The Experiences of Community Service Rehabilitation Professionals Who Managed Their Own Department in South Africa

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BY

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Abstract:

Background:

A compulsory community service year for all healthcare professionals, including rehabilitation healthcare professionals was introduced to address the challenges of access to healthcare especially in rural South African communities as a result of inequalities brought about by apartheid. Even though the focus of the community service year was for healthcare professionals to render clinical services under the supervision of a more experienced healthcare professional, this has changed over the years. Due to the lack of resources and funding and subsequently the shortage of healthcare professionals, community service rehabilitation professionals often find themselves placed in healthcare facilities without the supervision of a senior member of staff. Community service rehabilitation professionals therefore end up taking up the role of head of department without prior preparation or training.

Aim:

The aim of this study is to explore the experiences of rehabilitation community service healthcare professionals who have managed their own department during their community service year.

Methodology:

Semi-structured interviews were conducted with 15 rehabilitation healthcare professionals. A purposive sampling strategy was used to recruit participants. Interviews were conducted online via Zoom. All interviews were transcribed verbatim and analysed using a framework analysis approach employing Faloy's five elements of management.

Findings:

The following 16 themes demerged from data analysed from the semi structured interviews with participants: (i). Undergraduate training does not prepare students for managing a rehabilitation department; (ii). Insufficient handover from the previous community service therapist and not enough orientation at the beginning of the year; (iii). Create new documents that outline plans for their community service year; (iv). Duties expected of a community service rehabilitation professional, (iv- a) Clinical duties expected of a community service rehabilitation healthcare professional heading a department; (iv -b). Administrative duties expected of a community service rehabilitation professional heading a department; (v). Not having enough time for clinical and administrative duties; (vi). Co-ordinating with staff

members within the healthcare facility; (vii). Discovering outside resources to collaborate with to assist with managerial and clinical duties; (viii). Staff negative attitudes towards community service rehabilitation professional; (ix). Staff's lack of knowledge of rehabilitation healthcare professions; (x). Meetings with other managers; (xi). Little to no feedback or verification structures in place, (xii). Creating a handover for the next community service therapist, (xiii) Ethical considerations, (xiii -a) Language barriers, (xiii-b) performing duties outside of scope of practice, (xiii -c) Lack of carryover of treatment due to lack of personnel (xiv) Safety, and (xv) Emotional toll on community service rehabilitation professionals

Conclusion:

Findings from the study suggest the need for different kinds of informal and formal support structures that are needed for rehabilitation community service practitioners who have no access to a supervisor during their community service year. This includes creating a better support network of professionals in the same district who can assist each other as well as better support from the healthcare professionals at the healthcare facility. Furthermore, the findings highlighted the need for continued professional development (CPD) courses that could be capacitate community service rehabilitation professionals who are heading a department by focus on providing both practical support and assistance with managerial duties. These implications will allow community service rehabilitation professionals to feel more supported and have greater confidence in their abilities as a clinician and a manager leading to better service given to patients.

Key Words:

Community service, rehabilitation healthcare, supervision, rehabilitation professionals

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Declaration:

I, Julia Allsop, hereby declare that this research project and report are my own work and that all due credit has been given to authors whose work was consulted. This work is being submitted in partial fulfilment of the degree: Masters of Speech Pathology at the University of the Witwatersrand. It has not been previously submitted at this university or any other institution.

Signed: ____________________________

Date: 14 March 2024

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Glossary of Terms:

Table 1: *Table describing the glossary of terms.*

Term:	**Definition:**
Community Service	A compulsory year in which a newly graduated rehabilitation professional has to work in a government healthcare facility in order to qualify for independent practice (Department of Health, 2006).
Rehabilitation Professional	A person who has completed a four-year professional degree that provides rehabilitation services focusing on limitations of function (Campbell et al., 2016).
Healthcare Facility	A location where healthcare is provided either at a clinic, a district hospital or a tertiary hospital (Lederer & Wetzel, 2014).
Supervision	To observe and give feedback on the completion of a task (Hess, 2014).
District	A district within the healthcare system is defined as a self-contained part of the healthcare system that services the outlined administrative and geographical area (Pillay et al., 2001).

Chapter 1: Background and Rationale

This chapter provides a background to the study. It particularly addresses what is known about community service in South Africa, with specific reference to the history of community service, why it was implemented, how the purpose and outcomes of community service have changed over time and how these changes have affected access to healthcare and particularly rehabilitation healthcare services and professionals as this is the main focus of the study. The chapter also argues for the relevance of the study in South Africa through outlining what is known about the subject in terms of the available literature and current literature gaps that necessitates the study. This chapter furthermore outlines the different chapters that form part of the dissertation and a brief description of the contents of each chapter.

Prior to 1994, access to healthcare services was demarcated across socio-economic, racial and geographical lines (Maphumulo & Bhengu, 2019). As a result, there were inequalities in the provision of healthcare services in South Africa. To redress the inequalities of the past, the government of the new dispensation implemented a 12-month compulsory community service year, wherein healthcare professionals are placed in a government healthcare facility to provide healthcare services to communities, with a special focus on rural government healthcare facilities (Department of Health, 2006). Compulsory community service was initially implemented only for medical doctors in 1998, however, by the year 2003 a total of 17 healthcare professional disciplines were legislated to complete a year of community service before being able to practice independently. These healthcare professional disciplines include audiologists, clinical psychologists, dentists, diagnostic radiographers, diagnostic sonographers, dietician, environmental health practitioners, medical practitioners, nuclear medicine, radiographers, occupational therapists, pharmacists, physiotherapists, professional nurses, radiotherapy, speech and audiology therapists and speech language therapists (Department of Health, 2006). The aim of the community service year was and still is to provide necessary access to healthcare in underserviced communities as well as to provide young professionals with the opportunity to grow their clinical skills and knowledge under supervision (Reid et al., 2018), while increasing the number of doctors and other healthcare professionals working in rural South African areas (Hatcher et al., 2014).

Problem Statement and Significance:

Approximately 50 percent of the population of South Africa lives in rural areas, with insufficient access to healthcare (Dubois et al., 2017). Poor access to healthcare services is compounded for people living in rural areas. This is due to amongst other factors, the fact that 70 percent of doctors in South Africa prefer to work in the private sector, leaving only approximately 11000 doctors in the public sector to service the 85 percent of the population who do not afford a private medical aid scheme (Dubois et al., 2017). In South Africa, people who live in rural areas also struggle to access rehabilitation services as a result of the factors outlined by Sherry, (2014) which include no access to transport to travel to healthcare facilities, long waiting times, and lack of knowledge of other healthcare workers to refer to rehabilitation professionals. Rehabilitation professionals, namely speech language therapists, audiologists, occupational therapists, dieticians, and physiotherapists (previously known as allied health professionals), are an integral part of healthcare. These professions make up a group of tertiary educated healthcare workers who are not doctors or nurses, but specialists in specific diagnosis, management and intervention of acute and chronic therapeutic conditions and specifically focus on impairments, functional limitations and assist in participation in life (Campbell et al., 2016).

Rehabilitation healthcare professionals often face significant challenges in state run hospitals in South Africa due to the lack of funding and resources (Sherry, 2014). With a growing patient load seeking rehabilitation services, in South Africa, due to the increasing number of patients living with chronic non-communicable diseases that require therapeutic services to assist with everyday functioning and quality of life (Dizon et al., 2017). Non-communicable diseases form part of the quadruple burden of disease prevalent in South Africa. The quadruple burden of disease is made up of child and maternal health, non-communicable, injury due to violence and crime and HIV and TB. The high percentage of patients with these diseases puts strain on an under resourced healthcare system in South Africa (Haskins et al., 2016). With a lack of healthcare professionals but an increase in disease, this can lead to further challenges such as long wait times and insufficient supplies within the healthcare system (Haskins et al., 2016).

Non-communicable diseases are diseases such as cancer, cardiovascular diseases, diabetes and respiratory diseases (Nojilana et al.,2016). There has been an increase in the prevalence of noncommunicable disease in South Africa due to lifestyle choices such as unhealthy diets, lack of physical activity and tobacco use (Nojilana et al., 2016). Due to colonialism and

globalisation, food markets have altered to produce ultra processed foods in order to bring down the cost of food, the amount of time needed to cook and, to be most affordable to lower income families hence people living in poverty do not have access to healthy, fresh food (Manderson & Jewett, 2023). Furthermore, persons who work in low-income sedentary jobs may have less time to exercise. These points suggest that in lower income communities the personal power to consume healthy food and live an active lifestyle is taken away leading to a higher risk of these diseases (Manderson & Jewett, 2023). Therefore, due to the rise of non-communicable diseases due to the lifestyle choices made, rehabilitation professions require more budget in order to be able to adequately assist their patients with non-communicable diseases (Hanass-Hancock et al., 2013).

Adding to the difficulties faced by rehabilitation professionals practicing in state hospitals, is the low number of staff employed within the state healthcare system. It has been reported that the vacancy rate for rehabilitation professionals is 22 percent nationally (Ned et al., 2020). The provinces with the highest vacancy rate of rehabilitation healthcare professionals are Eastern Cape and Mpumalanga (Department of Health, 2013). Eastern Cape and Mpumalanga are two of the most under resourced provinces in South Africa and they also happen to have a larger percentage of their areas being classified as rural (Vergunst et al., 2017). This shows that the provinces with the poorest communities have the lowest number of rehabilitation healthcare professionals (Department of Health, 2013). There is also evidence that community service rehabilitation professionals prefer placements in tertiary institutions and being situated in more affluent areas which also has an impact on the number of rehabilitation professionals servicing under resourced communities (Maseko et al., 2014). The most notable reasons for rehabilitation professionals leaving the government sector have been fiscal austerity, immigration, moving to the private sector and the freezing of posts (Sherry, 2014). Many healthcare professionals are choosing to move to the private sector or to immigrate due to long working hours, poor renumeration, work related stress due to high patient loads, lack of resources and higher incidents of occupational hazards (Mumbauer et al., 2021). The freezing of healthcare worker's posts is a significant factor in the vacancy of personnel at state-run hospitals. This is caused by budget constraints and competing priorities that require more of the budget as determined by the Human Resource for Health Plan for South Africa (Ned et al., 2020).

The impact of the factors mentioned above, in particular the high vacancy rate in state run healthcare facilities is that community service rehabilitation professionals end up being placed in healthcare facilities where there is no supervising therapist within their profession and

therefore being placed in a position of having to manage a department with limited experience and resources in their year of community service (Shipalana, 2018). An example of this is in the Limpopo province, where there are no advertised vacancies for chief therapists or assistant director posts for rehabilitation professions, but community service rehabilitation professionals are placed at those facilities with no support and either not being supervised at all or being supervised by managers practicing a different profession to theirs (Shipalana, 2018). Management is defined as the process of organising, planning, directing, and controlling an organisation's members and resources to ensure that particular goals are reached (DuBrin, 2009). As of 6 March 2024, no advertisements for chief therapists or assistant director posts were found on the government website.

The lack of supervision at community service placement healthcare facilities can have a negative impact on the community service rehabilitation professionals placed at those healthcare facilities, as well as the patients that they serve. For example, for community service rehabilitation healthcare professionals, the first years of practice sets the foundation for future actions (Paterson et al., 2007). This may lead to bad habits, poor attitudes and lack of work ethic which can be difficult to change in future working environments (Paterson et al., 2007). Community service rehabilitation professionals who have had little supervision have rated themselves as competent after a year of practice (Paterson et al., 2007). Benner created a five-stage model of clinical competencies that need to be achieved during the learning process. Benner's stage model determined that it is expected that a nurse should take at least three years of practice under supervision before reaching a competent stage (Mohamed & Abouzaied, 2021). This suggest that a lack of a supervisor to guide a community service rehabilitation professional into ensuring they learn best practice, can lead to overconfidence in practical skills of a community service rehabilitation professional (Paterson et al., 2007). Overconfidence in clinical ability can impact the service provided to patients as the community service rehabilitation professional may not be aware they are not working in a way that is best practice without having a supervisor to correct them.

Studies that have been conducted on community service in South Africa have focused mostly on the medical professions experience of community service (Hatcher et al., 2014; Reid et al., 2018). Studies where the focus has been on rehabilitation healthcare professionals have highlighted the experiences of only one profession, for example studies have only highlighted the experiences of occupational therapists or speech language therapists, but not a sample made up of multiple professions representative of the rehabilitation team (Penn et al., 2009; van

Stormbroek & Buchanan, 2016). Where studies have been conducted with one rehabilitation healthcare professional discipline, the studies have only been conducted within one province of South Africa (Shipalana, 2018; Khan et al., 2009; Paterson et al., 2007) . Studies on specific rehabilitation professions have also tended to document their general experiences of community service without zooming in on specifics such as management of a department. This study will include participants representative of various types of rehabilitation professionals and will be conducted nationwide to gather as much data on this phenomenon as possible and be representative of different contexts. It is important to conduct this research in order to determine how to support and better prepare community service rehabilitation professionals for their community service to ensure that they provide the best care possible to their patients and are able to manage the managerial, emotional, and practical aspects of their role, especially in light of the current financial difficulties in the department of health that impact on filling of vacancies. By having a community service rehabilitation professional who is adequately trained to manage a department this will also benefit their patients as being able to adequately manage the administrative aspects of a department will allow the department to run more effectively and a community service rehabilitation professional who feels confident in their abilities will also make patients feel comfortable in the standard of care they are being provided. Community service rehabilitation professionals who have a positive experience during their community service may consider working in state run healthcare facilities. If more community service rehabilitation professionals are prepared to work in state run healthcare facilities post community service, this could increase the amount of rehabilitation professionals in the state healthcare system. This in turn, will allow more access to rehabilitation services for patients by having more rehabilitation staff available.

The main aim of the study is to determine the experiences of community service rehabilitation healthcare professional managing their own respective rehabilitation departments in South Africa during their community service year.

The sub-aims of the study are as follows:

- To determine how and by whom community service rehabilitation healthcare professionals were prepared to manage a department.

- To explore the challenges experienced by community service rehabilitation healthcare when managing their own department.

- To describe the facilitators and support systems community service rehabilitation healthcare professionals had access to when managing their own department

Outline of different chapters included in this dissertation:

Chapter 1: This chapter argues for the relevance of the study. This is done by the chapter providing a background on community service and the state of the healthcare system in South Africa as well as introduces the concept of rehabilitation professionals. It then outlines the factors which led to community service rehabilitation professionals managing their own departments. This chapter then also outlines the different chapters to come.

Chapter 2: This chapter describes, discusses and critiques literature relevant to the key constructs of the study. Literature covers, international and local policies around rehabilitation and what rehabilitation is in the South African context. Furthermore, it gives a background into community service in South Africa as well as introduces the theoretical framework underpinning this study.

Chapter 3: The methodology section begins by describing the aims and sub aims of this study. It then highlights the positionality of the researcher as well as explain the research design used. It goes on to describe the participants through explaining the participant selection criteria as well as giving a breakdown of the demographics of the participants. This chapter then goes into further details about data collection and the process of analysing the data through using a framework analysis approach which gave rise to the themes generated in this study. Finally, the ethical considerations are outlined and the trustworthiness strategies used are described.

Chapter 4: This chapter outlines and describes the findings of the study. The themes of the study are then mapped onto Faloy's five elements of management and described in further detail using quotes from participants to demonstrate the themes spoken about.

Chapter 5: This chapter discusses the findings of the study in relation to published literature and argues whether the findings agree, correlate with, or refute already published studies.

Chapter 6: This chapter highlights the conclusions from this study through determining if the aims of the study are met. The strengths and limitations of the study are highlighted along with the implications of the study in terms of bettering rehabilitation policies, how the findings of the study can be used to improve current practice and what further research can be done.

Chapter Summary:

This chapter gives an introduction into the implementation of community service and highlights the healthcare professions who are required to complete a community service year. It also informs about the aims of the community service year. It then goes on to explain the different rehabilitation professions and their importance in assisting persons with non-communicable diseases. The challenges faced within the state run healthcare facilities are also highlighted and it is explained that due to these challenges many healthcare professionals are leaving the state run healthcare facilities and choosing to work in private healthcare. The lack of staff in state run healthcare facilities both due to healthcare professionals choosing to work in private healthcare as well as the freezing of government posts leads to community service rehabilitation professionals being placed at healthcare facilities with no senior personnel of the same profession. This leads to the phenomenon of community service rehabilitation professionals managing their own department. The lack of supervision in the formative years of professional development and the consequences thereof are also explored in this chapter. This chapter then highlights other studies conducted on community service and explains why this study is important and the impact it can have on professional development. Finally, an outline of the chapters in this dissertation is provided.

Chapter 2: Literature Review

This chapter will outline the different literature pertaining to the topic of community service rehabilitation professionals who have managed their own department. It gives background into the different policies around rehabilitation professions both internationally and within South Africa as well as outlining what rehabilitation professions and community service are, highlights community service readiness, and finally outlines the theoretical framework Faloy's five elements of management which underpins this study. Google scholar was used to access the articles cited. The keywords used were community service, rehabilitation professionals, South Africa, allied professionals, healthcare and management. The time period given was 1994 – 2024 to give access to more articles due to the scarcity of research on this topic.

Community Service in The South African Context:

Prior to 1994, inequality in South Africa's health care system was historically caused by five main factors. The first factor was the lack of a central, binding health care policy which led to ineffective management systems and poor policy measures which allowed the healthcare system to become divided by socioeconomic, racial and geographical factors (Van Rensberg & Fourie, 1994). The second factor is racial segregation and white dominance which created a foundation of inequality where discriminatory measures and practices of inequality were used to serve the healthcare needs of population groups unequally (McLaren et al., 2014). Thirdly, due to free markets (laws of supply and demand govern the economic system without government interference), market justice (healthcare should be based on an individual's ability to pay through their own efforts) and profit-taking (selling an asset when it has risen in price) in the South African health care system, this gave rise to unequal distribution of resources and healthcare personnel, where disadvantaged race groups such as persons of colour were given insufficient resources to serve their populations (Van Rensberg & Fourie, 1994). The fourth factor is the white dominance of healthcare professionals who determined how to run healthcare facilities based on their own personal interests and occupational gain without taking into account the healthcare most needed by the whole population leading to disparities in healthcare between the different racial groups (Van Rensberg & Fourie, 1994). The final factor is that South Africa has a large population made up of a multitude of cultures which each have their own traditions and belief systems. This in turn determines what a person defines as an illness and whom they will consult for medical assistance based on their beliefs. A culture of traditional healers is prevalent in South Africa which also influences the population's use of

healthcare especially when traditional healthcare is not readily available (McLaren et al., 2014). Medical pluralism is defined as differing medical traditions and practices based on different principles and cultural beliefs but can coexist within a society (Amzat & Razum, 2014). Medical pluralism is common within South Africa through the use of both modern medicine as well as traditional healers. In African and Asian countries, traditional medicine is widely sought after especially in rural areas where access to healthcare is scarce. The impact of medical pluralism is that a patient may consult multiple healthcare providers (both medical and traditional) who give conflicting options which leads to confusion and mistrust in healthcare systems. In turn, due to the mistrust in healthcare systems, essential care and procedures may be delayed which effects treatment outcomes (Moshabela et al., 2012).

