THE NURSING COMMUNITY SERVICE PROGRAMME: **THE ANSWER TO RURAL HEALTH SYSTEM CHALLENGES?**

RHAP
Rural Health
Advocacy Project

CONTENTS

EXECUTIVE SUMMARY

Nursing retention is a global problem. A January 2022 report – Sustain and Retain in 2022 and Beyond – released by the International Council of Nurses (ICN) reveals the extent of the impacts of the Covid-19 pandemic on the nursing profession, which include burnout on an individual level and increasing nursing shortages in the health system as a whole. Unless interventions to retain nurses are adopted, the consequences will be dire – and more pronounced in low- and lower-middle-income countries, which are currently most affected by nursing shortages and made worse by 'fast tracking' – recruiting nurses into high-income countries. A shortage of nurses would likely limit the response to the pandemic (Buchan, Catton and Shaffer, 2022).

In this study, RHAP explored whether nursing community service could be repurposed to meet current health system challenges, including the aging demographic of the profession, which has been identified as a major contributor to the crisis. The study also looked at the possibility of community service nurses being placed according to regional health needs. System-wide consultations were conducted with a range of role players and created platforms for collective sense-making. The convenings in August 2021 aimed to examine and understand the existing system and then envision a better one.

There is no magic bullet. As with other health-sector problems, the nursing shortage is complex; solving it will require a range of interventions from different quarters: a network approach with various levels of health governance working closely with each other and other non-state partners. Many of the recommendations in this report can be found in the WHO guideline on health workforce development, attraction, recruitment, and retention in rural and remote areas and in the 2030 Human Resources for Health Strategy for South Africa.

This report differs, however, in that it identifies existing work that can be remodeled or grown, as well as partnerships that can be strengthened, for example, the mentoring and rural onboarding programme recently established by the Rural Doctors Association of South Africa (RuDASA) and the work of The Exceptional Nurse campaign in 'raising the status of nurses in South Africa' and advocating for increases in nursing budgets. We hope this report will be used as a discussion document to inspire and reinforce connections between the stakeholders with whom we convened.

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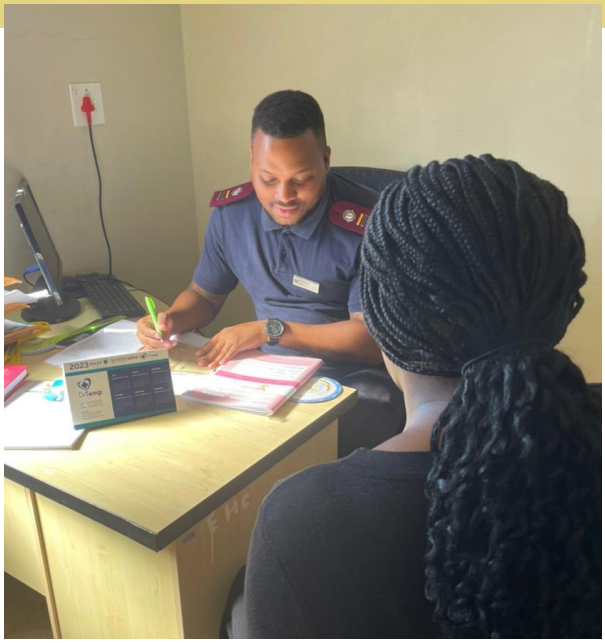

Increasing trainee nurse intakes and advocating for speedy accreditation of nursing education institutions were not raised at the convenings and require serious consideration because of their impact on rural health systems. Another serious issue, also not raised, is that most of the nurses produced by the nursing education system are generalist nurses who are not eligible for community service. They are often trained at nursing colleges which are strategically located in rural areas to ensure a supply of nursing staff to underserved areas.

Despite reviewing literature extensively and consulting widely, there are still gaps in our knowledge base. Although nurses account for the largest portion of health professionals and are vital to the achievement of Universal Health Coverage (UHC), research in the field of community service favours the topic of junior doctors over that of junior nurses. The need for more studies of the latter cannot be overstated. ■

A SUMMARY OF RECOMMENDATIONS

For ease of access the recommendations are presented before the findings.

