr MP Kekana
Co-Supervisor: N/A
School: Health Care Sciences
Degree: Masters in Public Health


PROF. TAB MASHEGO
CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE

The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council, Registration Number: REC-0310111-031

Note:

- i) Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee.
- ii) The budget for the research will be considered separately from the protocol.
PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.

APPENDIX 8: TRANSCRIPT

Interviewer: My name is Evans Shipalana, I am the researcher, I am conducting a study on the experiences of community health professionals working in rural hospitals of Limpopo province. I am going to be interviewing you and what is your name sir.

Participant 1: My name is X and I am dentist working in W hospital

Interviewer: Where did you do your comm. Serve

Participant 1: I did my comm. Serve in the same hospital W hospital

Interviewer: Which year was that

Participant 1: in 2015

Interviewer: How did you experience community service? Basically what I want to understand is that for you as a health professional, a dentist, how did you experience community service.

Participant 1: I had expectations from my university years, there were things that we were told that we should expect from rural hospitals and practicing in the community. It was to mentally prepare us before coming here.

Interviewer: If I were to ask about the expectations, would you brief me on it

-I was going to get to that, most of the expectations I had were not met. The sense of reality that we were taught as students, was not the same reality I came across when I came to work in this hospital.

Interviewer: Basically you mean, you had expectations from school but the things that. But who was preparing you?

Participant 1: It's our community dentistry department because they do a lot of outreaches and as student it was to prepare us. The environment in the university was sort of ideal to what we will come across as, So I think it was to help us prepare to

learn to compromise in such instances. So personally what I experienced since I was here, firstly I expected to learn a bit more than what I knew at school.

Interviewer: So you expected the hospitals to provide some form of learning?

Participant 1: Yes, My assumption at the time was hospital that take comm serves will have a program in place to receive and take you from where you ended up at school in terms of knowledge. So it's done in very different way than we did at school. At school it was as if there is an official program and you come here that you just go and fit. for example my first day when I came here I had to do a lot of paper work and I had to move into the place where I would be staying. The second day I expected to have someone come to me and show me around the hospital. Usually we work with dental assistants and one of the assistants called me to see a patient. At that point I didn't know, yes I knew how to write on the file, how to talk to the patient, but at the time because it was a new environment, I didn't know which room is available, I didn't know what kind of information but what we are taught at school is more extensive than what we are expected to do here. I am not saying that there is information that is vital but left out but for the purpose of training you should do more. I didn't know what policies because there are policies and protocols that each department operates or functions so I was not yet introduced to that. So one of the assistants called me in and I had to do a procedure and something went wrong not to endanger the patient but it did not go as I expected and I had to call a senior dentist and ask please take over. It felt like yes someone was assigned to supervise me at the hospital but it felt like I was treated like I was experienced already and it was not so easy because I had to learn through making a lot of mistakes

Interviewer: What would you have preferred in that situation.

Participant 1: I would have preferred to be started off with the simplest procedures. And then moving into the more difficult procedures. Under supervision for at least two to three months. I was under supervision but it did not come in that way and would

have liked to be started off with the simplest procedures and then moving on to the more difficult procedures. Sometimes I would be scared and I would be sitting waiting for patients and I would be and I would wish that the patient who is given to me is something simple that I would boost my confidence on.

Interviewer: Basically what you are saying to, me is that you would wanted to go step by step and not working like an experienced one but you wanted step by step?

Participant 1: Yes

Interviewer: I thought you had supervisors, is it that the supervisors just didn't approach it in that way?

Participant 1: Yes, I think the mistake on my part was assuming that how I expected them to approach me will be the same with what I had expected. After sometime I realised that it is their way of training community service or health professionals. My assumption at the time was that I am fully capable and I accept tha I needed experience.so that was my challenge at the time, the manner in which I was introduced, I felt is a form of introduction because the way we work now is not the way we worked at school.so when I was introduced into the profession it was nt the same way that I expected that it will be done.it was done in a very different way and I felt as new dentist coming in I had no say. Although it was encouraged from time to time that if there is anything you want to say, how you feel, how view things what you would prefer, I felt like I don't want to come as some who is choosy, I wanted to be viewed as someone who will do whatever is brought to him so that.