Post-apartheid, three different levels of healthcare were introduced, namely a primary, secondary, and tertiary level of healthcare. A primary healthcare facility consists of local clinics and community health centres where preventative, promotional, curative and rehabilitation services are offered and are only open for eight hours a day (Cullinan, 2006). These facilities are mainly run by nurses, but a doctor may visit and provide regular visits to the clinic (Cullinan, 2006). A person who has an ailment must first visit a primary healthcare facility before they are referred to a secondary facility for further management. A secondary healthcare facility consists of district and regional hospitals. A district hospital provides both inpatient and outpatient services where patients receive care from a general medical practitioner and have access to other rehabilitation services (Cullinan, 2006). This hospital does not employ any specialised medical doctors and only has access to basic diagnostic equipment such as x-rays and laboratories (Cullinan, 2006). A regional hospital employs at least five of the following specialised doctors: surgery, medicine, orthopaedics, paediatrics, obstetrics and gynaecology, psychiatry, diagnostic radiology, and anaesthetics as well as general medical practitioners and other rehabilitation services (Cullinan, 2006). Tertiary hospitals are academic hospitals where multiple specialists and services are available and complex operations take place. In order to gain access to a tertiary level hospital a patient must be referred from a level two hospital first (Cullinan, 2006).

A scoping review conducted by Maphumulo and Bhengu (2019) which aimed to determine the challenges to improve the quality of healthcare services in South Africa found that the most significant factor found that hindered the quality of healthcare in the government healthcare system was shortage of human resources due to not enough staff being employed in state-run healthcare facilities. The shortage of human resources due to fiscal austerity, immigration,

freezing of posts and healthcare professionals moving to the private sector has an impact on service delivery as prolonged waiting times occur, which means that patients are not being treated as quickly as they should be and this can have an effect on their prognosis (Maphumulo & Bhengu, 2019). Multiple adverse events such as complications and sometimes death occur due to patients being turned away or not helped at state healthcare facilities because of lack of human and medical resources (Maphumulo & Bengu, 2019).

Community service was therefore implemented in South Africa to attempt to increase the number of healthcare workers in government hospitals in order to address the shortage of human resources and provide access to adequate healthcare to more patients at all levels of healthcare facilities in the country (Reid et al., 2018). The aims of community service for healthcare professionals, as stated in the background, is to provide healthcare to rural areas in South Africa as well as allow young healthcare professionals the opportunity to develop their clinical skills under supervision (Reid et al., 2018). Both these aims should be regarded with equal importance, however, as it is deemed as 'service' community service placements are made according to healthcare needs deemed by the Department of Health and not necessarily where sufficient supervision will be given to the community service healthcare worker (Reid et al., 2018). Community service in South Africa can be described as a compulsory service completed within a year post qualification which allows for education and employment. This can be used at a strategy to place additional healthcare workers in rural areas where healthcare services are limited and therefore may not have additional personnel to act as supervisors to community service healthcare professionals (Reid at el., 2018).

Policy Reforms Pertaining To Rehabilitation:

The Sustainable Development Goals (SDGs) for 2030 is an initiative that was created by the United Nations in 2015. This is a collection of 17 goals each targeting a different humanitarian and environmental challenge in order to improve the overall wellbeing of the global population (United Nations, 2015). Sustainable goal number three mandates states to ensure good health and wellbeing for all citizens at all ages. It further states that within Sub-Saharan Africa the shortage of healthcare professionals is a potential threat for the realisation of this goal (United Nations, 2015). The goal specifically states that there are ten nurses and midwives for every 10000 people in sub-Saharan Africa (UN, 2015). Before the Covid-19 pandemic, progress had been made towards the achievement of this goal in the form of increasing life expectancy, decreasing the number of infections of non-communicable diseases and reducing maternal and child mortality (Khetrapal & Bhatia, 2020).

The Rehabilitation 2030 framework on the other hand is a call for action, which is a framework initiated and coordinated by the World Health Organisation (WHO) aimed at increasing the availability for rehabilitation services globally (World Health Organisation, 2017). This initiative was created in February 2017 in order to assist in fulfilling goal three of the SDGs through rehabilitation services as well as primary healthcare by aiming to optimise functioning and support persons with health conditions to become as independent as possible in order to participate in society (WHO, 2017). The overall goals of the Rehabilitation 2030 initiatives are for rehabilitation policies to be implemented from a leadership and governance level, planning and implementation of a standardised toolkit to make rehabilitation services more readily available and initiate research and find evidence on rehabilitation services and health policies in low- and middle-income countries (Negrini & Gimigliano, 2017). This framework highlights that rehabilitation services are deemed as necessary in a global context. The aims of the framework in theory would assist in increasing access to rehabilitation worldwide. However, it is at the behest of local governance to initiate the aims outlined in this policy and as such, so far South Africa has made policies to improve access to rehabilitation service but a standardised toolkit is not in existence yet.

Specific policies relating to the implementation of rehabilitation services in South Africa include the National Rehabilitation Policy which was adopted in 2000. This policy has a total of seven aims listed as to improve access to rehabilitation services, to improve intersectoral collaboration in order to create a comprehensive rehabilitation program, to facilitate appropriate distribution of resources and ensure they are used appropriately, to improve human resource development to ensure the needs of the consumer and service providers are met, to ensure persons with disabilities are included during planning, monitoring and implementing rehabilitation services, and to encourage research into rehabilitation initiatives (Mji et al., 2017). The intention behind this policy is to improve access to rehabilitation services as well as improve the ability of rehabilitation professionals to work more effectively through more human resources and ensuring all persons accessing rehabilitation services needs are met. However, there is little evidence to show that these aims have been put in place as rehabilitation departments are still under resourced leading to long wait times and the inability to provide sufficient care to their patients (Haskins et al., 2016).

Another policy outlining the importance of rehabilitation services in South Africa is The Framework and Strategy for Disability and Rehabilitation Services in South Africa 2015-2020. This policy framework aimed to facilitate the provision of appropriate, affordable, accessible

and quality rehabilitation services to persons with disabilities throughout their life span in South Africa through appropriate and effective resource allocation and intersectional collaboration (Department of Health, 2015). This was aimed to be done through seven strategies outlined by the Department of Health (DoH) (2015) as follows: (i) ensure rehabilitation services are available at every level of healthcare; (ii) developing an effective referral system between the different rehabilitation units at every level of healthcare; (iii) foster collaboration between different department; (iv) create standards for accessibility by improving signage, infrastructure and means of communication (v) increase healthcare worker's knowledge and awareness of persons with disabilities and the attitudes toward them; (vi) improve monitoring of rehabilitation services, (vii) improve the human resources available for disability and rehabilitation services (viii) improve access to appropriate assistive devices and technologies. The implementation of this policy has been hindered by actor dynamics, insufficient resources, rushed processed, poor record keeping, inappropriate leadership, negative staff attitudes, and insufficient monitoring (Hussein et al., 2022).

These international, regional, and national healthcare and rehabilitation healthcare policies outline how important rehabilitation services are in the medical field as they provide integral services needed by patients to assist in improving quality of life. When looking at these policies however, it is obvious that there is a gap in policy on community service. There are no community service guidelines that explicitly state the role and duties of the community service healthcare professionals and how much supervision they should be receiving. It is important to note that whilst South Africa has instated policies to improve rehabilitation healthcare, there has been little actual progress in improving rehabilitation departments such as being short staffed and not having sufficient resources (Hussein et al., 2022). A great barrier to accessing rehabilitation services is the lack of rehabilitation professionals (Sherry, 2014). This has a direct impact on incoming community service rehabilitation professionals and it creates the phenomenon where there are no senior rehabilitation professionals available for supervision and a community service therapist is expected to become a manager of the department. This can have further implications post their community service year where it may deter community service rehabilitation professionals from wanting to work in state healthcare facilities creating a further shortage of personnel.

Rehabilitation Professions in South Africa:

Rehabilitation professions are a four-year professional degree which entails becoming a healthcare working specialising in identifying, treating and providing aids for chronic

conditions (Campbell et al., 2019). Rehabilitation professionals focus on the everyday functioning of persons with health difficulties. Each profession specialises in a certain type of body function and how to address difficulties within that aspect of the body (Campbell et al., 2019). Speech language therapists specialise in speech and language and a person's ability to communicate and feed effectively (South African Speech and Hearing Association, 2022). Audiologists focus on hearing and balance disorders (South African Association for Audiologists, 2022). Physiotherapists concentrate on mobility and gross motor movements (South African Society of Physiotherapy, 2022). Occupational therapists focus on activities of daily living and fine motor movements (Occupational Therapy Association of South Africa, 2022). A dietician works with nutrition and assisting patients with their diet and lifestyle choices (Association for Dieticians in South Africa (2022).

Ned et al (2020), conducted a study looking into the changing demographic trends of South African occupational therapists between 2002 and 2018. This study concluded that 65 percent of working occupational therapists identified as white, 16 percent as black, 9 percent as coloured and 8 percent as Indian. However, the growth of incoming black and coloured occupational therapists was noted at 61.8 percent and 60.5 percent respectively whereas the population of incoming white occupational therapists has declined to 31.5 percent. Ned et al (2020), explain that although segregated policies have been abolished in universities and that universities have instated quotas to improve the number of black, coloured and Indian students, the rehabilitation professions are not as well-known as other careers such as medicine or engineering especially in rural areas. It is also noted that the rehabilitation professions do not tend towards as high a renumeration despite requiring high levels of academic ability. Therefore, there is a likelihood that matriculants may choose careers that afford them a higher renumeration rate and status than a rehabilitation profession.

In South Africa there is a shortage of rehabilitation professionals especially in the public sector. According to the Framework and Strategy for Disability Services in South Africa approximately 22-27 percent of posts for rehabilitation professionals in the state healthcare facilities are vacant (Morris et al., 2019). In 2015 there were 1213 occupational therapists, 1256 physiotherapists and 596 speech language therapists and audiologists employed in state posts. The data on specific patient to rehabilitation professional ratios is currently unreliable. However, according to the 2011 census there were approximately 2.8 million people living with a disability in South Africa and 84 percent of these people rely on government provided healthcare services. This equates to each rehabilitation healthcare professional servicing 1051

persons living with disabilities in South Africa assuming that they all require rehabilitation services (Morris et al., 2019). These statistics only take into account persons classified as living with disabilities and not persons living with disabilities due to chronic illness which is also a significant portion of a rehabilitation professionals' case load and would increase the number of patients seen per professional if included (Morris et al., 2019).

The quadruple burden of disease encompasses child and maternal health, HIV and TB, non-communicable diseases, and injuries due to violence and crime. These are statistically the most common cause of death within South Africa. Due to the increased number of patients with such diseases but not enough rehabilitation professionals within the government sector, this creates more strain on an already under resourced and understaffed healthcare system (Haskins et al., 2016). The rehabilitation professions provide a number of services to persons diagnosed under the burden of disease. Firstly, rehabilitation professionals provide a holistic well-being approach to treatment as opposed to management of an impairment. They focus on improving physical, mental, and communicative abilities (Ebrahim et al., 2020). Multidisciplinary interventions are also a key aspect of rehabilitation service as working with other professionals allows for integrated treatment plans that target all areas of need. Rehabilitation professions primarily focus on function and ensuring the patient is able to function to the best of their abilities to be able to have quality of life and as much independence as possible (Ebrahim at al., 2020). Therefore, understaffing of rehabilitation professionals has a great impact on patients with such diseases. Understaffing is especially prevalent in rural areas where over 46 percent of the population reside and who have the highest risk for being effected by non-communicable diseases and are also the most dependent on government healthcare services which are serviced by only 19 percent of health professionals who work in remote and rural areas (Haskins et al., 2016).

Community Service Readiness:

A study conducted by Wranz (2011), explored the perceived readiness for community service from the experiences of speech language therapists that had graduated from Stellenbosch University and completed their community service in different contexts in 2009. The results from this study indicated that the community service speech language therapists who participated in the study felt that their clinical and theoretical training had been adequate to allow them to practice in their community service year. However, many participants reported that additional knowledge should be given on aspects of working within a hospital and multi-disciplinary team. Participants in the study recommended lecture series on administrative and

managerial skills that may be needed during the community service year as well as being given the opportunity to work within a multi-disciplinary team during their undergraduate training (Wranz, 2011). The results from this study indicate that community service speech language therapists that participated in this study feel as if they have adequate training in the clinical aspects of their profession but need more exposure to managerial aspects (ordering stock and monthly reports) of their profession during their undergraduate studies.

Naidoo et al (2017), conducted a study to determine occupational therapy graduates' readiness to work in primary healthcare and rural practice once graduating from The University of Kwa-Zulu Natal. This study found that graduates were well prepared to work in urban and peri-urban settings where their clinical training had been conducted, but struggled to practice in rural settings which they had less exposure to during their undergraduate studies. A main concern in this study was the linguistic and cultural barriers they had faced in a rural setting which they felt had not been adequately addressed while studying. Furthermore, this study once again highlighted the need for multi-disciplinary training during undergraduate training as due to the rural setting a multi-disciplinary approach is often used and allows the rehabilitation professions to better understand each other's professions. The lack of knowledge of administrative and managerial tasks was also mentioned and highlighted in this study. The participants further recommended that being aware of the managerial systems within the Department of Health and hospitals as well as being aware of how to go about securing resources to ensure adequate service delivery should be included in the undergraduate curriculum (Naidoo et al., 2017).

A study looking at community service physiotherapist's suggestions on how to improve the curricula to better prepare students for community-based therapy suggested that including exposure to different stakeholders such as organisations that advocate for persons with disabilities would be beneficial during their undergraduate studies (Mostert-Wentzel et al., 2013). This would allow students to be more knowledgeable about a variety of conditions they may be exposed to and to understand the condition on a personal level in order to treat patients respectfully and culturally appropriately (Mostert-Wentzel et al., 2013).

This information is important to note as it highlights that community service rehabilitation professionals who have access to supervision and are not managing their own departments still report wanting to have been given more information during their undergraduate studies about managerial and procedural systems within a government hospital as well as other factors such

as experience working in more rural settings. For community service rehabilitation professionals who are managing their own departments, the need for this type of information is even greater and being provided such information before their community service year could mitigate some of the challenges experiences during community service as they would already have some idea on how to manage a department and managerial procedures and duties that are required of them.

Conceptualising Management Using Faloy's Five Elements of Management:

Management is defined as the process of organising, planning, directing, and controlling an organisation's members and resources to ensure that particular goals are reached (DuBrin, 2009). Faloy (1916), describes management as encompassing five elements namely, planning, organising, co-ordination, command and control (Fells, 2000). Planning encompasses predicting the future and creating an action plan to prepare for it. This must take into account the available resources and future projects which may arise. Organising is outlined by Fayol (1916) as the duties undertaken by the different personnel and how to ensure that these duties are being fulfilled to the highest standard by all personnel. Commanding is described by Fayol (1916) as ensuring each manager within the personnel fulfils their responsibilities to their subordinates and to ensure the interests of the business are met. Co-ordinating is ensuring that each individual department is able to harmoniously work with other departments to reach a shared goal. Lastly, control is having verification and measures when implementing a plan in order to identify weaknesses and problems before they arise and address them (Fells, 2000).

This theory of management has previously been used in a rehabilitation study, one conducted by Du Toit et al (2010), which explored creating a competency-based curriculum for eye care managers in Sub-Saharan Africa. In the study by Du Toit et al., (2010) which used this framework, many stakeholders were approached to give feedback on what they deemed should be included in the curriculum of training eye care managers. The results from participant responses were then analysed and tabulated according to Faloy's five elements of management. This approach allowed the researchers to organise the data in a concise and precise manner in order to present it in a way which allowed the reader to understand the data easily. This study also highlights how this theoretical framework can be used when analysing managerial practices of rehabilitation professionals. It allowed the researcher to identify gaps within the managerial system that community service rehabilitation professionals managing their own department experience and the researcher can suggest ways in which these gaps can be

mitigated to assist future community service rehabilitation professionals who have to manage their own department.

Igbokwe et al (2020), also used this theory of management but in a more practical manner. Igbokwe et al (2020)'s, study investigated how to prepare schools in Nigeria for students to return after lockdown during the Covid-19 pandemic. The authors outlined the different stakeholders within a school and using Faloy's five elements practically outlined how each stakeholder (such as principals and teachers) could prepare their environment and implement policies to ensure the safety of personnel and students. This study illustrates how this theory of management can be used not just for managers of a team or the heads of an institution but also can be adapted to include different types of managers, stakeholders and different styles of management. This is important for this study as community service rehabilitation professionals who manage their own department do not manage a team of people but are responsible for managerial duties that ensure their department is able to run efficiently. Therefore, this framework allows for considering that in this situation there is a lone manager without employees to manage. It also shows how a manager interacts with different departments to be able to run an institution efficiently which is important to a community service rehabilitation professional who may rely on senior staff in different departments for assistance.