LEVEL OF INTERVENTION	INTERVENTION	KEY ROLEPLAYERS	OUTPUT
National Department of Health (NDoH) and Treasury	• Increase PHC expenditure through Budget and Health Portfolio Parliamentary submissions. • Sensitise influential NGOs on the need to increase PHC expenditure.	RHAP and other health equity NGOs (TAC, SECTION27, HEALA)	PHC expenditure based on need.
National Department of Health	• Advocate for pro-rural community service policy. • Mobilise key rural stakeholders within our network to lobby NDoH • Encourage a participatory approach with active involvement from rural provinces.	RHAP, with support of key stakeholders: CNO, YNITU, academia	Rural-proofed community service policy must cover the following: • A clear method of how CSOs are allocated based on need. • Mandatory rural-oriented orientation and induction. • All CSOs must be placed in rural areas. • All community service health workers must be supervised.
	Advocate for ring-fencing of community service posts and funding allocation for rural provinces and bursary holders	RHAP and other health equity NGOs.	Funding for community service nursing posts and rural bursary holders are ring-fenced for the duration of 'give-back' years.
Provincial departments of health	Introduce a pro-rural orientation and induction programme for community service officers.	• Relevant PDoH, with support of nursing champions in the province and professional associations. • Rural Doctors Association of SA (RuDASA) has a Rural Onboarding Programme for rural doctors. Dr. Madeleine Muller: drmullerbz@gmail.com	A well-established orientation and induction programme for all community service officers.
	Mentorship	PDoH, with support of Umthombo Youth Foundation: Dr. AJ Ross (www.umthomboyouth.org.za), nursing champions in the province, and professional associations	A functional, fit-for-purpose mentoring programme for rural provinces.
	Learning platforms for nurses	PDoH and NGOs with capacity	A user-friendly easily accessible learning platform for nurses that considers rural contexts.
Regulatory body – SANC	Annual community service exit survey that covers accommodation, geographical location of placements and supervision.	SANC with support of PDoHs	A functional annual survey that is appropriate for the need.
	Community service scope of practice.	SANC, with support of chief nursing officer (CNO).	• A scope of practice that clearly defines the roles of community service nurses. • Community service nurses are supervised by a professional nurse.
	Mandatory rural training, rural blocks, and PHC training for all nursing students.	SANC, with support of an NGO focused on nursing education (FUNDISA) www.fundisa.ac.za	Rural training that is accredited.
Academia	• Studies to identify the extent to which academic institutions comply with pro-rural admission criteria. • Compliance with pro-rural recruitment admission criteria (WHO R+R)	Researchers with a special interest in nursing and rural HRH: Prof Ian Couper, Prof. Steve Reid, Prof Laetitia Rispel, Mrs. Sanele Sukhele	• Research outputs to advocate for increased rural-origin student admissions. • An increase in rural-origin student admissions

PART 1

BACKGROUND

Nursing is critical to the delivery of health services in South Africa. Nurses account for 56% of the health workforce and are integral to the Primary Health Care (PHC) approach within the District Health System framework (NDoH. 2020). The three streams of PHC re-engineering – PHC outreach teams, school health services, and District Clinical Specialist Teams (DCSTs) – rely on nursing to function effectively. From a rural perspective, the role of nurses cannot be understated. Rural communities, which are more likely to utilise primary healthcare services than hospital-based services, interact with nurses more than other healthcare workers in the health system.

South Africa currently has a shortage of between 26,000 and 62,000 professional nurses and it is estimated that by 2030 the demand for nurses in South Africa will increase to between 305,000 and 340,000 (NDoH, 2020).

Both public and private health systems depend heavily on nurses. If the current shortage persists – and grows as predicted – it will have dire consequences for the functioning of the health system and realisation of universal healthcare (UHC).