Interviewer: So you were talking about expectations and one of them is supervision that was going to build you and you didn't have much of that?

Participant 1: yes

Interviewer: Do you think this was because of lack of supervisors or was just a

mishandled situation?

Participant 1: I think it's a bit of an oversight, I did have supervisors and I think it was the method that it was done that I felt it was a bit difficult for me to adapt to it quickly. so that what I feel.

Interviewer: Tell me more on the other expectation

Participant 1: For my part I think my expectation were too high for the setting I was working, I found a lot of equipment to be doing a lot of procedures but when I came here I realised that the challenge at school was not having patients for certain procedures, we would have the equipment and other resources but we would have the patients but when I came here you have the patients for all the other procedures but the challenge is shortage of resources. it is one of the things we encountered.

Interviewer: So basically equipment

Participant 1: Yes, that sort of reduced my work and with some of my friends when we communicated, it's like of the 100 percent that we practiced at school it's like we are doing 30 to 40 percent you know. Obviously we cannot do because we don't have the equipment and when I enquired into that there was issues like budget and it was something new to mean it led to, I had to do things in different ways

Interviewer: You mean adapt

Participant 1: Yes, it was not something that I expected that i will have to alter how, not that you do things wrongly but in such way, I would say I had to be more preventative because at school we had everything and when the patient presents with this you have that, so now knowing we don't have this and that, the patients you see to have to try and make sure that you prevent that patient knowing that next time they come you will not have equipment to deal with whatever they will present with and I realised that working in the rural hospital you have to change your method of practice because you have to find a way to deal with things. I realised with experience that operators have found a way even if there is no this and that, they found ways to practice and do in the

absence of certain materials. And they would use materials that are not meant for certain procedures but you will find that they can be actually used from such procedures because they are of no harm to the patient. So that is something I didn't expect to come across. I thought the way a person practices at school will continue, that is one the things.

Interviewer: Right now we have spoken about supervision and we have spoken about equipment and those things come to as some of the lows that you have experienced during your community service, is there any other thing?

Participant 1: Yes, another one is we were always trained to work in a team but i think it was alright because we were roughly of the same age group, we had the same goals although we were from different walks of lives and different backgrounds, we were similar in some sense but when I came to the hospital you get different personalities working together, you get older people, younger people so I had to, when I came here, but it also helped because it was not the first time I worked in the hospital. I worked as a dental assistant before I went to school and then I returned. so somethings like conflict management, how to maintain a good relationship when you have people with different opinions working, it could be opinions based on religion or lots of other things then all those things you have to work towards a common goal. And one of the first things I asked about when I get here was ,there was a doctor orientating me, I used ask what the environment was like in the dental department, a lot of people would refrain from telling me because they felt that they didn't want to give their opinions so they left me to find out, so yes, one of the things I learned from all of that was a lot of things one would read in books working as a team, having different people and trying to work as a team, like i saw it happening seeing that so and so wouldn't agree with so and so. and not that one person was right or wrong.

Interviewer: Basically, if I were to some it its interpersonal relations you found it to be a struggle because of age differences because at school you were people of the same

group who could relate

Participant 1: Yes

Interviewer: I am not saying its limited to that but I think these are challenges, did you get anything that was more...

Participant 1: Yes, you get the freedom to explore, within your profession and you get the freedom to expand, expand in the sense that you get freedom work without restrains, not that restrains were negative but in the sense that when you are a student, I think because they wanted to protected the patient there are ways and rules that when you treat patients and stuff like that. Some supervisors, had methods that they wanted to teach us but because if they were to teach us those methods we were not experienced enough, or grown in knowledge to start applying them.so for the sake of the patient we had to abide by what the university recommended.it felt like a baby who had started walking, you know that you can start running, you can jump as high as you want, the second thing was especially with regard to the more experienced doctors, there was one professor who used to speak about stages of development of a dentist in particular but it can apply to other professions, you are full of knowledge, then you begin to understand the knowledge and then you develop wisdom, those are the three stages he used to say.so when I came I saw one of them happening, when I came it was me with knowledge and I began to understand what I was doing, and one of the supervisors that I had, I have not developed wisdom but I understand and I am beginning to appreciate my profession even more.