Chapter Summary:

This chapter has highlighted how community service came about post-apartheid and the factors that led to the creation of community service mainly to improve access to healthcare in rural communities as well as give newly graduated medical professionals an opportunity to learn and improve their clinical skills. The international and local rehabilitation policies are also outlined to highlight how important rehabilitation services are deemed to be but there is a lack of specific policies relating to community service for rehabilitation professionals. Furthermore, it is important to note that even though South Africa has ratified these policies access to rehabilitation healthcare is still limited due to lack of rehabilitation professionals. This leads into rehabilitation within the South African context where there is a lack of rehabilitation professionals for the population. This is due to lack of access and awareness of the rehabilitation professions in rural communities which means people of colour were not given equal access to study the rehabilitation professions. The quadruple burden of disease has led to an increase in patients seeking rehabilitation professionals which puts strain on an already under resourced system. Freshly graduated community service rehabilitation professionals enter this system without having the appropriate knowledge of administrative and managerial

tasks expected of them which causes an emotional toll on them. Finally, Faloy's five elements of management are explained in detail and it is shown how this framework can be used in different contexts. It is highlighted that this framework was chosen for this study as it allows for management for a department without any other personnel as well as how a manager interacts with different departments to run their department effectively.

Chapter 3: Methodology:

This chapter will outline the aims and sub-aims of this study. It will describe the positionality of the researcher. It also goes on to detail the research design, the recruitment of participants and demographics of the participants as well as the materials used during data collection. The data collection process is also outlined. This chapter then explains how the data was analysed using the framework analysis method as well as details the trustworthiness methods used during the study to ensure rigour and the ethical considerations of the study.

Research Question: What are the experiences of community service rehabilitation healthcare professionals who have managed their own respective rehabilitation departments in South Africa during their community service year?

Main Aim: To determine the experiences of community service rehabilitation healthcare professional managing their own respective rehabilitation departments in South Africa during their community service year.

Sub-Aims:

- To determine how and by whom community service rehabilitation healthcare professionals were prepared to manage a department.
- To explore the challenges experienced by community service rehabilitation healthcare when managing their own department.
- To describe the facilitators and support systems community service rehabilitation healthcare professionals had access to when managing their own department.

Positionality:

This research is especially important to the me based on my own experiences during my community service year. During my community service year, I was placed in a level 1 district hospital in rural Thabazimbi, Limpopo where I was the only speech language therapist and audiologist to service the hospital. I was also expected to service the community within the surrounding municipality. I was therefore, "appointed" head of the speech and audiology department of the hospital and was given additional managerial duties I had not been prepared for. This was also the first time I had practiced without supervision and had to trust in myself to provide the best service delivery to my patients without consulting a more experienced professional. The challenges I faced during my experience included feeling very isolated with

a lack of support. I did not feel confident in my abilities as I was used to having other peers and senior professionals around to assist me or to bounce ideas off. Where I was placed, no one in the rehabilitation department really understood my profession and could not assist me. The nearest speech language therapists and audiologists were all over an hours drive away. I met the head of speech and audiology in my district once and could phone their department if I was in need of assistance but this was not the same as having onsite supervision to see the daily therapy sessions and to give guidance on whether or not I was doing due justice to my patients. Therefore, this research is very important to me as I have been through this situation and would like to explore ways in which future community service rehabilitation professionals can be better assisted if put in a managerial position with no experience.

Research Design:

This study employed a qualitative research design. A qualitative research method is described as a scientific method of gathering non-numerical data (Babbie, 2017). It aims to determine why certain phenomena occur and focuses on the meanings, concepts, definitions, characteristics, metaphors, symbols and descriptions of the subject of the research (Babbie, 2017). This approach was deemed ideal for this study because the study aimed to describe the experiences of community service rehabilitation professionals in terms of managing their own department which entailed non-numerical data collection but rather data in the form of participant testimony which gave insight into the phenomena from their perceptions and experiences.

An exploratory research approach was employed. Exploratory research is used when the problem being investigated in the study is not extensively researched and documented (Creswell et al., 2007). This type of research is beneficial as it allows the researcher to determine different themes and ideas from the results which can be used in future studies to gather more information on the topic. Therefore, exploratory research was selected for this study as it allowed the researcher to analyse the data from the interviews that took place to determine different themes and trends and to better describe the experiences of community service rehabilitation professionals when heading their own department. This information can then be used to discuss how these experiences can help improve the way in which community service rehabilitation professionals are prepared for community service and heading their own department. There is also paucity of research in this area and therefore by conducting this study, more research is done on this phenomenon which has the ability to give rise to further research.

This research was conducted using semi-structured interviews which are defined as an open style of interviews, in which the interviewer has a framework of open-ended questions to ask but can ask additional questions based on what the interviewee says and can further probe for more information (Edwards & Holland, 2013). The main theme or topic of the interview is thought out in advance by the interviewer and is usually written up into an interview schedule for guidance during the interview (Edwards & Holland, 2013).

Adams (2015) highlights the advantages and disadvantages of semi-structured interviews. They state that advantages of semi-structured interviews include allowing the interviewer to determine the individual thoughts and opinions of the participants about the research subject as well as probing participants on topics they may not feel comfortable talking about in a group setting. The disadvantages stated include that interviews can be time-consuming due to having to arrange interview times with participants and the time of actually conducting the interview. Semi-structured interviews are also labour-intensive as transcribing and analysing the data can be a laborious process. (Adams, 2015). These disadvantages were addressed by using a Google form where prospective participants inputted their contact details and preferred method of communication (Whatsapp, email or phone call) in order to arrange a suitable time for the interview. The researcher had an interview guide with questions to ask during the interview which assisted in ensuring the interview ran smoothly and all information that was needed was gathered. The participant was informed ahead of time approximately how long the interview will take in order to plan their schedule around the interview.

The semi-structured interviews were synchronous online interviews. Synchronous interviews were conducted online via Zoom where both the interviewer and the interviewee were online at the same time to conduct the interview (Janghorban, 2014). Some advantages of synchronous online interviews include the ability to interview people in a different location which is not accessible to the interviewer physically due to distance, which in turn opens up the study to more participants. As there is a small population of rehabilitation professionals who have managed their own departments, which had the potential to limit the number of participants to be interviewed for the study, synchronous online interviews allowed the researcher access to more potential participants. This also allowed the researcher to gather more data from many different participants from different parts of the country to allow for representation of participants and contexts.(McDermott & Roen, 2012).

The disadvantage of synchronous online interviews is that the interviewer may have less opportunity to create a welcoming interview ambiance which may lead to the interviewee feeling uncomfortable and less willing to open up to the interviewer. To mitigate this, the participants were asked to have the camera option on, so that the researcher and the participant were able to see each other, as being able to see the other person when talking creates a more natural conversation environment and assisted the participant in feeling more relaxed by being able to see the researcher. Ensuring the participant also has access to the correct software and had a stable internet connection may also be a difficulty with synchronous online interviews as not everyone has these services readily available to them. This was addressed in the participant information sheet where the participants were made aware of what was to be expected of them to be able to participate in this study and what applications they needed to participate in the interviews. The final disadvantage of synchronous online interviews is ensuring the correct identity of the participant as the researcher may not have had contact with the participant before and therefore would not be able to verify who they are due to technological advancements such as artificial intelligence which makes it easier to conceal one's identity online. Online video call applications also have audio only options and the interviewee may choose this option which makes ensuring the participant is who they say they are more challenging (Deakin & Wakefield, 2014). This was mitigated through only conducting video call interviews in order to ensure that the person being interviewed was who they said they were. The was one instance where a participant's video camera was broken and an audio only interview was conducted but the participant verified that they had read the participant information sheet and consented to the interview and therefore it was determined that their identity was correct and the interview went ahead.

Study Participants:

Sampling Strategy:

Purposive sampling was used first to recruit participants, as qualitative research relies on the experiences of individuals (Merriam, 2019). This method of sampling entails gaining access to participants who have experienced the phenomena being studied and can provide the most relevant and rich information on it (Merriam, 2019). Purposive sampling was selected for this study as community service rehabilitation professionals have lived through the experience of heading their own department and were therefore in a better position explain their own personal experience as opposed to others explaining their experience for them. The researcher recruited participants through contacting the professional boards of the different professions namely,

South African Speech Language and Hearing Association (SASLHA), Occupational Therapy Association of South Africa (OTASA), South African Association of Audiologists (SAAA), South African Society of Physiotherapy (SASP) and, Association for Dieticians in South Africa (ASDA). The researcher asked to advertise the study through these organisations to their members. After the organisations gave their permission to advertise the study, the researcher sent the organisation a research advert with a google forms link. The potential participants were asked to show their interest in participating in the study through leaving their name and contact details as well as preferred method of being contacted on the google form. The researcher then contacted the participants who had indicated their interest to participate in the study through the google form via their preferred method of communication and requested that they complete the consent form before arranging an interview. Once the completed consent form was received via email, the researcher organised an online interview through Zoom at a time that was most convenient for the participant.

Selection Criteria:

A selection criterion is made up of an inclusion and exclusion criteria. An inclusion criterion is made up of characteristics a participant must have that the researcher will need to explore in order to answer their research question (Patino & Ferreira, 2018). In contrast, an exclusion criterion is when a participant may have all the characteristics the researcher needs to answer the research question but they may have additional characteristics that will impact the results they provide and not provide the researcher with the desired outcome (Patino & Ferreira, 2018). It is important to have these criteria in order to ensure that the participants that are selected will be able to provide the correct type of information to answer the research question and in turn reliable results will be obtained (Patino & Ferreira, 2018).

The following selection criteria was used to select participants for the study:

1) The participants had to have managed their own department when they were in their community service year.
2) Participants had to have a degree in a rehabilitation healthcare profession, namely, speech language therapy, audiology, physiotherapy, occupational therapy, and dietetics.
3) Participants had to have been registered with the Healthcare Professions Counsil of South Africa (HPCSA) as a rehabilitation professional.

4) The participants had to be employed and practicing within the South African context.
5) Participants had to have a device that connects to the internet and be willing to make use of their own data to participate in the online interviews.

Sample Size:

Due to this study using a qualitative research approach, the sample size was small. According to Vishnevsky and Beanlands (2004), an exploratory research approach consists of a sample size of ten or less individuals as this is an adequate number of participants to collect enough data to be able to obtain adequate detail for analysis. On the other hand, Crouch and McKenzie (2006), state that to conduct research using semi-structured interviews a sample size of less than 20 participants is sufficient due to the nature of the topic being researched. Because the topics that utilise semi-structured interviews as the method of data collection mostly deal with personal experiences and opinions of the participants, less participants are required due to the nature of such interviews and the data collected from the interviews should provide enough information to analyse in order to complete the study (Crouch & McKenzie, 2006). Data saturation must also be considered when determining sample size (Ness, 2015). Data saturation is a term used to describe when sufficient data has been collected and as such, the themes and results are the same across participants and therefore no new themes are being highlighted during data collection. In fact, Ness, (2015) reports that ten participants would suffice data saturation when conducting qualitative interviews. Furthermore, Braun and Clarke (2013), state that for studies that explore the experiences of a population of people, a small sample size is sufficient and using interactive data collection methods such as interviews, a sample size of between 10-20 participants is sufficient for a medium size study. Ultimately the final sample size of this study was 15 participants as determined by data saturation and the study being medium sized as. Table 2 below outlines the participants of the study and their demographics.

Table 2: *Table of participant demographics*

Year Community Service Was Completed In	Current Age	Gender	Profession	Province Community Service Was Completed In	Type of Healthcare Facility Where Community Service Was Completed
2019	26	Female	Occupational Therapist	KwaZulu Natal	Level 1 hospital
2022	23	Female	Speech Language Therapist	KwaZulu Natal	Clinic
2020	26	Female	Occupational Therapist	Eastern Cape	District hospital
2022	24	Female	Audiologist	Gauteng	Tertiary and provincial hospital
2020	26	Female	Dietician	Gauteng	Community healthcare centre
2021	25	Female	Occupational Therapist	KwaZulu Natal	Community healthcare centre
2022	22	Female	Audiology	KwaZulu	Community healthcare centre

Year Community Service Was Completed In	Current Age	Gender	Profession	Province Community Service Was Completed In	Type of Healthcare Facility Where Community Service Was Completed
2023	24	Female	Occupational Therapist	Free State	Primary healthcare
2023	26	Female	Occupational Therapist	Free State	District hospital
2017	29	Female	Physiotherapist	Western Cape	Regional hospital
2007	38	Female	Physiotherapist	Gauteng	Primary healthcare
2008	38	Female	Occupational Therapist	KwaZulu	District hospital
2010	36	Female	Physiotherapist	Gauteng	District hospital
2016	29	Female	Audiologist	KwaZulu	TB hospital
2006	38	Female	Speech Language Therapist	KwaZulu	Tertiary hospital

As seen in Table 2, a total of 15 rehabilitation healthcare professionals participated in the study. The sample size was made up of six occupational therapists, three physiotherapists, three audiologists, two speech language therapists and one dietician. Participants were between the ages of 22 and 38 years old with a mean age of 28.6 years. All participants were female. Seven participants completed their community service in KwaZulu Natal, two participants completed

their community service in the Free State, three in Gauteng, one in the Eastern Cape and in the Western Cape respectively. Four participants completed their community service in district hospitals, six participants at primary healthcare level, two at a tertiary hospital, one at a regional hospital and one at a tuberculosis hospital.

Study Site:

All interviews were conducted online via Zoom. The researcher is based in Johannesburg and conducted the interviews from her home. The participants were based throughout South Africa as stipulated in the Table 2 above and their location during the interview was not recorded.

Data Collection:

1. Ethical clearance was obtained from the University of Witwatersrand Non-Medical Human Research Ethics Committee . Protocol Number: H22/09/01

2. Organisations representing different rehabilitation healthcare professionals (SASHLA, OTASA, SAAA, SASP and ASDA) were contacted. The researcher asked the organisations to advertise the study and if members of these organisations are willing to be participants in the study, then they were asked to contact the researcher. They were also be given a link to a Google form for the participant to fill out with their name and contact details if they were interested in participating in the study.

3. A pilot study was then conducted, and the results thereof determined that no changes needed to be made to the study's data collection tool (interview schedule) and the process.

   Pilot Study:

   A pilot study acts as a trial of the main study which can be used to assess either the feasibility of a study or testing a research instrument before the actual study is conducted (Malmqvist et al., 2019). The pilot study in this research was used to assess the interview guide in order to determine if the questions asked provided the researcher with rich data to analyse and result in substantial results. The pilot study also assessed the process of the study, namely if the data collection process that was planned would be appropriate. The pilot study was conducted with one participant known to the researcher that fits the selection criteria. This was done through an online interview where the researcher used the interview guide to ask questions and gather data from the participant. This data was analysed using the data analysis method of framework

analysis and it was determined that the questions asked were appropriate in gaining the data needed for the study.

4. Once a participant had agreed to the study, then a consent form and participant information sheet was sent to them via email. They had to complete the consent form before participating in the study.
5. The researcher then conducted semi-structured interviews with the participants via video call on Zoom online at a time specified by the participants. Video call was chosen as being able to see the researcher's face allowed the participants to feel more comfortable.
6. The online interviews were also recorded with consent from the participant to record the data for analysis and reporting.

All interviews were conducted in English. Data collection took place between 21 February 2023 and 26 May 2023. Fifteen interviews were conducted including the pilot study; however, one interview was unusable as the participant did not meet the selection criteria. Therefore, sixteen interviews were conducted but only fifteen were analysed. The average duration of the interviews was 28 minutes.

Data Collection Materials:

The data collection materials used for this study included a self-developed interview schedule. Table 3 gives an outline of the interview guide with questions and the theoretical justifications of these questions. The researcher probed further if needed. A computer with Zoom was used to conduct the interviews and video recorded the interview to record the data for later on analysis and reporting. `

Table 3:*Outline of Questions to be included in the interview guide and a theoretical justification for each question.*

Question:	**Theoretical Justification:**
Section A: Demographic Questions	
Age	One reason demographic questions are asked is to increase repeatability of the study as the more detailed the information about the participants are, the easier it is to replicate
Gender	
Your Profession	

Province where Community Service was completed	similar participants. (Hughes, Camden & Yangchen, 2016).
Type of healthcare facility where community service was completed	
Section B: Questions on Readiness for Community Service When Managing a Department.	
What aspects of managing a department where you exposed to during your undergraduate studies?	Questions on readiness are important to ask in order to assess how the participants perceived their readiness when entering community service in order to determine how undergraduate programmes can better prepare them for community service when heading a department alone. It is also important to determine how the participants perceive their readiness for independent practice to determine whether the community service year can be altered to ensure competent and confident clinicians are created (Wranz, 2011).
What do you wish you had more exposure to during your undergraduate studies before community service?	
Section C: Questions on Management as a Community Service Rehabilitation Professional	
What structures were in place to assist in planning for future needs that may arise throughout the year?	Questions relating to management are important to ask as it gives insight into the workings of the department and what was expected of the community service rehabilitation professional. These questions also allow the participant to explain how they were able to manage a department and if they were able to collaborate with others (Naidoo et al., 2017).
What duties were you expected to complete as a department head?	
What forms of collaboration with other managers were available?	
In what way would the different departments interact with each other to assist with management duties?	

<table>
<tr><td>What measures were in place to reflect on tasks done and allow to better prepare for the future?</td><td></td></tr>
<tr><td colspan="2">Section D: Questions on Challenges Experienced when Managing a Department as a Community Service Rehabilitation Professional.</td></tr>
<tr><td>In terms of being prepared to manage a department, what do you wish you had been exposed to during your undergraduate studies?</td><td rowspan="3">Questions on challenges are asked to determine any barriers that are faced by a population of people. This is important information to find out as it helps to determine how the experience can be improved for the population being studied (Bissell, May & Noyce, 2004).</td></tr>
<tr><td>Describe any additional challenges you had during your community service year.</td></tr>
<tr><td>Do you have any suggestions on how to improve these challenges?</td></tr>
<tr><td colspan="2">Section E: Questions on Support Structures Offered When Managing a Department</td></tr>
<tr><td>What support structures were offered to you whilst heading a department during your community service year?</td><td rowspan="3">Determining the support structures present within a system is important as it can highlight either the need for more support structures or how to improve the current support structures offered. If sufficient support structures are present then this can assist in being an example on how to improve other organisations support structures (Baxter & Glendinning, 2010).</td></tr>
<tr><td>How did you find the support structures available to you to be beneficial?</td></tr>
<tr><td>What other additional support structures do you wish had been made available to you?</td></tr>
</table>

Data Analysis:

The data was analysed manually by the researcher whilst imploring the framework analysis approach outlined by Gale (2013). The data was obtained from the online semi structured interviews. In accordance with the framework approach to data analysis, both a deductive and an inductive thematic analysis of data approach was employed. With regards to the inductive thematic analysis, the researcher first transcribed the data verbatim from the audio recordings of the semi-structured interviews. Secondly, the researcher familiarised themselves with the

interviews and transcribed data through reading and re reading the data. Thirdly, the data was coded using collaborative coding between the student researcher and their supervisor. Collaborative coding involved simultaneously going through and reading the transcripts and highlighting any important information that was mentioned within and across the different interviews and categorising these into codes as agreed upon by the researcher and the supervisor. Where discrepancies arose in the process of collaborative coding, discussions occurred between the researcher and the supervisor until consensus was reached and a code was agreed upon. The end result of this process was the creation and reviewing of a codebook (Richards & Hemphill, 2017). It was important to use this method to code data to ensure trustworthiness of the study (Richards & Hemphill, 2017). The researcher then independently collapsed the codes into more defined themes, which were checked by the supervisor as a mean of inter coder reliability (O Connor & Joffe, 2020). Once the researcher and the supervisor agreed on the themes, then the second level of analysis, the inductive step was employed. In this step of data analysis, the researcher inductively mapped the themes that emerged from the analysed data into the tenets of Faloy's framework. The themes mapped on Faloy's framework were also sent to the supervisor for checking before the next step of interpreting the data and reporting the data as key findings occurred.