The inequitable distribution of healthcare workers across the country is well documented, with marked discrepancies between private and public and rural and urban (NDoH, 2020).

The bulk of South Africa's health workforce is concentrated in the private sector, which provides healthcare to only 27% of the population. In addition to whole number disparities, skills-mix is also a problem. An example of this can be seen in the predominantly rural Eastern Cape province; while nurses comprise 63.9% of the public-sector workforce a very small proportion are specialist nurses.

Rural regions fare poorly in key health indicators. According to the District Health Barometer 2019/20, rural districts are in the majority among the 10 worst performing districts in both maternal and neonatal health (Massyn, N; Day, C; Ndlovu, N; Padayachee, T 2020).

A persistent shortage of nurses threatens the achievement of key SDG targets such as those concerning maternal and child health. The community service programme injects health professionals into the public health system every year. In 2020, 2,724 professional nursing graduates from universities and nursing colleges were eligible for community service – a marginal increase over the previous year's total of 2,709.

In this report we propose that the mandatory nature of the programme provides a mobile workforce that can be strategically placed to address staffing shortages and health needs in rural areas. ■

The total number of nurses currently registered is approximately 280,231, which represents all categories of nurses. Of this number, 186,000 are in clinical practice and 154,024 are professional nurses. By 2030, we will require 305,000 to 340,000 professional nurses but it is estimated that only 26,000 nurses will be trained by then.

Hospital Association of South Africa; NDoH, 2020.

PART 2

LINE OF INQUIRY

An aging nursing population and the poor performance of rural districts in key health indicators prompted the following question: Can the nursing community service programme be used to mitigate health systems challenges in rural areas? The two health system challenges identified in this study are current and pending nursing shortages and poor performance in rural health districts.

WHAT THE NUMBERS SAY

Nurses in South Africa fall into three categories:

- Professional/registered (PN/RN) nurses who receive four years of training,
- Enrolled nurses (EN) who undergo two years of training, and
- Nursing assistants/auxiliaries (ENA) who receive one year of training (Rispel, 2015).

Only professional/registered nurses are mandated to perform community service.

Nursing production targets are hindered by an aging nurse demographic and low numbers of nurses being trained (The Hospital Association of South Africa; National Department of Health 2020).

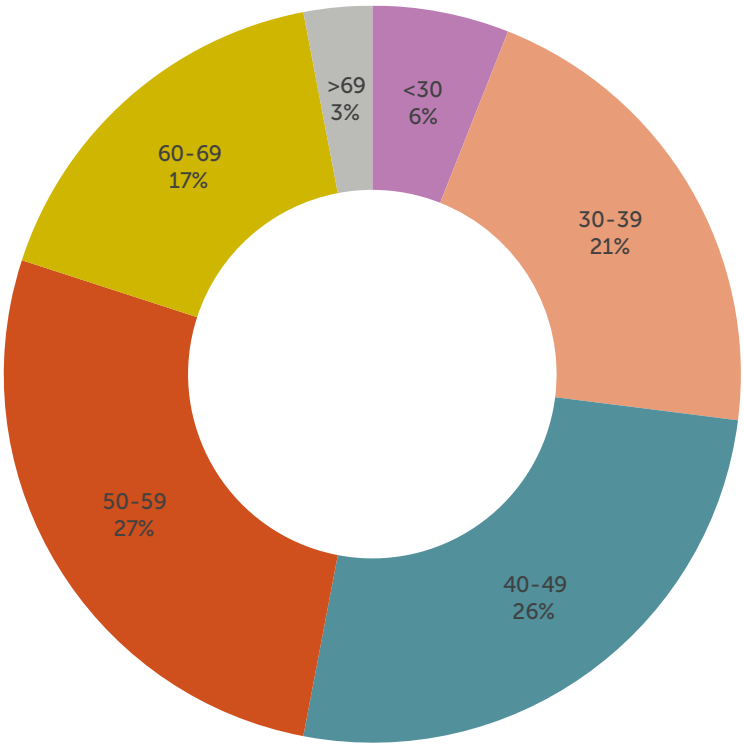

Figure 1: Age bands in the nursing profession in South Africa.
Source: SA Nursing Council

DEMOGRAPHICS

Currently, 47% of professional nurses are over the age of 50, and only 6% are under 30. Of all enrolled nurses registered with SANC, 27% are in the 50 to 59 age band, which means they are either close to retirement age, eligible for retirement, or past retirement age.