Interviewer: Basically what you are saying is that because of community service you got to experience freedom?

-yes

Interviewer: Any other thing? Any other experiences?

Participant 1: Salary, there were a lot of patients at school who would ask us because

we worked from morning till half past 5 Monday to Thursday, Friday was a day we knocked earlier, she asked what you guys do, do you get paid because we are doing a lot of work, because she felt we were supposed to be paid as students and we told her that all that we are benefitting from this is the training and knowledge.

Interviewer: So you were happy to have been paid?

Participant 1: Yes

Interviewer: So the remuneration was it what you expected?

Participant 1: No, it was enough but I expected a lot more. I think about the expectations was students who had completed in the last years they came to school in big cars and you have a notion that these guys are making a lot of money but when I came it was not the case, but it was just enough, but I'm satisfied.

Interviewer: So basically you said this is my salary and you were happy with it?

Participant 1: Yes

Interviewer: Any other thing?

Participant 1: With accommodation think as a community service, it could apply to other department I think there is a period that we are given, because community service is over a period of 12 months, I think we were given 12 months and after that you are expected to vacate, get your own accommodation, personally I felt it was a bit too short.

Interviewer: So your saying 12 months is not enough?

Participant 1: Yes, 24 months, that would be better

Interviewer: I am not trying to derail you but I just want to find out more, So with accommodation you found that the time frame was too short?

Participant 1: Yes

Interviewer: What other things did you experience

Participant 1: I think the environment itself was not what I had expected

Interviewer: What do you mean by that?

Participant 1: The grass outside it was not kept the way i expected for health professionals in the hospital, I believe the government can't retain health professionals like that.

Interviewer: Basically what you are saying is that you were not happy by the surroundings?

Participant 1: Yes, I think they could have done better.

Interviewer: You mean clean

Participant 1: yes

Interviewer: Accommodation itself, what do you think

Participant 1: I wouldn't say I had a problem, for one the house i was staying was too old and somethings were not functioning. Out of 10 I would rate where I stayed 5.5 meaning I had the things I needed but they were not in their optimum state. And yes personally I felt it was just ok.i felt that coming from school into the real world is like there is a lot dished into your plate at one go. Yes, you were independent but had some form of coverage at the university. But when you come to the hospital you suddenly have to be an adult, take your own decision, have your own security and you have your own world, your own world in the sense that you have to manage your finances, there is what i call the adult world.

Interviewer: So you mean they have to give more time at the hospitals?

Participant 1: Yes, you learn all this thing so that you can make good decisions when you go to private residential area.

Interviewer: So you think if you had good accommodation this was going to prepare you when you go to your own place?

Participant 1: Yes, you would have had enough time to plan,

Interviewer: Is there any other thing for me?

Participant 1: no

Interviewer: The last question is if you were to improve community service what do you think should be done?

Participant 1: I think the departmental of health of health in hospitals where community service are working, they should have a formalised program, there has to be some form of monitoring for the development of community service professionals, there should be some form of feedback, a way that the department can track those professionals how they are doing.

Interviewer: Basically you mean that that they should make sure that they check out community service making sure that there are people checking out community service

Participant 1: Yes

Interviewer: What is it that they should check out?

Participant 1: Accommodation, the environment where they are practicing, resources, it would help retain them if you feel that you are wanted, you would want to stay, you have a say how things should be for you later, that will help a bit,

Interviewer: I am happy with the interview and our interview has come to an end, I appreciate your effort sir. thank you

Participant 1: Thank you.