Trustworthiness:

Table 4 below outlines the different trustworthiness strategies, their definitions, and how they were implemented within this study.

Table 4: *Table Depicting Trustworthiness Strategies*

Trustworthiness Strategy:	**Definition according to Shenton (2004):**	**How it will be ensured in the study:**
Credibility	Credibility aims to ensure the research measures what it is supposed to measure.	This was done through iterative questioning which involved probing of answers to ensure truthful responses. This was done through data analysis ensuring the data is relevant to the research aims

Trustworthiness Strategy:	Definition according to Shenton (2004):	How it will be ensured in the study:
		and answers the research question. Member checking, peer debriefing and peer scrutiny were also used to ensure credibility.
Transferability	Transferability seeks to determine if the study's findings are applicable to other situations.	This was done by including detail such as research methods, participant selection criteria and the time period over which the data was collected in the final research report.
Dependability	Dependability is defined as whether the research study is repeatable, and the same results will be obtained if repeated.	This was done by including detail such as research methods, participant selection criteria and the time period over which the data was collected in the final research report. Thick description was also used to ensure the concepts and methods used in the study are accurately described and can be repeated.
Conformability	Confirmability is ensuring the data is as a result of the participants testimony and	This was achieved by justifying within the research report why certain techniques and methodologies were used

Trustworthiness Strategy:	Definition according to Shenton (2004):	How it will be ensured in the study:
	not influenced by the biases of the researcher.	as well as outlining any limitations of the study. This was also done by using opened ended questions within the interviews to ensure the participants answer the questions using their own experiences and are not led by the researcher. Another technique that was used was supervisor debriefings to ensure the researcher has another person to check the work and determine if bias was present. Recording the interviews also assisted with this as the researcher could refer back to exactly what the participant said to ensure it is accurately portrayed in the study.

Ethical Considerations:

Ethical Principles:

This study was submitted to the Wits HREC (Non-Medical) for ethical clearance before commencement. Protocol Number: H22/09/01

1.Confidentiality, anonymity, and safekeeping of information:

The participants were assured that the interviews conducted will be kept confidential and only the researcher and her supervisor have access to the recordings and transcripts. The data collected from the interviews was adapted to ensure the participants remain anonymous as all identifiable information about the participant was removed. The information gathered during this study will be stored on a password protected computer and password protected word documents to ensure only the researcher and their supervisor has access to the interviews and transcripts.

2. Autonomy:

Participation in this study was voluntary. The participants were allowed to withdraw from the study at any moment in time if they so wished and were able to refuse to answer any questions they did not wish to answer.

3. Consent:

Participants had to give informed consent before participating in the study. They were provided with an information sheet which outlined what the study was about, what their participation entailed and how their confidentiality was ensured during the study. They were given an opportunity to ask the researcher any questions they had before consenting to participation if they so wished. They were then given a consent form to sign to show their consensual willingness to participate.

4. Beneficence and non-maleficence:

This study did not appear to pose any direct risk to the participants, and they did not stand to gain from this study. Participants were informed as such.

5. Justice:

As the study was low risk there was little to no chance of potential harm to the participants. The researcher was aware that the participants were giving of their time and knowledge to assist in gaining data for the study and therefore treated the participants with the respect due to them. All participants were given equal opportunity to describe their experiences and be treated in a fair manner.

6.Debriefing and results for participants:

The participants were given the opportunity to discuss any concerns they may have had about the study with the researcher before, during and after their participation. A copy of the research report will be made available to them at their request.

Distress Protocol:

The ethical implications of semi-structured interviews as a method of data collection must be considered. The subject matter of the interviews may be sensitive and may cause emotional reactions during the interview. This was considered during the interview and if there were any signs of emotional distress the interview could be terminated as well as access to counselling provided at the willingness of the participant. A distress protocol was also in place for if such an event occurred then appropriate action could be taken. The interview process may also be strenuous and take a long time therefore, the option to take breaks during the interview was provided if needed (National Disability Authority, 2009).

Another aspect of the research study that needed to be considered under ethical considerations was online interviews. As video calling applications have the option to conceal one's face there was a possibility that the participant may not be who they say they are. As the researcher was also not having face to face contact with the participant, it may be more difficult to determine the reliability of participant (Rodham & Galvin, 2006). This was addressed by only conducting video interviews where the face can be seen.

Chapter Summary:

This chapter has outlined how this study was conducted by first stating the aims and positionality of the study. The research design of this study was a qualitative exploratory research approach due to this study highlighting the experiences of community service rehabilitation professionals who managed their own departments. Semi-structured online interviews were used to conduct data collection as this allowed the researcher to further probe the participants as well as have more access to participants nationally through online

interviews. The participants were made up of rehabilitation professionals who has completed their community service having to manage a department. The data from these interviews was then analysed using the framework analysis method where the themes were mapped onto Fayol's five elements of management.

Chapter 4: Findings

This chapter outlines and details the findings of the study in the forms of themes and subthemes. The themes and subthemes that emerged from the data are mapped onto Faloy's five elements of management, namely, planning, organisation, co-ordination, command, and control. These themes are presented accompanied by further detail with quotations from the participants. Additional themes that did not necessarily align with Faloy's elements but were relevant to the study are outlined and are also narrated with quotes to support them.

This study sort to explore the experiences of community service rehabilitation professionals who were managing departments in the year of their community service. The study specifically determined community service rehabilitation professionals' perceived readiness to head or manage a department, the challenges that they experienced when heading or managing a department, and the facilitators and support systems that were made available to them in their role as "managers" of their own departments.

The following themes and subthemes emerged from the data that was analysed from the interviews with participants: (i). Undergraduate training does not prepare students for managing a rehabilitation department; (ii). Insufficient handover from the previous community service therapist and not enough orientation at the beginning of the year; (iii). Create new documents that outline plans for their community service year; (iv). Duties expected of a community service rehabilitation professional, (iv- a) Clinical duties expected of a community service rehabilitation healthcare professional heading a department; (iv -b). Administrative duties expected of a community service rehabilitation professional heading a department; (v). Not having enough time for clinical and administrative duties; (vi). Co-ordinating with staff members within the healthcare facility; (vii). Discovering outside resources to collaborate with to assist with managerial and clinical duties; (viii). Staff negative attitudes towards community service rehabilitation professional; (ix). Staff's lack of knowledge of rehabilitation healthcare professions; (x). Meetings with other managers; (xi). Little to no feedback or verification structures in place, (xii). Creating a handover for the next community service therapist, (xiii) Ethical considerations, (xiii -a) Language barriers, (xiii-b) performing duties outside of scope of practice, (xiii -c) Lack of carryover of treatment due to lack of personnel (xiv) Safety, and (xv) Emotional toll on community service rehabilitation professionals

The above-mentioned themes were mapped onto the elements of Faloy's 5 functions of management. Table 5 presents an overview of the findings, specifically the themes that emerged through deductive thematic analysis alongside the elements of the theoretical framework.

Table 5: *Table depicting the themes mapped onto Faloy's 5 functions of management.*

Elements:	**Themes:**	**Subthemes:**
Planning	1. Undergraduate training does not prepare students for managing a rehabilitation department*:* 2. Insufficient handover from the previous community service therapist and not enough orientation at the beginning of the year 3. Create new documents that outline plans for their community service year	
Organisation	1. Duties expected of a community service rehabilitation professional 2. Not having enough time for administrative and clinical duties	1. Clinical duties expected of a community service rehabilitation professional 2. Administrative duties expected of a community service rehabilitation professional
Co-ordination	1. Co-ordinating with staff members within the healthcare facility 2. Discovering outside resources to collaborate with to assist with managerial and clinical duties	
Command	1. Staff negative attitudes towards community service rehabilitation professionals 2. Staff's lack of knowledge of rehabilitation healthcare professions 3. Effectiveness of meetings with other managers	

Control	1. Little to feedback or verification structures in place 2. Creating a handover for the next community service therapist	
Themes That Did Not Fit Into The Framework	1. Ethical considerations 2. Safety 3. Emotional toll on community service rehabilitation professionals	1. Language barriers 2. Performing duties outside of scope of practice 3. Lack of carryover of treatment due to lack of personnel

Element 1: Planning

Planning is described by Faloy (1916), as predicting the future, and creating an action plan to prepare for it. The themes idealised under this element of management are ; undergraduate training does not adequately prepare students for managing a rehabilitation department, the main form of handover for the incoming rehabilitation professional is from the previous community service rehabilitation professional who left a handover document due to there being little to no guidance to assist with management duties and the current community service rehabilitation professional having to create new documents as a plan for the year. These will be described separately in the following paragraphs.

Theme 1: Undergraduate training does not prepare students for managing a rehabilitation department:

The majority of participants in the study reported having minimal or no exposure to management during their undergraduate studies. Management is defined as the process of organising, planning, directing, and controlling an organisation's members and resources to ensure that particular goals are reached (DuBrin, 2009). The few participants that reported having been exposed to some form of training in management in their undergraduate training expressed that they attended short lectures or seminars about the different types of healthcare systems in South Africa (private practice compared to public healthcare). Participants reported that these lectures and seminars focused more on establishing a private practice post community service and did not necessarily cover in depth information on how to run a rehabilitation healthcare department in a government healthcare facility. This may be owing to the fact that it is generally not an expectation that at community service rehabilitation

professionals should be managing departments, but rather that the community service year should be a year where rehabilitation professionals are mentored and learning from more senior staff members of the same profession (Reid et al., 2018).

Participant 3, an occupational therapist who completed their community service in the Eastern Cape stated the following: *"We did a whole week of kind of like managing a department but I feel like it was very surface level like record keeping and filing and there was a few people that came to speak to us about key features of running a department and starting comm serve but there wasn't anything clear cut that I remember that made me feel ready to run a department."*

Participant 1, an occupational therapist who completed their community service in KwaZulu Natal also stated that : *"Not a lot. They did sort of prep us because they knew some of us would be going to hospitals without other people. So they gave us worksheets and specific assessments and stuff but not necessarily management type of information.".*

The majority of participants stated that management did not necessarily form part of their curriculum, but rather training on the practical aspects related to their profession were prioritised in their undergraduate studies such as ensuring they know the theory of their profession and how to use that theory in practice. Participant 7, an audiologist who completed their community service in KwaZulu Natal stated the following;

"Um so nothing and I will say to be very honest, people only thought about audiology specific. So specific to my degree, but we weren't given any training in terms of how to run a department or any other professional training in terms of running the department or anything like that. We only thought about our degree about our scope of practice."

Based on what participants of the study revealed, it can be stated that the universities do not consider management training an important subject to include in their curriculum as there is a substantial amount of theory and practical skills which need to be taught. Therefore, it may be seen as there is not enough time to include a course on managerial skills as well. The purpose of the community service year has been stated as an experience to assist in furthering clinical skills through supervision (Reid et al., 2018). However, it may be beneficial for universities to consider including some aspects of managerial training into the curriculum to assist community service rehabilitation professionals who may not have the ideal placement in which they are working under supervision but are rather placed in a healthcare facility that does not have another senior rehabilitation professional of the same profession and are therefore expected to manage a department in their community service year. By including a course on managerial

skills this may lead to the community service rehabilitation professional feeling more adequately prepared for such responsibilities.

Theme 2: Insufficient handover from the previous community service therapist and inadequate orientation at the beginning of the year.

Multiple participants mentioned some form of a handover being done by the previous community service rehabilitation professional to attempt to assist with managerial duties and to formulate a plan for the year ahead through different means. Handovers took different forms and were health facility specific. For example, some participants reported being left a handover document by the previous community service rehabilitation professional who had been there the year before and noted down what they had deemed important for the new community service rehabilitation professional to know. This document included what were the most common pathologies seen, how to organise their caseload most effectively, some had prebooked patients in advanced for the next year, information about outreaches and clinic schedules, as well as basic outlines of managerial duties and deadlines. The previous community service rehabilitation professionals deemed it necessary to create a handover document as there is no senior professional of the same profession at the healthcare facility where they are placed who can assist in mentoring about profession specific duties and responsibilities.

It should also be noted that community service rehabilitation professionals either had a supervisor at their facility but of a different profession such as a doctor who was head of the facility or another rehabilitation professional such as a speech language therapist who was head of the rehabilitation department. Many also had a discipline specific supervisor at the district office who was not based at the same healthcare facility but acted as a supervisor. Mixed feedback was reported about external supervisors at the district office. Some participants found this beneficial as the supervisor would assist them with their queries about both clinical and administrative tasks and other participants stated they did not find this beneficial as their supervisor was unhelpful in assisting them due to lack of communication and infrequent meetings. Some personnel of the same profession at other facilities or the assigned supervisor at district level were willing to assist with clinical or district responsibilities but would not know the procedures specific to the facility the community service rehabilitation professional is at. On the other hand, personnel of a different profession at the same facility would be able

to assist with facility specific administrative duties but will not be able to assist with profession specific enquiries.

For example, Participant 2, a speech language therapist that completed their community service in KwaZulu Natal stated that *"The previous year's comm serves had written a handover document. I think it should have been the supervisors' jobs to let us know what we needed to do and by when and how but it was all supposedly left just in the handover doc. It is difficult to convey everything that you are responsible for in a document, you know, where to find this"*.

It was said by most participants that whilst the handover document was helpful to a certain degree to give basic assistant in terms of structuring their department, having a person that was familiar with this information would have been more helpful as not all situations that arise throughout the year can be detailed in one document.

Other participants mentioned having been given one short orientation meeting at the beginning of the year during either a district, provincial or facility-based meeting, but no follow up meetings were held throughout the year. A meeting held by the department of health at either district or provincial level was conducted to introduce the community service rehabilitation professional to the district and orientate them about the department of health and some administrative duties such as statistics and chain of command. An orientation by the healthcare facility where the community service rehabilitation professional was placed was also beneficial in orientating community service rehabilitation professional to the layout of the hospital, what their daily and monthly duties were as well as the chain of command of the hospital. Unfortunately, participants stated that these orientation processes were not always conducted and they often found the orientation not informative enough for all the discipline specific duties and responsibilities expected of them.

Participant 3, an occupational therapist who completed their community service in the Eastern Cape shows the lack of orientation to the healthcare facility at the beginning of the year: *"I think definitely either having a permanent rehab member that has been there for at least the year before you and is able to hand over things and chat through processes and orientate you to the hospital. There wasn't even anyone to show us around the hospital. Like we arrived and the head pharmacist was like, oh, you're here, that's where rehab is you can go, I don't know what you do there but go do that."*

Many participants highlighted how an initial induction process at the beginning of the year stating all the duties and what is expected of a community service rehabilitation professional

who is managing a department would have been beneficial to allow them to better be able to plan for the year ahead and deal with situations as they arose throughout the year. Some provinces do host induction forums in the beginning of the year to orientate new community service rehabilitation professionals but these do not have specific information for community service rehabilitation professionals managing their own department in terms of additional administrative tasks they needed to complete such as ordering stock.

This is highlighted by Participant 14, an audiologist who completed their community service in KwaZulu Natal: *"So I think the initial process needs to be better. And I think I think there needs to be more communication and there needs to actually be a proper like, induction period, not just a one day where everyone's all together. And the provincial leader, you know, says a couple of words and says, you know, come on, guys. Off you go. And that was also the three months into the job anyway. So I think there should be actually a proper induction process. I think that it should be time to, you know, meet with the department, and I think it should be made clear from the beginning, like, what is expected in terms of you know, initially we'll support you with X, Y and Z. But after you know, three months, we're expecting you to be able to do 1234 independently. This is some examples of how it was done previously, you have leeway within certain ways to make it your own. All these things have to be done too, the protocol, stuff like that."*.

Theme 3: Creating New Documents That Outline Plans For The Year

Some participants recalled being instructed and expected to compile budget, business plan, and standard operating procedure document to assist in planning managerial duties throughout the year. An undergraduate student is not expected to be able to write these types of documents therefore, a community service rehabilitation professional who is in their first year of employment who has yet not been exposed to such documents and would not have the knowledge and skills to be able to formulate these types of documents would struggle with this task as expected.

Participant 12, an occupational therapist who completed their community service in KwaZulu Natal recalls*:"I remember the first quarter of the year was we were asked to write a business plan for the therapy department, which was a bit ridiculous. So the physio comm serve and myself had to quickly google how to write a business plan and we did it completely wrong to how they actually wanted it. So in terms of planning, we weren't really prepared and what this*

is how you plan your department in terms of resources, and we just kind of did a wish list. This is what we want resources wise, this is what we want training wise.".

Very little guidance and support was given on how to compile documents such as a budget, business plan or standard operating procedure and what was expected of the community service rehabilitation professional, therefore many had to seek assistance from senior staff of a different profession in how to properly write up these documents. These types of documents are important as they assist the community service rehabilitation professional in ensuring that the department has a financial budget in order to obtain resources needed to assist patients. A business plan therefore assists the community service rehabilitation professional in planning how to run the department on a day-to-day basis and a standard operating procedure gives the community service rehabilitation professional a guideline on what is duties and services are expected that the department must comply with.