The fact that this age group makes up the bulk of the nursing population poses a threat to the retention of nurses (SANC n.d.). It also means that articulating to higher nursing qualifications is risky because of the limited productive working years older nurses will have after they have qualified.

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TRAINING

An upward trend in nursing training from 2000 to 2015 was followed by a decline that was aggravated by a shortage of accredited Nursing Education Institutions (NEIs).

The nursing profession is also inadequately skilled; there is an undersupply of PNs and ENAs (shortages of 18,000 – 29,000 and 17,000 – 33,000, respectively) and an excess of about 9,000 ENs (The Hospital Association of South Africa; National Department of Health 2020). This was highlighted in 2021 when hospitals in a South African metro in KwaZulu-Natal were unable to admit patients who needed high and critical care because of a shortage of ICU-trained nurses. This was particularly significant since metros generally have higher numbers of specialist nurses.

Large numbers of nurses are also unemployed because of mismatches between the categories of nurses being trained and the categories of nurses needed, inconsistent and poor-quality training, the reluctance of nurses to work in rural and remote areas, and unfunded vacancies in the public sector (The Hospital Association of South Africa; National Department of Health 2020).

THE IMPLICATIONS FOR SOUTH AFRICA'S HEALTH SYSTEMS

Unless the nursing shortage is addressed, and very soon, it will jeopardise realisation of Universal Health Coverage (UHC) (Massyn, Day, Ndlovu, Padayachee, 2020) and key Sustainable Development Goals (SDGs).

The state of primary healthcare (PHC) viewed through a nursing lens captures the enormity of the impact. In addition to supporting school-health services and home-based care, PHC nurses are responsible for the management of chronic diseases, geriatrics, HIV and STIs, mother and child health, mental health, minor ailment treatments, and tuberculosis. They are also expected to perform a range of administrative tasks (McKenzie, Schneider, Schaay, Scott, Sanders, 2017) which is at odds with the human- and material-resource constraints that characterise PHC. Many of the top ten failed elements on the Ideal Clinic Realisation and Maintenance (ICRM) programme can be attributed to these shortages like the appointment of staff in line with workload indicators of staffing needs.

As of 2019/20, just over half of the 3,472 fixed PHC facilities had achieved Ideal Clinic Status. Rural provinces such as Mpumalanga, Northern Cape, Eastern Cape, and Limpopo all performed below the average for South Africa (Massyn, Day, Ndlovu, Padayachee, 2020).

Rural areas dominate the ten worst performing districts in maternal and infant health (Massyn, Day, Ndlovu, Padayachee, 2020). Nursing plays an integral role in maternal and infant health as well as other key health indicators. If the demographic transition within the nursing profession is not addressed, we will not achieve SDGs 3.1 and 3.2 targets for maternal and infant health.

SDG 3: ENSURE HEALTHY LIVES AND PROMOTE WELL-BEING FOR ALL, AT ALL AGES

Target 3.1:
Reduce maternal mortality
Target 3.2:
End all preventable deaths under 5 years of age

THE ROLE OF COMMUNITY SERVICE

Mandatory community service is used worldwide to recruit health workers to rural and remote areas. Although South Africa's community service policy is yet to be drafted, the objectives of the community service programme are to:

- Address maldistribution of the health workforce across the country by placing health professionals in rural and remote areas.
- Aid the growth and development of junior health professionals (Reid 2018).

The literature reviewed for this report, as well as the responses received from stakeholders, were divided over whether service obligations should take precedence over professional development. The National Department of Health is to review the community service programme to determine its value in capacitating rural health systems (NDoH 2020).

In recent years, NDoH has struggled to meet its obligation to fund the community service programme. Although the Human Resources Capacitation Grant has been used to fund both internship and community service programmes, austerity measures arising from persistent economic recession have led to tightening of health budgets and although community service is pro-rural, there is no incentive for rural provinces to fund posts with competing financial demands. Rural recruitment and retention thus depend on precarious funding streams from already incapacitated provinces.

PART 3

METHODOLOGICAL REVIEW

A review of available literature on community service, nursing and human resources for health (HRH) in South Africa was conducted to address the original question of whether the community service programme for nurses could be used to mitigate health systems challenges in rural areas. The review enhanced our understanding of the current discourse on challenges in these three areas and identified key informants with a vested interest.

Key stakeholders in the community service programme include health officials at the National Department of Health, leading figures in the fields of nursing, community service and HRH, young nurses, labour representatives and representatives from the regulatory body for nurses. RHAP's memorandum of understanding with one of the predominantly rural provinces facilitated access to provincial-level individuals.

Of the 27 stakeholders interviewed in one-on-one consultations between May and August 2021, we identified a smaller group with whom we convened over three sessions. During these convenings we asked three questions:

- What does the system currently look like?
- What is the future system we envision?
- How do we get there?

The HRH team consolidated and reviewed findings of the individual consultations and the group convenings against current literature and key HRH policies: 2030 Human Resources for Health Strategy: Investing in the health workforce for Universal Health Coverage and WHO Guideline on Health workforce development, attraction, recruitment, and retention in rural and remote areas.

Recommendations were developed individually and then deliberated over collectively. We created the following matrix to support our sense-making. The metrics guided us in determining the overall value of the recommendation to the health system, whether there was sufficient evidence to support the recommendation, who the key decision-makers are, and who was best suited to advocate for this. This approach was influenced by the WHO guideline on Systems Thinking for Health Systems Strengthening.

Metrics	Example
Leverage point: a place in a the structure of a system where a solution element can be applied	**Rural background (WHO Recommendation 1, medium to long term):** Enrol students with a rural background in health worker education programmes
System value	Rural retention (WHO)
Supporting evidence	• WHO guideline on health workforce development, attraction, recruitment and retention in rural and remote areas (2021). • Evidence – Strong • Aligns with HRH 2030 Strategy: Goal 3 • A rural scholarship model addressing the shortage of healthcare workers in rural areas (2018)
What do we want to achieve?	• Pro-rural admission criteria for all NEIS. • Rural exposure during the programme.
Who should lead on this?	Researchers with a special interest in rural and nursing
Who is the decision maker?	Nursing education institutions
Unintended consequences	
Level of difficulty	3
Alignment to RHAP: Resources, Positionality, Vision/mission	

Figure 2: Matrix to determine the appropriateness of a recommendation

The absence of a community service policy was identified as a gap in programme implementation and resulted in differences in how the programme was perceived and implemented across provinces.

PART 4

KEY FINDINGS

The findings of this report are categorised as follows: administration, health financing, capacity of community service nurses, demand for skilled nurses in rural areas, experiences of community service nurses in rural areas, nursing culture, nursing education, information, and recruitment of rural-origin students.

4.1 ADMINISTRATION OF HRH AND THE COMMUNITY SERVICE PROGRAMME

The National Department of Health (NDoH) is responsible for allocating healthcare workers for community service through the Internship and Community Service Portal (ICSP), a national online application and allocation system, with which all eligible healthcare workers must register. Funded posts are identified by provincial departments of health and submitted to NDoH to be uploaded to the portal.

Participants in the one-on-one consultations and the convenings noted that **a lack of leadership and oversight of HRH** were drivers of dysfunction across the health system. Issues around capacity and resources echo those highlighted in the 2030 Human Resources for Health Strategy. Stakeholders remarked that to grow a strong health system, stewardship must extend across all programmes, not community service alone.