Participant 10, a physiotherapist who completed their community service in the Western Cape highlights: *"Well, I mean, I didn't know how to set up any of the paperwork. I've never set up any SOPs* (standard operating procedure)*, any any other things. So I remember I was literally having panic attacks when they told me okay, here's the document, read through that and set up your SOP according to that. And they would highlight certain sections for me and then I would go and ask them a question about something. In general, not even physio related and it would be like no, sorry, can't help you. So, ya, it's it was not the best year of my life".*

Element 2: Organisation:

Organisation is explained as the duties undertaken by the different personnel and allowing the manager to ensure these duties are being fulfilled to the highest standard by all personnel (Faloy, 1916). The following themes and subthemes from the study denote the element of organisation; duties expected of a community service rehabilitation professional managing a department, clinical duties, administrative duties and time constraints. The following paragraphs will give further detail on these themes.

Theme 1: Duties Expected of A Community Service Rehabilitation Professional Managing a Department

The participants outlined the duties that were expected of them during their community service year whilst managing a department. These duties were split into clinical duties and administrative duties which will be further explained.

Subtheme 1.1: Clinical Duties

The clinical duties undertaken as mentioned by the participants in the study included treating hospital inpatients, running an outpatient clinic, attending outreach clinics to give therapy to the wider community when possible as well as running group therapy sessions. These are the core duties in the scope of any community service rehabilitation professional regardless of whether or not they are placed in a healthcare facility that has a discipline specific supervisor or not. These duties are what is expected of all community service rehabilitation professionals as this is where they are expected to learn and grow their clinical skills to become competent independent healthcare workers.

Participant 12, an occupational therapist who completed their community service in KwaZulu Natal stated the following as the clinical duties that were expected of them: *"So we had inpatient care it was a about 130 bed hospital. So inpatients was, ya, peads, male, female ward, maternity ward, nursery. So we had to see inpatients and they were referred by doctors to us. And then we had out patients that were either were walkins or were booked and then we had I think it was five or six clinics that we would go and visit on a regular schedule."*.

Theme 2: Administrative Duties

Administrative tasks expected to be completed by the community service rehabilitation professionals varied depending on the healthcare facility where they were placed, but included attending management meetings, both hospital based and district based, procurement of resources for their department, daily, monthly, and quarterly statistics, monthly reports, take responsibility for their therapy area, stock taking and managing occupational therapy or physiotherapy technicians. A community service rehabilitation professional who does not manage their own department may be expected to complete some of these administrative duties over and above their clinical workload, such as recording their statistics but would not have to complete all these duties as there would be more senior personnel in the department whose responsibility it would be to complete the rest of the duties.

Participant 6, an occupational therapist who completed her community service in KwaZulu Natal lists her administrative tasks as *"I had to attend district meetings. There weren't many, I think it was about two in the year. But that was when they come up, I had to do that. I had to do all the statistics every month. And I had to do all the procurement for any splinting materials, and any kind of consumables needed. So had to report back to an informal meeting to report back to our department head, who was a physiotherapist just in terms of how things*

going. If there's any big challenges happening, I also had to keep our OT area neat and make sure everything's working how to report any faults, or if there was, if there was no water, or there's no toilet paper, things like that in our area, then I had to report that and then also had to if there was any deliveries that happen, like if there's any stock or consumables being delivered. I had to sign off on that to make sure that the supply chain management was aware that the things had been delivered. So I just had to follow up on that. I had to supervise the OT technician and had to get feedback every day. If he went on home visits or delivered wheelchairs. I had to make sure that all the stock count was balancing between what we had received what I issued out and what he had taken out on home visits, I had to sign off on his, the OT technician's. What do you call it? When he applied to take the clinic's car out on home visits and actually sign off on the the request for that. I had to attend all of the infection control meetings, and just do the training on that. Also had to give feedback to the provincial coordinator on a quarterly basis about what was happening in the clinic. What the needs are. Yeah, that was pretty much like the head of department kind of things. Yeah."

Theme 2: Time Constraints

A common theme that kept being mentioned by participants in this study is not having enough time to complete both their clinical and administrative duties to the highest standard. A head of department may see less patients in order to make time to complete administrative tasks but when there is only one person in the department it is difficult to manage time to ensure they see all patients that need to be seen as well as ensure that the managerial duties are also done. A community service rehabilitation professional is expected to be learning and growing their clinical skills as the main focus of their community service year and administrative duties are important but should not take away from their opportunities to learn and improve their clinical skills and abilities (Department of Health, 2006). A community service rehabilitation professional should spend the majority of their time during the working day completing clinical tasks and not have to have the burden of the extra administrative tasks undertaken by a head of department, that other community service rehabilitation professionals are not managing a department do not have to complete, over and above their clinical training duties.

This is highlighted by Participant 8, an occupational therapist who completed their community service in the Free State said *"So on a day I would see eight individual patients and then a group of 14 patients or something like that. So which is a lot and then we are scheduled to work until three o'clock and then do statistics. Sometimes we run a little bit over the depending. But*

even if I would finish at half past two, I don't have enough time to do all the admin. Like writing, first off, just writing all my SOAP notes, then going to register on the computer writing it because you have to write each name of each person and that attended in both of the books, you know, and then do my own statistics on the computer. So that for me is the is the most challenging part is having to do the, the admin, as well as the heavy patient load that we have.".

Participant 11, an occupational therapist who completed their community service in the Free State also shared their difficulty with workload versus time constraints: *"We were very under resourced. With like, physical resources, but as well as hands, so it was just me and the physio running the department and treating patients. And it was a very high workload. So we saw probably like, sometimes sixteen patients a day. Which is not enough time for our professions, like it's, and I know that other hospital, their comm serves saw, like 26 patients a day. So resources were like, the big thing. And then if you have that high workload, and your primary concern is for the patients, then the managing of the department kind of like takes a dive, which is not good, because it's supporting your physical work with the patients, but you just don't have the time or energy to like, focus on either of them. So that was like, the big thing is the resources, both like with the actual resources, and then with people."*

Element 3: Co-ordination:

Co-ordination is defined as ensuring that each manager within the personnel fulfils their responsibilities to their subordinates and to ensure the interests of the business are met (Faloy, 1916). The themes that arose under this element of management were co-ordinating with various staff members at the healthcare facility as well as co-ordinating with other professionals, colleagues or organisations not associated with the healthcare facility.

<u>Theme 1: Staff members at the healthcare facility</u>

Many participants were at healthcare facilities where there were other rehabilitation healthcare professionals of different professions in the departments. These staff members were available to assist the community service rehabilitation professional in running their department to varying degrees. Often the community service rehabilitation professionals at that facility were all leading their departments and therefore would collaborate to assist each other in figuring out what managerial duties had to be done and how to do them.

Participant 12, an occupational therapist who completed their community service in KwaZulu Natal stated that: *"Well, the physio and I worked very closely together, obviously because we were we were very reliant on each other to figure stuff out, and then the same with a dietitian,*

so we were three comm serves who were all on our own mission. And, and the three of us worked a lot together just with planning things and figuring things out."

Besides other rehabilitation healthcare professionals, some participants would co-ordinate with other senior staff members of a different profession in the hospital such as medical doctors and matrons in order to be able to co-ordinate to run their department smoothly. This would include asking these other senior staff members for advice on administrative tasks that had to be done such as filling in forms to order stock or find out about administrative processes at the healthcare facility.

Participant 5, a dietician that completed their community service in Gauteng stated: *"Then also the matron of the clinic was very open and very welcoming so we worked well together. She didn't really provide me with explicit advice but she was very supportive with any ideas I had or if I had to work with the nursing staff. She was very very supportive."*.

As the community service rehabilitation professional was the only one in their department, they therefore did not have subordinates to manage. However, a few participants did have an occupational therapy technician or a physiotherapy technician they were to manage. This included signing off on stock the technician would allocate to patients and ensuring that the technician would do home visits for some people in the community. It was reported that the technicians were great sources of assistance for the community service rehabilitation professional as they had worked at the healthcare facility for many years and had worked with the previous rehabilitation professionals and therefore were familiar with the processes and structures in terms of administrative tasks already in place.

Participant 12, an occupational therapist who completed their community service in Kwa-Zulu Natal speaks to the assistance she received from a physiotherapy assistant: *"There was a permanent therapy assistant, a physio assistant. So he was kind of a continuity across all the years of like, just giving us guidance on this is how this works. This is how you do requisitions this is how you do fill in these forms and this is how you do that because he'd been there and seen all the other therapists coming through previously."*.

Another aspect of having an occupational therapy or physiotherapy technician was that participants reported they felt uncomfortable with having to manage someone who was a lot older and more experienced than them. They felt as if the technician was a valuable source of information but the power dynamics between the community service rehabilitation professional

and the technician did not make sense as a young professional being in charge of a more experienced and older technician.

Participant 6, an occupational therapist who completed their community service in Kwa-Zulu Natal reported: *"I had an OT technician with me in the department. So how to how to manage that relationship. And in terms of also just supervising or being in a supervisory role for someone who's been in their job for 15 years and knows a lot more than I do, and how to do it to manage that on a relationship basis, but also, just what are the professional boundaries?".*

<u>Theme 2: Discovering outside resources to collaborate with to assist with managerial and clinical duties.</u>

Because the community service rehabilitation professionals were heading a department by themselves with no other senior rehabilitation professionals of the same profession, many participants looked to outside sources such as senior therapists or other community service rehabilitation professionals at a different healthcare facility to collaborate with to assist them in running their departments. Participants in this study sought support from outside personnel especially for specific questions about both managerial and clinical aspects of their professions. These were valuable sources of information as other rehabilitation professionals in surrounding areas were familiar with the population of the area and how the administrative duties may work. Reaching out to senior professionals and other community service rehabilitation professionals who were not necessarily at their healthcare facilities, but are part of the district would then often result in the creation of a network of rehabilitation professionals both community service and senior professionals in the district who could provide both administrative, clinical as well as emotional support for one another.

This is demonstrated by the following quote from Participant 3, an occupational therapist who completed their community service in the Eastern Cape: "*But I would mostly ask people in surrounding hospitals. We formed quite a close knit community because the hospitals are all 1 hour to 4 hours away from each other and we all met at the beginning of the year. Ya, that was the support network I would access, other therapists. I would message them and be like, listen, this person is asking for this, what does this mean?".*

Other resources that were accessed by participants to get support with questions and support related to clinical practices, were their professional organisations. Some professional organisations had organised forums especially for community service rehabilitation professionals to assist them with any clinical related questions they may be struggling with.

These forums would take place monthly throughout the year to assist community service rehabilitation professionals with any questions regarding clinical skills.

Participant 13, a physiotherapist who completed her community service in Gauteng, outlines how she found the assistance from her professional organisation by stating: *"So of the ones that I did have, so the one's at my society SASP* (South African Society of Physiotherapists) *were very helpful, they got back to me pretty quickly, whenever I had a question for them. I think at one stage, I even had a phone call, which was very helpful. So from that point of view, yeah, very, very helpful."*.

Element 4: Command:

The element command is described as each individual department being able to harmoniously work with other departments to reach a shared goal (Faloy, 1916). The themes realised under this element of management were difficulty working with other departments due to staff's negative attitudes towards community service rehabilitation healthcare workers, other staff member's knowledge of the rehabilitation professions and the effectiveness of rehabilitation department meetings.

<u>Theme 1: Staff Attitudes Towards Community Service Rehabilitation Healthcare Professionals</u>

The majority of participants had difficulty with the more senior and permanent staff who were not of the same profession in terms of their attitude towards the community service rehabilitation professionals at the healthcare facilities they were placed. This included both other rehabilitation professionals of a different profession and staff members from different departments such as doctors, nurses, and administration staff. They reported that some staff both healthcare professionals (of a different profession) and administrative staff, saw community service as a revolving door and thus community service rehabilitation professionals as not permanent staff members and as such they were not keen or interested in investing their time and effort in training or assisting them with clinical or managerial tasks.

Participant 2, a speech therapist who completed their community service in KwaZulu Natal, reported the following: *"Ya, it was difficult with the comm serves because all the other staff was permanent. So the xray, short stay, all the nurses and doctors were all permanent. So it was almost like they didn't want to interact with us because they knew we were leaving. So like it doesn't make sense to have us in all these meetings because we were leaving and will have to explain it to the next group so lets just not from the beginning. Then you would still have those same questions that would have to be answered via, via, via"*.

Participant 3, an occupational therapist who completed their community service in the Eastern Cape highlighted how some permanent staff members had become tired of constantly having to assist new community service rehabilitation healthcare professionals every year*: ": I think it's really tricky if there's comm serves only and a constant influx of new people every year. You can't really gain traction or like keep information handing over properly. People just get over trying to help the comm serves try to understand the processes because they've done it for 7 years.".*

<u>Theme 2: Staff's Lack of Knowledge about Rehabilitation Professions</u>

Participants highlighted how staff members in permanent positions and not part of the rehabilitation departments or professions who worked at the same healthcare facility had a lack of knowledge about the scope of practice of rehabilitation professions. The lack of knowledge impacted their ability to assist the community service rehabilitation professionals with managerial duties specific to their profession as well as clinical duties. As the community service rehabilitation professional would be told that they are not familiar with what should be done and must find someone else to assist them as other staff members are not familiar with what is expected of the community service rehabilitation professional's profession. This made it difficult for the community service rehabilitation professionals to be able to fulfil their duties without support in guiding them to correctly complete their managerial duties.

Participant 7, an audiologist who completed their community service in KwaZulu Natal, highlights how this impacted her ability to interact with other staff members as they were not sure what her role was: *"So it was very difficult, I must say, in terms, no one really regards audio as important. So they always see us, we are a lighthouse, they don't see us like, you know, we are irrelevant. And we are we are there. They just like doctors as important and nurses, because they are in majority in comparison to us, it was just literally just me and in my entire department. So that was difficult. Trying to get my message across to the other to the managers was very difficult. Like, just to get an budget allocated for audio was very difficult."*

<u>Theme 3: Effectiveness of Meetings with Other Managers</u>

Participants in the study also reported that another form of collaboration between departments both within the healthcare facility and with outside personnel (district supervisors), were meetings held to discuss matters relating to the rehabilitation departments or meetings at a district level to discuss the community service experience. These were both formal and informal meetings but often times the rehabilitation department meetings were not always

implemented despite being scheduled monthly. Participants reported that they felt frustrated by the lack of meetings and the disorganization which led to meetings not being scheduled. They reported that this lack of meetings takes away a forum for community service rehabilitation professionals to ask for assistance with anything they are struggling with in a collaborative manner.

Participant 2, a speech language therapist who completed their community service in KwaZulu Natal, reported that *"They were very frustrating. We were supposed to have like an allied monthly meeting but it actually only happened twice last year. So in theory we had a monthly meeting but it wasn't in practice."*.

Participant 9, an occupational therapist that completed their community service in the Freestate also highlighted that meetings took place but community service rehabilitation professionals were not always welcomed: *" It was very disorganized. There were meetings happening in the hospital, but we were never made aware of it. Because, like, they were so used to the comm serves just doing their own thing. So we were never, like looped into it. But we got the meeting schedule from our supervisor, and then we really tried to, like attend, especially if it was things like the finance things or the resources, because that was a big struggle that we had."*

Other participants stated they did have monthly meetings but they were not collaborative and rather informative in which the head of the rehabilitation department would be telling them what to do. This also did not create an outlet for a community service rehabilitation healthcare professional to feel comfortable asking for assistance or sharing ideas or plans they may have.

Participant 13, a physiotherapist who completed their community service in Gauteng stated the following: *"We did have either as a weekly or bimonthly kind of chat in our multidisciplinary department, just to kind of see where we were, because obviously, I was running the physio one, the speech and language therapist was doing their one, the OT comm serve, obviously, just kind of had to slot in underneath the manager who's an OT herself. So we did kind of have these on and off meetings, just to kind of see where everything was, and see what collaboration can be done things that I'd say that was probably the only manager at regular managerial meetings we probably had. And again, it was more kind of being told what things needed to be done, as opposed to collaborative discussions"*.

Another form of collaboration in a meeting style were informal meetings. These informal meetings occurred between the community service rehabilitation professional and a senior staff member such as their supervisor at district level or another rehabilitation profession at the

facility. These meetings would be in the form of discussions in which the community service rehabilitation professional; could feel safe in talking about any struggles they were having. Collaborative informal discussions between the whole rehabilitation department also were beneficial for community service rehabilitation professionals as often the rehabilitation personnel shared patients and could collaborate in therapy as well as discuss shared duties to ensure the rehabilitation department ran smoothly.

Participant 6, an occupational therapist who completed their community service in KwaZulu Natal highlights such an instance: *"Well, with the other managers, also the speech therapist, community service officer was also the only person there so she was head of her own department as well. The there was a permanent audiologist and then the permanent physiotherapist. So we all shared office space like one small office room. So that was kind of we we would collaborate the and talk about things and talk about patients that we shared. But it was more just because we were conveniently near each other the whole day. So it wasn't it wasn't a formal structure that was in place. And it wasn't like, okay, every week we're going to sit down and have a meeting or anything like that I was on the go."*.

Participant 8, an occupational therapist who completed their community service in the Free State mentioned how her district supervisor assisted her with informal discussions: *"Then the supervisor district office, ideally, that we should have a monthly meeting with her, but we've only had like one meeting. But when we, when we do clinic visits, they have to get the district office to collect the transport vehicles. So then we have like informal meetings with her and she just hears are we still coping and things like that."*.

Element 5: Control:

Having verification measures when implementing a plan in order to identify weaknesses and problems before they arise and address them is how control is defined by Faloy (1916). The themes that arose under this element of management include having little to no feedback or verification structures in place and trying to assist in the handover for the next community service therapist.

Theme 1: Little or No Feedback and Verification Structures in Place

Many participants reported having no verification or feedback measures on their performance both as managers and as clinicians throughout their community service year in order to assist in improving their abilities during their community service year. A verification measure is a structure such as a detailed standardised guide outlining what the goals and aims for the

community service year are and what duties need to be completed by when which is given to all community service rehabilitation professionals to ensure all duties are completed and to the same standard. The few that had measures stated that these were in the form of a questionnaire at the end of the year, rating how they experienced their community service year. These were not very beneficial as they did not provide assistance in ensuring that all duties were done to the acceptable standard but rather a reflective measure to look back at what had been done throughout the year. It was reported by participants that, it is also not known whether changes are made based on the feedback given to the district based on the experiences the community service rehabilitation professional reported.