The **absence of a community service policy** was identified as a gap in programme implementation and resulted in differences in how the programme was perceived and implemented across provinces. The question of whether community service is a service platform or a training platform is a key consideration that needs thoughtful inquiry and has implications for community service nurses and the patients they treat in rural areas. It may also influence the settings in which community service nurses are placed, the types of cases they can manage, and the need for and extent of supervision provided.

Stakeholders flagged the practice of **placing unsupervised community service nurses in PHC settings** as a potential risk to patients that increased with management of maternity cases. Some provinces have responded by providing junior nurses with training on how to manage maternity cases effectively.

Despite the best intentions of the central allocation platform, **allocation of community service officers through the ICSP without consideration for existing local recruitment and retention interventions** inadvertently undermines the objectives of the programme. For example, nursing colleges in rural areas source students from local areas with the aim of placing nurses in the same area post training. The ICSP places nurses trained at nursing colleges in areas far from home. Ensuring that nurses trained in nursing colleges can continue to practice close to their homes will serve to increase rural retention.

Typically, bursary recipients serve in the province that funds them, which creates a conflict of interest for students from rural areas who are funded by provinces that are more urban. In addition, the recent trend of releasing bursary recipients from their bursary obligations means they are not obliged to return to rural areas if they were funded by a rural province and also threatens job security.

For many, a government bursary not only allows access to higher education but also guarantees employment. The funding of nursing studies must be viewed in the context of the overall HRH strategy for the country. Greater synergy across provinces will ensure funding is based on need and aligns with existing pro-rural and pro-equity DoH interventions.

RECOMMENDATIONS

- Advocacy for a strengthened NDoH Human Resources and Workforce Planning Unit.
- A community service policy that adopts participatory policy development.
- Greater synergy between provinces in workforce planning and allocation of community service nurses.

4.2 HEALTH FINANCING

Despite a lack of correlation between PHC expenditure and health outcomes, **underfunding cannot be ignored** when considering the challenges PHC nurses face – many due to material and human-resource shortages. It must also be noted that the Ideal Clinic elements include greater spending as a prerequisite for Ideal Clinic compliance.

The **equitable share formula** (ESF), based on population size rather than need, places rural provinces, which bear the brunt of historical underfunding, at a further disadvantage. Despite their smaller populations, delivering health services to rural communities costs more because of economies of scale and higher compensation of health workers through incentives such as rural allowance, amongst other factors.

The Department of Health has struggled to meet its obligation to fund the community service programme. The ongoing economic crisis in South Africa has led to the tightening of health budgets and PHC expenditure in rural provinces is far below the national norm.

RECOMMENDATIONS

- Ring-fence funds for community service for rural provinces.
- Advocate for increased PHC funding for rural provinces.

4.3 CAPACITY OF COMMUNITY SERVICE NURSES

Feedback on the capacity of community service nurses varied. Rural nurses were expected to be well-rounded, to respond to the wide variety of cases presented in PHC. University-trained nurses were welcomed into health facilities because of their 'competence and confidence' and because 'they challenged doctors'.

Inferior nursing education was blamed for the poorer quality of nurses produced by nursing colleges, a topic raised repeatedly by different stakeholders. There was a mass exodus of nursing educators from nursing education institutions to clinical practice when the Occupation Specific Dispensation (OSD) was introduced in 2010 because it excluded nursing educators, many of whom had specialist nursing education skills (Armstrong, Geyer and Bell 2021). Interviewees felt that a lack of capacity affected the quality of nursing services, which resulted in an increase of medico-legal claims.

A **lack of supervision at PHC and inadequate clinical experience** exacerbates the quality issue. Interviewees claimed community service nurses were expected to do what doctors do in their internship years.

> The idea was to have supervision of community service nurses by registered nurses, but this has been a challenge due to the shortage of nurses.

Serious concerns were raised about **staff shortages** and **community service nurses being placed in healthcare facilities without direct supervision**, and how this affected patient care and rural retention of nurses after community service.

> Staff shortages often affect the decisions for nurses to not want to stay in rural facilities, because they feel that it is risky (for patients) to work in these circumstances.

While university-trained community service nurses were praised, there were concerns around **community service nurses being used as the core capacity in healthcare facilities** without the necessary support.

> Nurses are so scarce that when they are placed in that hospital, the community service nurse needs to function as a registered nurse. No one will comfort, mentor, and supervise them.

RECOMMENDATIONS

- A clearly defined scope of practice for community service nurses that mandates supervision.
- A rural-friendly mentoring programme that draws on local institutional and individual capacity.

4.4 DEMAND FOR SKILLED NURSES IN RURAL AREAS

> There is a shortage of nurses in rural areas, especially midwives, maternity nurses, and pediatric nurses. There is a need to train more of this cadre of nurses. This might help reduce medico-legal claims ... because most of these claims are related to maternity and pediatric services.

An investment in resourcing rural areas with skilled nurses may reduce the burden of medico-legal claims attributed to maternity.

RECOMMENDATIONS

- Career pathing of young, motivated nurses with a strong interest in specialist areas.

4.4 THE COMMUNITY SERVICE NURSING EXPERIENCE AND RURAL RETENTION

Stakeholders reported a **lack of support programmes** for community service nurses and other young health professionals in the public sector to transition from student to working professional.

> The orientation before the commencement of internship or community service is often not as comprehensive as it needs to be.

Post-community-service retention is influenced by management capacity, facility resources and level of supervision. Community service nurses working in health facilities with significant staff shortages are less likely to opt to remain within the same facility after completing community service. **Transport, accessible and decent accommodation**, and a **shortage of good schools** are also barriers to rural retention for community service nurses. There is a strong bias towards studies that focus on medical doctors; studies of the experiences of nurses completing their community service, and of other young nurses, are urgently needed.

RECOMMENDATIONS

- Mandatory, rural-friendly orientation programmes.
- Support networks for community service and junior nurses.
- Explore public–private models for accommodation.

4.6 NURSING CULTURE

A **deterioration of study and working conditions and loss of incentives** were cited as barriers to the nursing profession. This is supported by recent media reports of nursing students protesting poor working and living conditions as well as a lack of financial support to adequately address student needs.

A **lack of ethical leadership** was raised on several occasions by different stakeholders during the individual consultations and was echoed during the convenings. Poor leadership was not located in one sector but across all sectors of nursing:

> Ethical leadership is missing across the board. Ubuntu is gone. Too much self-centeredness – there is no space to think of the profession.

Some felt there is undue **pressure on nurses to fix rural health systems without considering the contribution of other health disciplines**, which is reasonable considering the effect of the evolving burden of disease and policy changes on South Africa's nurses (Armstrong, Geyer and Bell 2021).The convenings underlined the importance of including young nurses and nursing students in discourses about the future of nursing in South Africa, even though older nurses are in the majority.

RECOMMENDATIONS

- Identify and groom young nurses working in rural areas.
- Create initiatives that support young rural nurses or support existing initiatives.

4.7 NURSING EDUCATION

The new nursing education strategy came into effect in 2021. The first cohort of students was provided with a new curriculum that has raised fears for its effect on the quality of nurses being produced. The new strategy is focused on producing general (staff) nurses; psychiatry and community health have been removed.

Nurses trained according to the new curriculum are to be based at district hospitals rather than PHCs and nurses will not be able to perform community service. This is likely to have grave implications because of the numbers they represent in the nursing education outputs.

Comparisons to medical doctors were made regarding the duration and intensity of training.

> Nurses are given six months to specialise in their chosen field, but doctors are given four years. The knowledge gap is huge. Nurses do not perform internship whereas doctors do two years of internship under supervision before their community service year.