This was stated by Participant 15, a speech language therapist who completed her community service in KwaZulu Natal: *"So there was only something at the end of year where we had to rate our experience as community service therapists, and how was that experience and how we found it, but it was not available throughout the year."*.

Participants placed at healthcare facilities where they had to start a department especially noted that very little feedback and verification was done as there was not a precedent of what should be done by a community service rehabilitation professional managing their own department. Therefore, no one was able to provide feedback on how they had managed their department as the senior personnel had no previous rehabilitation professional or documents to compare the community service rehabilitation professional to.

Participant 7, an audiologist who completed their community service in KwaZulu Natal states: *"Yeah, there were there were no feedback as such, given because I was just starting everything afresh, so they could see an improvement in the place. Yeah, so I think they were quite satisfied with that. But yeah, there were nothing as such, if I could recall."*.

<u>Theme 2: Creating a Handover for The Next Community Service Rehabilitation Professional</u>

As many participants had difficulty with administrative tasks and structuring their departments during their community service year, they attempted to make the transition easier for the next community service rehabilitation professional taking over from them. Some added to the handover document that had been left for them with tips of what worked for them during their community service year for the next community service therapist to have some sort of guide to look back on.

Participant 13, a physiotherapist who completed their community service in Gauteng outlines how they amended the handover document given to them: *"Because what I did, I think I did from the, from the middle of the year. And this was on advice from a family member who kind of recommended to do as I started putting down, noting down all the things that I had to figure out for myself, or all the things that I found that worked really well like for example, I split up the diary in terms of inpatient versus outpatient and how I ran the outpatients and things that and I just kind of put in what worked for me where there's leeway and things that that's what I started putting into that document. Just because to make it a bit of an easier transition, then I kind of felt I really felt especially that first week of comm serve that you I was literally dumped in in the deep end.".*

Other participants were able to have an in-person handover with the next community service rehabilitation professional and were able to orientate them to the department and show them what needs to be done.

Participant 4, an audiologist who completed their community service in Gauteng, outlines what they did to assist the next community service therapist: *"They all came for a day to see what it was like, to see where to park, which populations they'll see. Then I wrote a handover report. I had like a file for my ABR patients, these patients who are for educational support, I had a whole thing set out with a spreadsheet for them. Just so they know what they're getting themselves into because you know anyone can walk in and then you know what is happening with them. That's what I tried to set up."*

Participant 7, an audiologist who completed her community service in KwaZulu Natal, outlines how she orientated the next community service therapist: *"But I had like, two to three meetings with the next comm serve. And I literally gave a whole rundown of how the department how I run the department and what worked for me. So I took it through all the admin staff, I took it through all the basically everything ordered and what I did, and I made sure and I told her, this is what I did and this is what worked for me but that doesn't necessarily mean that you have to do things the same way. There's a lot of scope for development improvements here. So had a one on one meeting. Very interactive session with her. So I didn't give her anything as such, but I had a meeting meetings with her."*

These interactions were beneficial as it allowed the incoming community service rehabilitation professional to have verification measures to refer to.

Themes That Did Not Align With The Framework of Faloy's 5 Elements of Management: The following themes may not be accounted for in the framework as this framework is not based on the South African context. South Africa is a multilingual, multicultural society which has an impact on the workplace and working environment in that each language spoken and different cultures need to be accounted for. This may not be the case in other countries which do not have the complex lingual and cultural differences South Africa does. It is also important to note the contextual issues in South Africa such as poverty, violence and crime, and the strains of the healthcare system which give rise to some of the themes outlines below.

Theme 1: Ethical Concerns

Most of the participants mentioned experiences that they had during their community service year which brought up ethical concerns. These ethical concerns will be further discussed in the following subthemes.

Subtheme 1.1: Language Barriers

South Africa is a multilingual, multicultural society which has an impact on the workplace and working environment in that each language spoken and different cultures need to be accounted for. This may not be the case in other countries which do not have the complex lingual and cultural differences South Africa does. Therefore, it is not uncommon for a rehabilitation professional to have to treat a patient who does not speak the same language as theirs. This can lead to instances in which informal interpreters are used to allow the therapist and patient to be able to communicate with one another. Some participants reported language barriers being a challenge they encountered during their community service year. This lead them to use other patients to translate for them during a therapy session. This can be an issue due to patient confidentiality as having someone such as another patient translate for someone who is receiving therapy means there is a breach in the confidentiality afforded to a patient in terms of best practice. Another patient is not bound by the same confidentiality a healthcare worker is bound to and can discuss private matters about another person. There is also the question of the quality of the translation and whether what is being said is accurately translated both to the patient and the information given to the healthcare worker. This can cause the patient to not fully understand their condition or the treatment being given to them as the translator is not a trained healthcare professional and may not accurately translate the information being given to them. Informal interpreters may also impose their own beliefs on consultations and fill in gaps

they missed with their own knowledge leading to the patient being given inaccurate information and the therapist is not aware of this.

Participant 2, a speech language therapist who completed their community service in KwaZulu Natal, highlights the difficulty with language barriers and translators: *"Then language barriers was really hard. We obviously just had to find our feet with that. Also, learn to ask for help with that. It was always other patients that would be translating for the patient before them."*.

Subtheme 1.2: Performing duties outside of their scope of practice.

It was reported by participants in the study that they were expected to be able to conduct treatment on patients who required a different rehabilitation professional such as an occupational therapists being required to conduct physiotherapy treatment. These issues arise due to the lack of rehabilitation personnel within the government healthcare system especially in rural areas. There is a misconception that occupational therapists and physiotherapists can perform the same scope of practice. This leads to the community service rehabilitation professional trying their best by using online resources and enquiring with other professionals on how to perform these duties in order to assist the patient even though they are not trained to do so.

Participant 3, an occupational therapist who completed their community service in the Eastern Cape comments on having to attempt to be both an occupational therapist and physio therapist: *"Oh oh oh, I was also the OT and physio for the department which was also a big challenge because I'm not a physio and there were a lot of physio cases that I had to phone a friend slash Google what to do. "*.

This is an ethical issue as this participant is not trained in physiotherapy and may have caused harm or incorrectly treated a patient as physiotherapy is not within the scope of practice of an occupational therapist. This also shows the lack of knowledge of the different scopes of practice between these two professions as well as the impact of not having enough personnel in a department to be able to attend to all the different pathologies that may arise. This can also cause an emotional impact on the community service rehabilitation professional as they are trying to learn how to become a competent therapist within their own profession whilst having to perform another profession's therapies as well without supervision. This can lead to feeling overwhelmed as well.

Subtheme 1.3: Lack of carryover of treatment due to lack of personnel

Another ethical issue is not having any community service rehabilitation healthcare professionals to replace the current community service rehabilitation professional who heads a department and do not have any other permanent staff to keep the department going. Without an incoming community service therapist, the patient load of the current therapist will not be seen to which leaves patients who are not being giving the care they need to assist with their pathologies or will have to incur a cost of transport fees and long waiting times to go to another hospital which may be further away.

Participant 9, an occupational therapist who completed their community service in the Free State highlights their concerns of not having an incoming community service therapist: *"We kind of just left it as it was. We have the document that was given to us. But then the, like, the main issue for us and leaving was our patients and how they would be dealt with. So our focus, before we left was like setting up a waiting list or managing referrals, telling people in the hospital how to manage our patients, because that was the the main anxiety for us at that stage."*.

Theme 2: Safety Concerns

Safety is a theme that regularly arises in South Africa but is especially important when looking at community service rehabilitation healthcare professionals as these are predominantly female professions and can work in areas with a higher incidence of striking or looting as reported by participants. However, there are additional factors that lead to safety concerns for female professionals. South Africa has a high incidence of gender-based violence and therefore some female healthcare professionals may experience gender-based violence in the workplace. South Africa also has high incidences of violent and petty crime. It is also possible for healthcare workers who are doing outreach clinics to be targeted especially when visiting low-income areas. The safety concerns experienced by healthcare workers may also contribute to healthcare professionals feeling overwhelmed and stressed as they need to be able of their surroundings and their safety.

It was reported that some participants were unable to report to work on some days due to concerns about safety because of striking and looting. As a young female professional, it may be a bigger concern to some to be exposed to such areas especially if majority of the professionals are female. This also leads to the inability to provide to perform their duties as without being able to reach the clinics due to strikes and concerns of safety, this impacts the ability to see patients in those areas who need assistance. This theme is not covered in the

framework as the framework focuses on the practicalities of managing a department and not on outside factors such as safety which can impact the ability to manage a department effectively.

Participant 11, a physiotherapist who completed their community service in Gauteng, indicates how strike action impacted their ability to do clinic visits: *"Well, we couldn't always go into the clinics because they were burning tires. So you couldn't get into the locations. Although, after a while you learn all the back roads, but then the clinics are closed anyway, because they're scared. So often services were not delivered because you couldn't get there. That was a problem. The some of the people in the community themselves felt that it's dangerous for us to be there, because we stick out like a sore thumb that I didn't feel at risk. But I suppose if you female alone, it is dangerous. So. So there's that."*.

Participant 6, an occupational therapist who completed their community service in KwaZulu Natal, highlights how the KwaZulu Natal looting had an impact on the healthcare facilities ability to operate: *" ...it was during the July unrest as well. Now we had to, we had to have online discussions over the phone about suddenly, we couldn't go to work one day, and the roads were blocked off, and it was protesting happening in the town nearby. That it was, we had to wait for our head of department to give us information from the head of facility, who had to wait for Provincial management to give them feedback. So that was, that was a lot of waiting, waiting. And then the information would come so late to us, because there's so many channels that it had to first go through before ending by us."*.

Theme 3: Emotional impact of managing a department as a community service rehabilitation professional

Many participants also highlighted the emotional toll of having to run a department by themselves had on them. They indicated that because they did not feel supported and accepted by some other staff, it was a hard emotional toll to have to figure out duties and responsibilities as well as learning as a clinician all alone with minimal input. The framework does not take into account the emotional impact managing a department can have on a manager as it focuses on the practicalities of managing a department and not looking at a manager holistically and how this may impact their state of mind as well. Participants reported feeling burnt out due to high case loads as well as feeling overwhelmed due to have a lack of support and adequate supervision.

Participant 10, a physiotherapist who completed their community service in the Western cape outlines the effect the emotional toll during her community service had on her: *"Um this was a bit more personal. So I don't know if that would, because what I think it had a huge effect on me is I was actually admitted for depression, because I went into such a deep depression by around this time of that year, that I was admitted for three weeks in Cape Town into a clinic, because I just couldn't anymore. It was just too much for me."*.

Participant 3, an occupational therapist who completed their community service in the Eastern Cape also shares how she did not feel emotionally supported during her community service year: *"So a clinical manager that knows about rehab services and some of the admin that goes along with that. Ya, just to support us in that way. Emotionally, I don't think theyre gonna be able to support us. I think more of like a team support structure. Because the meetings we would have were like doctors would report on the calls and then we would all leave. No one was interested in anything we had to say really. There was never a check in like how have things been, hospitals been busy, comm serves you okay, none of that. Like a monthly check in with our clinical manager would have been helpful. Just to know he was there."*.

Participant 6, an occupational therapist who completed their community service in KwaZulu Natal also highlights how being the only professional in the department can have an emotional impact: *"Um, I'd say a big challenge was, what happens when I go on leave, or when I do when I take sick leave, that there's there's no one to take my place that for for the time that I'm gone, the essentially the OT department is closed. So that was a big challenge, that I wasn't really sure how to manage that. And my the head of department said, you know, it is what it is, there's nothing we can do about it. I'm just, if I'm going to be on leave, then don't don't book any patients for that day or those weeks. But I saw a lot about half the caseload was hand injuries. So that was something we couldn't like if someone had come in with a tendon, laceration or tendon repair. But now if it was in the middle of the year, two weeks of leave. So that was a person came in on at the beginning of my two weeks. So then for two weeks, they couldn't get a splint couldn't get anything. There was no, there was no rehab taking place. And there's nothing I can do about that. So that was very hard to manage. And then yeah, just yeah, that's kind of guilty feeling for not being there. But also saying well, the government didn't, didn't put a second OT there. So this isn't really my fault. It is a bit stressful. So that was really hard to manage on an emotional level, but also just like, what do you what, what are you going to do in those times? That I felt like I couldn't, couldn't take leave? Very, yeah, I couldn't, I felt like*

I was kind of restricted in terms of leave just in terms of patients and closing the department. So that was, I think that was the biggest challenge.".

Chapter Summary:

The themes that have arisen from this study indicated that community service rehabilitation professionals who headed their own departments desire more formal supervision during their community service year to assist with both clinical and administrative duties. This lack of supervision leads to the community service rehabilitation professionals seeking out their own forms of supervision through handover documents and collaborating with other healthcare workers within their facility and at different facilities in the district. As there is only one person running the department, this also led to high caseloads which put a strain on being able to perform all duties to a high standard due to time constraints. Furthermore, feelings of burnout and frustration were also reported due to the negative attitudes towards community service rehabilitation professionals by other senior personnel, disorganisation in terms of scheduling meetings, safety concerns and high caseloads. The themes that did not fit into the framework highlighted the cultural, linguistic and contextual difficulties of working within South Africa. This was shown through attempting to provide a service through language barriers, working outside of scope of practice, lack of personnel, the safety considerations and the emotional toll the experience of managing a department during community service.

Chapter 5: Discussion

This chapter present a discussion of the findings of this study in relation to the findings outlined in chapter 4. The findings are also compared to the currently published literature to determine if these results are in agreement with or refute current literature.

The aims of this study were to determine how community service rehabilitation professionals who managed their departments were exposed to managerial duties during their studies, what challenges they faced during their community service year whilst managing a department and what support systems and facilitators were made available to them during their community service year whilst managing a department.

The results from this research have been analysed into themes which were then mapped into the elements of Fayol's five functions of management namely, planning, organising, commanding, co-ordinating and control.

Element 1: Planning

Themes:

1. Undergraduate training does not prepare students for managing a rehabilitation department

2. Insufficient handover from the previous community service therapist and not enough orientation at the beginning of the year

3. Create new documents that outline plans for their community service year

Undergraduate training does not prepare students for managing a rehabilitation department*:*

Newly graduated community service rehabilitation professionals felt they had not been adequately trained for the extra managerial tasks they had to complete during their community service but felt that they had been prepared for their clinical duties. Participants stated that they had attended short lectures on managing a private practice but could not use this information to assist them in managing a department during their community service year. These findings resonate with observations from a study conducted by Wranz (2011), in which the perceptions, attitudes and experiences of community service speech language therapists who had graduated from Stellenbosh University were assessed. The author found that community service speech language therapists stated that they would have benefitted from being exposed to managerial

and administrative tasks during their undergraduate training as the training would have capacitated them to perform managerial tasks more effectively during their community service year. It should be noted that the participants in this study completed their community service year under supervision. Furthermore, Wranz (2011) also stated that the participants in their study felt these were areas in which they lacked knowledge and skills which had an impact on them both emotionally and practically in not knowing how to complete clinical and administrative tasks given to them. Mostert-Wentzel (2013), conducted a study to determine how to revise the physiotherapy curriculum by exploring a model of community physiotherapy from the perspectives of newly graduated physiotherapists. The findings of this study state that instilling sound management and leadership principles in newly graduated physiotherapists is important as it is likely that they will be working in less than optimal working circumstances for their community service year.

Findings from Wranz (2011) and Mostert-Wentzel et al (2013), highlight how even community service rehabilitation healthcare professionals who have supervision during their community service year feel unprepared to take on the task of managerial and administrative tasks once graduating. This is therefore expected to be amplified in the case of community service rehabilitation professionals who manage their own department without supervision as they do not have assistance in completing these tasks and would greatly benefit even from being exposed to managerial and administrative duties such as stock taking, reading tender documents and ordering stock during their undergraduate training in order to have a basis of how managerial tasks are conducted when entering community service.

Insufficient handover from the previous community service therapist and not enough orientation at the beginning of the year

The main form of handover between incoming and outgoing community service rehabilitation professionals was a handover document. This is a document created by community service rehabilitation professionals who have already been at that healthcare facility and have detailed information they deem is appropriate for the next community service rehabilitation professional to know. This information included how to organise the clinic dairy, who to contact for certain information and the types of patients and therapy plans most commonly seen at that clinic. Parker et al (2011), researched the challenges of efficient health service delivery experienced by community service dieticians working in the public health sector in South Africa. They reported that five out of forty five of their participants suggested a handover period between

the outgoing community service dietician and the incoming community service dietician to assist with handover and orientation. Alternatively, they suggested the creation of a handover file which details precise information on what is expected of them. This period of handover or the creation of a handover file would assist the incoming community service rehabilitation professional in completing their managerial duties as they would have background knowledge of what is expected of them or would have a resource to consult to give them information about how certain managerial duties are done.

This study corroborates what was found during this research and shows that as these suggestions have not been implemented in the public healthcare sector, community service rehabilitation professionals have taken it upon themselves to create a handover document to assist the incoming community service rehabilitation professional to orientate themselves to the department.

<u>Create new documents that outline plans for their community service year:</u>

The creation of new documents that outline plans for their community service year entails the community service rehabilitation professional being expected by senior staff of a different profession to create documents such as standard operating procedures, business plans and budgets. These are not documents familiar to the community service rehabilitation professional as they have not managed a department before and therefore do not know how to create such documents in order to assist them in planning for future needs throughout the year. Naranjee et al (2019), explored the financial role of nursing managers in a provincial hospital in KwaZulu Natal. This study found that nursing managers lack the skills, knowledge, and training to be able to act as financial managers within the healthcare facility. If qualified managers who are permanent personnel at the healthcare do not feel adequately trained to complete tasks such as financial planning, then it can be argued that a community service therapist who has just entered the workforce would feel even less prepared to create such documents as business plans and budgets for their department.