Many nursing colleges are strategically located in rural areas to recruit youth direct from local communities and play an important role in satisfying nursing capacity in rural clinics and hospitals.

Generalist nurses appropriate for district hospital services may not support rural health systems, which are PHC heavy. It should be noted that these are preemptive comments; further studies are needed to determine the effect of the new strategy on rural areas.

The absence of learning platforms during service was identified as a barrier to the development of the nurse and the nursing profession. Progress in continuing professional development (CPD) can trigger creation of learning platforms that are appropriate for nurses working in rural areas.

RECOMMENDATIONS

- Monitor nurses undergoing the new education strategy.
- Develop learning platforms for rural nurses through relationships with NGOs.

4.8 THE INFORMATION CONUNDRUM

Nursing data challenges range from the quality of existing data, data gaps, and the absence of appropriate ratios to support nursing workforce planning.

Data quality is cited as a huge barrier to accurate nursing workforce planning, with SANC as the only source of national nursing data. It is difficult to differentiate between nurses in practice and those in education, those still working or and those who are retired, or those who have migrated (Armstrong, Geyer and Bell 2021). Anecdotal evidence suggests that similar challenges exist in the Department of Health in that the location of practicing nurses is unknown.

Research gaps include a lack of recent studies on academic institutions' compliance to pro-rural admission criteria and studies of the experiences of newly qualified nurses in the public sector. No global ratios for nurses and midwives exist. Developing appropriate nursing ratios is further complicated by the number of different nurse categories in South Africa.

Using community service and internship to collect health system data. Some professions have already begun using community service to collect routine data on rehabilitation workers at the end of their community service year. In the community service cycle, health districts are responsible for placing community service nurses at health facilities. However, despite numerous attempts, we were unable to engage health districts to understand their role in the process.

RECOMMENDATIONS

- Discuss research gaps with health researchers.
- Develop learning platforms for nurses.
- Engage more closely with rural health districts on how they manage the health workforce.

4.9 RECRUITMENT OF RURAL-ORIGIN STUDENTS

Admission of rural-origin students into health science programmes has been identified as an incentive for rural retention and is supported by the WHO guideline on health workforce development, attraction, recruitment, and retention in rural and remote areas. Despite this, data on admission rates of rural-origin students are limited.

A study published in 2009 revealed that in five of nine local universities reviewed, rural-origin students comprised less than 25% of the student population, which at the time was far lower than the national rural population ratio (Tumbo, Couper and Hugo 2009). The study excluded nursing students, which further reinforces the need for studies of nursing students and young nursing graduates.

RECOMMENDATIONS

- Conduct research on the compliance of universities with pro-rural admission criteria.
- Advocate for more rural-origin admissions.

PART 5

DISCUSSION

Delve deeper: We do not know enough about the role of health districts in allocating community service nurses. The capacity of community service nurses has been raised several times. If we want to allocate them according to health needs, we need to know whether their capacity meets the skill set required.

Fill the gaps: Without timeous and accurate data, we are unable to plan properly.

Develop what exists and connect with others with the same goal: It is wise to identify existing models of excellence that encourage rural recruitment and retention, and understand what works, rather than starting afresh.

- As part of their support to young doctors working in rural areas, Rural Doctors Association of South Africa (RuDASA) provides a comprehensive rural-tailored orientation programme.
- In recent years, Rural Rehab of South Africa (RuReSA) has run an annual survey for rehabilitation workers at the end of their community service year. This provides useful information on the experiences of rural therapists across the country.
- Zithulele Hospital partners with NGOs and has created a network of organisations that support it.
- The Exceptional Nurse advocates for the nursing profession in South Africa in the context of the demographic transition.

Small things can create a huge impact: A strong orientation and induction programme that draws on the expertise and passion of local nurses can go a long way to ensuring that recently qualified nurses transition smoothly into service.

Fund rural health: Fiscal constraints can further jeopardise pro-rural and pro-equity programs like community service. We must ensure that funds for community service are ring-fenced and that PHC is prioritised.

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