Element 2: Organisation

Themes:

1. Duties expected of a community service rehabilitation professional

Subthemes:

1.1. Clinical duties expected of a community service rehabilitation professional.

1.2. Administrative duties expected of a community service rehabilitation professional.

2. Not having enough time for administrative and clinical duties

<u>Clinical duties expected of a community service rehabilitation professional:</u>

Participants in this study outlined the following clinical duties expected of a community service rehabilitation professional: providing therapy to inpatients as well as running an outpatient clinic and organising to go on outreach clinics. This highlights that the first aim of community service which is to provide improved health care to persons in under resources areas is being met as the community service rehabilitation professionals are assisting in providing healthcare to persons who have limited access to healthcare. These duties are also duties expected of community service rehabilitation professionals who are placed at a facility where they are provided with supervision from a senior staff member of the same profession. April (2013) in a study that investigates occupational therapy graduates' conceptualisations of occupational justice in community service practice in South Africa, confirms that clinical duties completed by a community service occupational therapist include assessment and intervention of different pathologies in both inpatients and outpatients as well as attending to outreach clinics and running group therapy.

As research has not been done in terms of management duties expected of a community service rehabilitation professional, there is no literature outlining what the general clinical duties expected of a community service therapist are. As community service is a South African concept, there is limited literature as it is not possible to draw literature from foreign countries. Furthermore, there is no official governmental policy that the researcher was able to access, pertaining to the duties of a community service rehabilitation professional, therefore, the duties of a community service rehabilitation professional are not nationally standardised and can lead to community service rehabilitation professionals having exposure to different things depending on where they are placed.

<u>Administrative duties expected of a community service therapist:</u>

In terms of administrative duties, it was found that over and above the expected community service administrative duties, community service rehabilitation professionals who were managing their own departments had to fulfil all the duties expected of a head of department such as stock taking, procurement of stock, statistics and report writing. It can be surmised that some of these duties may be undertaken by a community service rehabilitation professional

who is not head of department but they would have assistance from a senior professional and not be expected to complete all these duties. A study such as one conducted by Naidoo et al (2017), conducted a study looking at occupational therapy graduates' reflections on their ability to cope with primary healthcare and rural practice during community service. They posited that managerial skills were important for all community service healthcare professionals to know as they were expected to complete a few managerial tasks. However, it is especially important for a community service rehabilitation professional who is made head of department to be able to complete the managerial duties assigned to them in order to ensure their department runs smoothly.

Not having enough time for administrative and clinical duties:

Another theme that arose when looking at a community service rehabilitation professional who is managing a department is the time constraints, they are under due to the amount of work expected for them to do. As they are the only professionals of their profession at the healthcare facility able to see patients and run clinics as well as having to complete their administrative duties, many participants found they did not have enough time to adequately complete their managerial duties as they had to put their clinical duties first to assist patients. The high patient load and managerial administrative tasks would impact how they ran their department as well as put pressure on them to complete all tasks given to them. A department head would normally have a lesser clinical load to be able to complete their administrative duties and a community service rehabilitation professional would prioritise seeing patients in order to improve their clinical skills as well as have less administrative tasks to complete (Department of Health, 2006). This is echoed by Naylor et al (2014) who conducted a study about the transition from student to practitioner in diagnostic radiography, states that a heavy workload, high patient volume and staff shortages were the greatest causes of work pressure amongst radiographers transitioning from studying to the workplace. Therefore, it can be argued that due to staff shortages, a community service rehabilitation professional is then expected to take on a heavier workload which can lead to higher incidents of stress.

Element 3: Co-ordination

Themes:

1. Co-ordinating with staff members within the healthcare facility

2. Discovering outside resources to collaborate with to assist with managerial and clinical duties

Co-ordinating with staff members within the healthcare facility:

Co-ordinating with staff within the same healthcare facility but of a different profession was reported by many participants. Although, staff of a different profession can be helpful in assisting with some administrative duties, they would not be able to give profession specific advice especially related to clinical competency of the community service rehabilitation professional. Studies conducted by Paterson et al (2007), and Steyn (2012) both reported that community service dieticians were often not supervised by persons of the same profession which led to having managers who were not aware of what was expected of them. Shipalana (2018), also stated that the lack of supervisors of the same profession in the Limpopo province led to community service healthcare professionals experiencing difficulties with completing more advanced responsibilities given to them. Khan et al (2009), whose study investigated the perceptions of and attitudes to the compulsory community service programme for therapists in KwaZulu-Natal, found that two thirds of community service therapists in KwaZulu Natal felt that they did not have adequate professional and discipline specific supervision. These studies highlight that without supervision of the same profession, community service rehabilitation professionals have difficulty with more complex cases as well as profession specific administrative tasks. Discipline specific supervision has been highlighted through this study and supported by the ones mentioned above as something that community service rehabilitation professionals seek in order to be able to develop their clinical and administrative skills. This in turn may lead to better patient care by having a rehabilitation professional who feels adequately supervised and more able to handle more complex therapy cases.

Discovering outside resources to collaborate with to assist with managerial and clinical duties:

Community service rehabilitation professionals who manage their own department had to seek out persons of the same profession at a different institution to collaborate with due to lack of personnel of the same profession at their healthcare facility. This would consist of contacting other rehabilitation professionals at different healthcare facilities within the same district to ask for assistance. Strombroek and Buchanan (2016) in a study that was conducted in South Africa on the general characteristics and experiences of a occupational therapist during their community service year, reported that occupational therapists who did not have a supervisor, had tried to seek out supervision with varying degrees of success, as some would be assisted and others would be refused assistance. April (2013), also found that community service occupational therapists who were working in rural areas and in an isolated setting heavily relied

on networking with nearby facilities and other rehabilitation professionals to assist them in creating a functional referral network to provide the best care for the communities they were placed in. By creating networks to find other rehabilitation professionals willing to assist is important as this can allow the rehabilitation professionals to feel more supported and therefore provide better therapy for their patients.

Element 4: Command

Themes:

1. Staff negative attitudes towards community service rehabilitation professionals

2. Staff's lack of knowledge of rehabilitation healthcare professions

3. Effectiveness of meetings with other managers

Staff negative attitudes towards community service rehabilitation healthcare professionals:

This encompassed how the community service rehabilitation professionals in this study had difficulty collaborating with other staff members due to the perceived view that community service rehabilitation professionals are only there for a short period of time therefore it is not worthwhile to train them. Ned et al (2017), highlights the experiences and challenges of rehabilitation healthcare professionals within the primary healthcare system in South Africa. Ned et al., (2017) states that one particular challenge faced by community service rehabilitation professionals was advocating for rehabilitation services to be prioritised and given adequate budgets and opportunities for health education to patients and their communities. This was met with little enthusiasm and engagement from senior management and other stakeholders as rehabilitation services were not deemed as important as medical services (Ned et al., 2017). This impacts the ability of rehabilitation healthcare workers to properly assist all members of the community who may need rehabilitation services due to lack of knowledge about rehabilitation professions. Ross (2014), noted that the lack of support from management and senior staff members was one of the main factors that deterred community service healthcare professionals (both medical and rehabilitation staff), from continuing to practice in rural areas. They stated that not having adequate support left them feeling overwhelmed and motivated them to look for a position at a different healthcare facility with more supportive staff members post community service. This results in a shortage of medical and rehabilitation staff members in rural areas where there is a great need for resources and personnel to assist populations who are not able to afford private healthcare. In turn, the lack of senior personnel in rural areas

means there are less personnel available to supervise incoming community service rehabilitation professionals which leads to the phenomenon of community service rehabilitation professionals managing departments in their community service year (Haskins et al., 2017).

Staff's lack of knowledge of rehabilitation healthcare professions:

Another theme highlighted under this element is other senior staff of a different profession's lack of knowledge of rehabilitation healthcare professions. Steyn (2012), noted that a substantial challenge for community service dieticians was that the other members of the medical team were not aware of their role within the multi-disciplinary team and therefore did not refer patients to them. Mostert-Wentzel et al (2013)., in another study where they aimed to create a model for community physiotherapy form the perspectives of newly graduated physiotherapist to assist in curriculum reform, found that community service physiotherapists stated that due to the lack of awareness of what a physiotherapist does and how they can assist within the medical team, led to less collaboration with doctors and other healthcare professionals which in turn impacted the inclusion of physiotherapists within the multidisciplinary team and on how many referrals were made to physiotherapists. This lack of collaboration impacts the number of patients seen by community service rehabilitation professional as if referrals are not made to them, patients who may need their services may not be seen by the correct rehabilitation professional. This also means that community service rehabilitation professionals were not able to develop their clinical skills if they are not able to see an adequate amount of patients.

Meetings with other managers:

Collaboration through meetings with other managers was not always beneficial to the community service rehabilitation professional who participated in this study, as they were often either left out of meetings, found the meetings to be more informative and less collaborative or had informal discussions with other senior staff members of a different profession instead of formal meetings. As the duties and integration of community service rehabilitation professionals who manage a department have not been researched, it may be surmised that little to no literature that speaks to how meetings between managers are not inclusive or a collaborative space for community service rehabilitation professionals who are managers of their departments. Mostert-Wentzel et al (2013), highlights the importance of discussion and collaboration in growing as a professional therapist. Other team members can be used as a

source of information and clinical decision making is developed through discussions. Community service rehabilitation professionals who are not given the opportunity for such discussions and collaborations may find that their ability to make clinical decisions is less developed than that of their peers who have been given adequate supervisor.

Element 5: Control

Themes:

1. Little to feedback or verification structures in place

2. Creating a handover for the next community service rehabilitation professional

Little to feedback or verification structures in place:

Community service rehabilitation professionals who managed their own department who participated in this study felt that they were not given adequate feedback on their performance both clinically and administratively throughout the year. Nemutandani et al (2006)., reported that community service doctors in Limpopo province felt that they either had no feedback from senior doctors or the feedback they did receive was lacking and unhelpful. This shows that even some medical professionals who do have supervision felt the feedback provided to them was not sufficient, which led to doctors underperforming in their clinical duties and feeling unable to adequately complete their clinical duties (Nemutandani et al., 2006). This speaks to community service rehabilitation professionals feeling as if they are not adequately equipped to handle some of the cases given to them and feeling as if they were learning the worst habits of their profession. This is due to not having onsite support of a senior therapist who is able to supervise and train them to properly follow correct protocols and therapy methods needed.

Creating a handover for the next community service therapist:

The creation of handover documents was the main form of information handover between the outgoing community service rehabilitation professional and the incoming community service rehabilitation professional as reported by participants of this study. Many participants reported that they added more information to the handover document given to them to assist the new community service rehabilitation professional with the managerial duties expected of them. Dlamini et al (2019), reported that community service radiographers felt profession specific orientation was important in order to feel integrated into the department and have an understanding of the duties expected of them. One can argue that due to the lack of profession specific orientation afforded to community service rehabilitation professionals, this led

outgoing community service rehabilitation professionals to create their own form of orientation through a handover document for the incoming rehabilitation professionals. This can then assist the incoming rehabilitation professional with having a basic knowledge of the healthcare facility and the duties expected of them.

Themes That Did Not Fit Into The Framework of Faloy's Five Elements of Management: Themes:

1. Ethical considerations

Sub-themes:

- Language barriers
- Performing duties outside of scope of practice
- Lack of carryover of treatment due to lack of personnel

2. Safety

3. Emotional toll on community service rehabilitation professionals

Ethical Considerations:

Language barriers:

The language barriers between therapist and patient led to having nonmedical professionals translating for the patient as found in this study. Mtimkulu et al (2023), conducted a studying identifying barriers and facilitators influencing hearing help-seeking behaviours for adults in a peri-urban community in South Africa. They found that the language barrier between hearing health professionals and patients was identified by thirteen percent of their participants as a barrier to accessing hearing healthcare. This issue has been well documented throughout literature and yet there has not been a practical solution to this problem (Mtimkulu et al., 2023; Watermeyer, 2020). All patients are entitled to healthcare services in a language that they understand in order to ensure they have some autonomy over their treatment (Watermeyer, 2020). However, there should be an official form of translation in order to ensure that information being transmitted is delivered correctly whilst allowing the patient the confidentiality they deserve (Watermeyer, 2020).

Performing duties outside of scope of practice:

Another ethical concern raised be participants was being expected to perform another profession's scope of practice. Strombroek & Buchanan (2016), reported that some community service occupational therapists described feeling like a physiotherapist due to physiotherapy services being limited or absent which led them to have to perform as both an occupational therapist and a physiotherapist. This is a concern as occupational therapists are not trained as physiotherapists and could do harm to a patient if not treated properly.

Lack of carryover of treatment due to lack of personnel:

The final theme that emerged from participants under ethical concerns was that many participants were told there were no community service rehabilitation professionals taking over from them the following year. This is a concern as the patients seen by the rehabilitation professionals would then not receive the specialised assistance they need and any new patients would not have access to these rehabilitation services. Sherry (2014) stated one of the main factors of a shortage of rehabilitation professionals in state run healthcare facilities is the freezing of posts due to budget constraints. Furthermore, Maseko et al (2014)., found that occupational therapy students favoured urban placements over rural placements for their community service year. These studies do not agree or refute the finding in this study but it can be noted that both these factors could attribute for the lack of personnel to take over from a current community service therapist which leaves their patients without any assistance for the foreseeable future.

Safety:

Safety concerns was another point raised by participants in the study. Many participants felt unsafe traveling into areas when looting and striking was occurring as most of them were young and females, as such, they felt vulnerable. Nelson and Madiba (2020) in a study that explored The barriers to the implementation of the ward based outreach programme in Mpumalanga, reported that community healthcare workers felt unsafe travelling into some rural communities due to threats of violence and the possibility of being hijacked. This meant that the community healthcare workers had to work in pairs which halved the amount of patients they were able to assist. It was also noted that majority of the community healthcare workers were female which increased the risk of violence due to gender based violence in South Africa. The inability to attend a clinic due to concerns of safety have been highlighted in this study and the one mentioned above. It is also highlighted that due to safety concerns this impacts the service

available to patients due to either not being able to access the clinics due to striking or looting or having to work in groups for safety reasons and therefore not be able to see as many patients.

Emotional toll on community service rehabilitation professionals:

Further emotional tolls can arise for a community service rehabilitation professional who is managing a department as reported by participants in this study. This is because there is little support from other staff members and there is a lot expected both clinically and managerially of the community service therapist which can be too much for one person to handle. This can impact their ability to perform their tasks to the best of their ability as feeling overwhelmed or burnt out can limit their capacity to make clinical decisions. Struwig & van Stormbroek (2023), highlighted that community service occupational therapists who were dissatisfied with the supervision given to them reported increased levels of emotional exhaustion. One can then argue that without supervision, emotional exhaustion can be expected as if rehabilitation professionals who have supervision but are not satisfied with it feel emotionally exhausted then without supervision then feeling can be exacerbated.

Chapter Summary:

In summary, the first aim of this study was to determine if rehabilitation professionals are exposed to aspects of management during their undergraduate studies. Participants felt that they had inadequate exposure to management during their undergraduate studies and would have benefitted from more exposure to administrative tasks and managerial tasks expected of them during community service. The challenges faced by participants included insufficient handover from the outgoing community service therapist and the orientation given at the beginning of the year was not detailed enough. Participants also struggled with the administrative tasks given to them as well as time constraints in terms of having enough time to complete their clinical duties as well as their administrative duties. A significant challenge for many participants with other personnel's negative attitudes towards community service personnel which led to the community service therapist not being assisted with tasks. Furthermore, other personnel within the healthcare facility had a lack of knowledge of the rehabilitation professions which impacted the number of referrals sent as well as expecting therapies to be done outside of the community service therapist's scope of practice. Another challenge was the lack of feedback and verification measures throughout the year which left the community service rehabilitation professionals with no indication of whether they were completing their clinical and administrative duties to the correct standard or knowing how they

could improve. A number of ethical considerations also arose during the study namely, language barriers, performing tasks outside of scope of practice and a lack of personnel to take over from the outgoing community service therapist. Safety was also a concern for some participants due to looting and striking making it unsafe to attend outreach clinics. The last challenge noted for community service therapist's managing their own department was the emotional toll it takes to be solely responsible for a department during your community year. The third aim of this study was to determine what support systems were available to community service rehabilitation professionals that have managed their own department. Some participants were able to collaborate with staff of a different profession at their healthcare facility to assist them with managerial and administrative tasks. Other participants relied on rehabilitation professionals at other healthcare facilities in the district not at their healthcare facility to assist them. Another integral support system was the creation of a handover document from the previous rehabilitation professional which was then revised by the participants at the end of the year to assist incoming community service rehabilitation professional.

Chapter 6: Conclusion and Implications of The Study:

The concluding arguments are described in this chapter as well as the strengths and limitations of this study. The implications of the study are highlighted as well.

In conclusion, community service was created in order to assist with providing access to healthcare to the wider population in South Africa as well as give an opportunity to newly graduated healthcare professionals to continue developing their practical skills and continue learning. However, due to understaffed state healthcare facilities, community service rehabilitation professionals often find themselves in a situation where they are managing a department with no supervision from a senior staff member practicing the same profession. Therefore, this study aimed to determine how community service rehabilitation professionals who manage a department dealt with this experience through exploring what concepts are learnt at an undergraduate level before community service to prepare for managing a department, what managerial concepts are used during the community service year, what challenges the community service rehabilitation professional faces and how these can be mitigated and what support structures are available to them during their community service year and how effective these are. The results from this study highlighted that community service rehabilitation professionals who managed their own department felt they were inadequately prepared to take on this role post graduating university. They had not been exposed to managerial concepts they had found beneficial to them to assist in managing a department. It was found that community service rehabilitation professionals had difficulty with managing both their patient caseload and administrative tasks expected of them. This was further exacerbated due to the lack of collaboration with other more senior personnel of a different profession at the hospital. This led to community service rehabilitation professionals relying on other staff of a different profession at the same healthcare facility for assistance or seeking assistance from personnel of the same profession at different facilities in the district. There was inadequate support and supervision given the community service rehabilitation professionals managing their departments and therefore, more should be done by healthcare facilities and the Department of Health to assist community service rehabilitation professionals who manage their own departments in the future by implementing better supervision and support structures.

Strengths of The Study:

The following were the strengths of this study:

Diversity of Participants in The Study:

The diversity of the participants in the study was a strength because there was a range of healthcare professions represented within this study. This allowed the opportunity for a clear indication of how this phenomenon is experienced by multiple community service rehabilitation professionals across the professions. By including a range of rehabilitation healthcare professions, more diverse information was obtained as the experiences of a speech language therapist versus a physiotherapist can vary as their scope of practice is so different. This also gives the opportunity to report on a wider range of experiences in order to gain insight into all aspects of managing a department as a community service rehabilitation professional.

Representation from Different Contexts:

The participants also completed their community service in a range of provinces and different types of healthcare facilities. This also gives insight into how community service rehabilitation professionals managing a department can have different experiences based on their placements but also have overall similar feelings and challenges during their community service year. The site where community service takes place can make a difference in the overall experience such as influencing what duties are assigned to the community service rehabilitation professional such as having a technician to supervise or the differences in senior staff of a different professions attitudes towards community service rehabilitation professions managing their own department. The difference between community service placements in rural areas compared to urban areas can also lead to different experiences of community service.

Participants Completed Their Community Service in Multiple Different Years:

Another strength is that the participants had completed their community service in multiple different years and had differing amounts of time since they had left community service. Some participants had completed their community service a year or two prior to being interviewed and others had completed their community service year ten to seventeen years prior to being interviewed. This shows how the phenomenon of a community service rehabilitation therapist is not a new phenomenon but is still taking place today and how relevant this study is to improve the experiences of future community service rehabilitation professionals to ensure that they are given the support and guidance needed to manage a department.

Online Interviews:

Online interviews can also be considered a strength of this study as they gave the researcher access to participants in different locations to where she is based. This enabled the researcher to interview more participants without having to incur travel costs. It also made participating in the study more convenient for the participants as they could participate at a time and place that best suited them.

Limitations of The Study:

The following were limitations of the study:

Small Sample Size:

The limitations of this study include a small sample size. A larger sample size may have given more insight into this phenomenon from more people and some themes not picked up upon may occur. Advertising the study on more platforms may have allowed the advertisement to reach more people and increase the sample size of the study.

Online Interviews:

While the use of online interviews was a strength of the study, in terms of having a wider reach for participants, it was also a limitation for the study. It was a limitation in the sense that not load shedding (planned power outages) made it difficult to arrange online interviews as the load shedding schedule can be erratic. Not all persons have access to alternative power sources which effects their access to internet, therefore in some interviews it was difficult to obtain a strong connection in which the researcher and the participant could clearly communicate. This was mitigated through rescheduling the interview if needed.

Lack of Literature on Community Service Rehabilitation Professional's Managing Their Own Department:

A lack of literature on community service and community service rehabilitation professionals managing their own departments is also a limitation of this study. Some of the literature found was more than ten years old which indicates that this area of study needs more research in order to better understand community service from different perspectives as well as how the experience of community service may have changed within the last ten years. The lack of new researcher into community service for rehabilitation professionals impacted this study as some of the references used may be out of date and therefore, may no longer be valid. It can also be noted that community service for healthcare professionals post graduating is a uniquely South

African concept. Therefore, this research is not easily applicable to healthcare systems outside of South Africa where the concept of community service does not exist. The relevance of this research is largely to South Africa and the healthcare systems in place here. This also impacts research into community service for rehabilitation professionals as it can only be studied within the South African context. Therefore, a small population of people will be able to research community service for rehabilitation professionals impacting the volume of research on this topic due to only a select few people researching topics around community service for rehabilitation professionals. As there are limited studies on community service for rehabilitation professionals, this meant that the researcher had less studies to draw information on to compare their findings to.

A Framework on Healthcare Management Should be Formed:

The framework used to analyse the data in this study was based on general management and not specifically on management within a healthcare facility. Managing a department within a government healthcare facility requires specific duties and skills related to healthcare. Therefore, the formation of a management framework based specifically for the healthcare sector would assist in critically analysing the strengths and weaknesses of management within a healthcare facility.

Only The Perspectives of Community Service Rehabilitation Professionals Was Explored:

This study also only took into account the experiences of the community service rehabilitation professional who managed their own department. It did not investigate other stakeholders such as senior staff of a different profession and how the phenomenon of having a new community service rehabilitation profession every year impacts the rehabilitation department and healthcare facility as a whole.

Implications of The Study:

The following were implications of the study:

Community Service Rehabilitation Professionals Should Have Access To Some Form of Supervision:

The implications of this study include that community service rehabilitation professionals who manage their own department require more formal support to be implemented. This could be done by assigning a supervisor of the same profession to each community service therapist either at their healthcare facility or at the district office. If the supervisor is not at the healthcare facility, then they should ensure that frequent communication between supervisor and

community service rehabilitation professional is possible. Regular meetings or check ins to ensure that the community service rehabilitation professional is coping with their caseload and administrative duties or to address any queries they may have should also be implemented.

The Creation of A Standardised Handover Document:

If it is not possible to have supervision at every community service site, then a formal handover document from the Department of Health should be created outlining the clinical and administrative duties expected of the community service rehabilitation professional. It would be beneficial to create an outline version of this documents and perhaps have a forum function to enable community service rehabilitation professionals to have a designated space to connect and assist each other. A healthcare facility specific handover can also be created in collaboration with the healthcare facility and the community service rehabilitation therapists which outline facility specific duties and responsibilities as well as contact details of specific personnel to assist in fulfilling certain administrative tasks.

Formal Support Networks Between Rehabilitation Departments In The Same District:

More formal support networks between rehabilitation departments within the same district should also be created. This will allow a community service rehabilitation professional who is managing their own department a reliable source of assistance in terms of clinical queries. This can also lead to more emotional support for the community service rehabilitation profession in possibly finding other people in the same situation who can all assist each other and not feel as isolated.

Amending The University Curriculum To Include Management Skills:

Another implication is amending the university curriculum to better assist newly graduated rehabilitation therapists in running their own departments. Including more information about how a government healthcare facility and rehabilitation department is run and including lectures about more administerial aspects such as ordering supplies and using tender forms would be useful. Including more hands on experience in management during undergraduate training may assist the transition into a management role during the community service year. Perhaps having mock management situations during a lecture series would assist in learning key skills needed to manage a department.

Formal Policy on Community Service:

This study also highlights the gaps in formal policy when it comes to community service for healthcare professionals. The purpose of community service should be more formally outlined and a national policy standardising community service across the country should be considered. Access to such policies should also be readily available for community service rehabilitation professionals as a guide on what is expected of them during their community service year.

Creation of Continued Professional Development Courses:

A further implication of this study is the creation of continued professional development (CPD) courses that specifically aim to assist community service rehabilitation professionals who do not have adequate supervision and can help guide them through the community service year by creating an additional support structure which may not have been available before.

Reflections:

This research study is based on a topic that is important to me because of my own experience as a community service speech therapist and audiologist who managed a department during my community service year. Hearing other people's stories who were in the same position I was in but had similar but also very different experiences showed me how varied the community service experience is. The emotional impact having no support had on a lot of the participants especially stuck with me. As a newly qualified therapist who is figuring out how to be treat patients alone for the first time whilst undertaking administrative duties which are also unfamiliar can be overwhelming especially without a proper support system. I am also hoping the themes that came up on how to improve the system to assist new community service rehabilitation therapists such as creating handover documents and better communication between district therapists will be implemented to improve the experience. This is a topic I am passionate about and really hope that some change can be made based on my findings and recommendations.

Further Research Topics:

The following are further research topics that emerged from this study:

The Impact of Frequently Changing Rehabilitation Professionals on Patients Experiences of Rehabilitation Healthcare:

Further research should investigate the impact that frequent changing of rehabilitation professionals has on patients that require long term therapy. Having to change rehabilitation

professionals once a patient has formed rapport with a different service provider can be upsetting for them. This can also impact the service they receive as not all rehabilitation professionals operate in the same way.

The Impact of Frequently Changing Rehabilitation Professionals on Healthcare Facilities:

The constant changing of rehabilitation professionals may also have an impact on the rehabilitation department and healthcare facility as well. Senior staff members will have to assist a new community service rehabilitation professional every year which may impact their views on community service rehabilitation professionals. This is another aspect of the phenomenon of community service rehabilitation professionals that can be researched.

How Healthcare Facilities and The Department of Health Can Implement Formal Support Networks:

It is worthwhile researching how healthcare facilities and the Department of Health can create more formal support networks for community service rehabilitation professionals who manage their own departments to access. What is the best way to support them and how can this practically be implemented?

The Ethics of Practicing As An Independent Practitioner During Community Service:

The Health Professional's Council of South Africa requires post graduating rehabilitation professionals to be registered as community service rehabilitation professionals. Before a rehabilitation professional can be registered as an independent practitioner, they must first complete their community service. However, a community service rehabilitation professional who is managing their own department without supervision of the same profession is technically practicing as an independent practitioner. Therefore, the ethics of this phenomenon and having a community service rehabilitation professional tending to patients without being an independent practitioner should also be further researched.

Reasons for Appointing Community Service Rehabilitation Professionals as Managers of a Department:

Further research can be done in terms of specific reasons why community service rehabilitation professionals become heads of their department during their community service year. If a formal study is done to determine what factors lead to this phenomenon then this can assist in trying to mitigate these factors and ensure that adequate supervision is given during the community service year.

Reviewing The Curriculum To Explore What Is Taught In Terms Of Management and Administrative Skills:

As community service rehabilitation professionals are being put in the position of head of department without adequate exposure to management skills, it is worthwhile to explore what management and administrative skills they are being exposed to. This can then help determine where the gaps in there training are in terms of management and what information needs to be added to the curriculum to assist them in being better prepared to manage a department in their community service year.

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Appendices:

Appendix A 1: Participant Information Sheet and Consent Form

The Experiences of Community Service Rehabilitation Professionals Who Managed Their Own Department in South Africa

Dear Potential Participant,

My name is Julia Allsop. I am Masters in Speech Language Pathology student registered with the University of Witwatersrand. In order to fulfil the requirements for my postgraduate degree, I am required to complete a research dissertation. I am therefore conducting a study on the experiences of rehabilitation healthcare professionals who have headed or managed their own department during the community service year in South Africa. The research study will be conducted under the supervision of Dr Khetsiwe Masuku.

I would therefore, like to invite you to be a participant in my study. `You will be required to participate in an online interview via Microsoft Teams or Zoom where you will respond to questions about your experience of heading or managing your department when you were a community service therapist. The interview will be between 30-45 minutes long and will be scheduled at a date and time that is convenient for you. Due to the interviews being online, you will require a stable internet connection and data.

Your participation in the study will be voluntary and you will be required to complete a consent form. Confidentiality as well as anonymity will be ensured as no identifying information will be included in the final report or conference presentations and publications that will emanate from the study. All data from the study will be safe guarded in the researcher's password protected computer, where only the researcher and the supervisor will have access to it. There are no risks or benefits to participating in the study. There will also be no penalties if you choose to withdraw your participation or not to give responses to questions that you feel uncomfortable with.

Findings from the study will inform support structures that are needed to assist other rehabilitation professionals who are tasked with managing departments while they are in the community service year. Findings will also inform continued professional development courses or more formal training during undergraduate studies to prepare graduating rehabilitation professionals for management roles in the community service year.

If you have any questions at any point during the research or after please feel free to contact me or my supervisor on the details listed below. If you would like a copy of the final report, I would be happy to send it to you. If you have any concerns or complaints regarding the ethical procedures of this study, you are welcome to contact the University Human Research Ethics Committee (Non-Medical), telephone +27(0) 11 717 1408, email hrecnon-medical@wits.ac.za

Yours Sincerely,

Julia Allsop

Student

1612003@students.wits.ac.za

Dr Khetsiwe Masuku

Supervisor:

Khetsiwe.Masuku@wits.ac.za.

Consent Form:

Name of Department: Speech Language Pathology and Audiology

Title of the study: The experiences of community service rehabilitation professionals who headed their own department in South Africa.

(Please cross or select the relevant options below)

I confirm that I have read and understood the information about the project as provided in the Participant Information Sheet **YES/NO**

I confirm that I have had the opportunity to ask questions and the researcher has answered the questions about the study to my satisfaction. **YES/NO**

I understand that my participation is voluntary and that I am free to withdraw from the project at any time. **YES/NO**

I understand that my interview responses will be recorded and I consent to this **YES/NO**

By signing below, I am indicating my consent to participate in this research.

Signed

Date

Appendix B 1: The Association for Dieticians in South Africa Permission Letter

Julia Allsop

University of The Witwatersrand

23 August 2022

The Association for Dieticians in South Africa

Block A Suite 10

59 Woodlands Avenue

Sandton, Johannesburg

Dear Cindy Chin,

RE: Permission to recruit participants for my study via your organisation

My name is Julia Allsop. I am Masters in Speech Language Pathology student registered with the University of Witwatersrand. In order to fulfil the requirements for my postgraduate degree, I am required to complete a research dissertation. I am therefore conducting a study on the experiences of rehabilitation healthcare professionals who have headed or managed their own department during the community service year in South Africa. The research study will be conducted under the supervision of Dr Khetsiwe Masuku.

I would therefore, like to ask for permission to advertise and recruit participates for my study through your organisation. I would particularly like to seek permission to share the study details included in the participant information letter with speech language pathologists and audiologists registered with your organisation. The information letter also consists of my details if potential participants are interested in participating in the study. Alternatively, potential participants interested in participating in the study can complete their details in the google form using the link below and the student researcher will contact them.

https://forms.gle/42pwkhTy7CnJCeBc7

Participants will be required to participate in an online interview via Microsoft Teams or Zoom where they will respond to questions about their experience of heading or managing a department when they were a community service therapist. The interview will be between 30-45 minutes long and will be scheduled at a date and time that is convenient for them. Due to the interviews being online, they will require a stable internet connection and data.

Their participation in the study will be voluntary and they will be required to complete a consent form. Confidentiality aswell as anonymity will be ensured as no identifying information will be included in the final report or conference presentations and publications that will emanate from the study. All data from the study will be safe guarded in the researcher's password protected computer, where only the researcher and the supervisor will have access to it. There are no risks or benefits to participating in the study. There will also be no penalties if participants choose to withdraw their participation or not to give responses to questions that they feel uncomfortable with.

Findings from the study will inform support structures that are needed to assist other rehabilitation professionals who are tasked with managing departments while they are in the community service year. Findings will also inform continued professional development courses or more formal training during undergraduate studies to prepare graduating rehabilitation professionals for management roles in the community service year.

If you have any questions at any point during the research or after please feel free to contact me or my supervisor on the details listed below. If you would like a copy of the final report, I would be happy to send it to you. If you have any concerns or complaints regarding the ethical procedures of this study, you are welcome to contact the University Human Research Ethics Committee (Non-Medical), telephone +27(0) 11 717 1408, email hrecnon-medical@wits.ac.za

Yours Sincerely,

Julia Allsop

1612003@students.wits.ac.za

_________ _____________

Dr Khetsiwe Masuku

Supervisor:

Khetsiwe.Masuku@wits.ac.za.

Appendix B 2: Permission letter received from The Association for Dieticians in South Africa

ADSA
ASSOCIATION FOR DIETETICS
IN SOUTH AFRICA

Association for Dietetics in South Africa
PO Box 868
Ferndale
2160
South Africa
011 061 5000 | www.adsa.org.za
03 November 2022

To whom it may concern

RE: PERMISSION TO ADVERTISE STUDY THROUGH THE ADSA MAILERS

This letter refers to the project: The Experiences of Community Service Rehabilitation Professionals Who Managed Their Own Department in South Africa
Protocol number: H22/09/01

The Association for Dietetics in South Africa (ADSA) is a professional association that represents dietitians in South Africa.

I confirm that ADSA has granted Miss E Allsop the permission to recruit participants for her study via the ADSA weekly mailer. This mailer is sent to the ADSA database of about 1 500 dietitians across the country. The advertisement will be in the format of a brief description of the study, ethics approval number, the invitation to participate and contact details to reach the principal investigator.

I trust the above information is sufficient. Please contact me for any further queries.

Kind regards,

Jessica Byrne
Association for Dietetics in South Africa (ADSA)
Chief Operating Officer
cooadsa@gmail.com
www.adsa.org.za

Appendix C 1 Occupational Therapy Association of South Africa Permission Letter

Julia Allsop

University of The Witwatersrand

23 August 2022

Occupational Therapy Association of South Africa

Hatfield Bridge Office Park

213 Richard Street

Hatfield, Pretoria 0083

Dear Aluwani Manenzhe

RE: Permission to recruit participants of my study via your organisation

My name is Julia Allsop. I am Masters in Speech Language Pathology student registered with the University of Witwatersrand. In order to fulfil the requirements for my postgraduate degree, I am required to complete a research dissertation. I am therefore conducting a study on the experiences of rehabilitation healthcare professionals who have headed or managed their own department during the community service year in South Africa. The research study will be conducted under the supervision of Dr Khetsiwe Masuku.

I would therefore, like to ask for permission to advertise and recruit participates for my study through your organisation. I would particularly like to seek permission to share the study details included in the participant information letter with speech language pathologists and audiologists registered with your organisation. The information letter also consists of my details if potential participants are interested in participating in the study. Alternatively, potential participants interested in participating in the study can complete their details in the google form using the link below and the student researcher will contact them.

https://forms.gle/42pwkhTy7CnJCeBc7

Participants will be required to participate in an online interview via Microsoft Teams or Zoom where they will respond to questions about their experience of heading or managing a department when they were a community service therapist. The interview will be between 30-

45 minutes long and will be scheduled at a date and time that is convenient for them. Due to the interviews being online, they will require a stable internet connection and data.

Their participation in the study will be voluntary and they will be required to complete a consent form. Confidentiality aswell as anonymity will be ensured as no identifying information will be included in the final report or conference presentations and publications that will emanate from the study. All data from the study will be safe guarded in the researcher's password protected computer, where only the researcher and the supervisor will have access to it. There are no risks or benefits to participating in the study. There will also be no penalties if participants choose to withdraw their participation or not to give responses to questions that they feel uncomfortable with.

Findings from the study will inform support structures that are needed to assist other rehabilitation professionals who are tasked with managing departments while they are in the community service year. Findings will also inform continued professional development courses or more formal training during undergraduate studies to prepare graduating rehabilitation professionals for management roles in the community service year.

If you have any questions at any point during the research or after please feel free to contact me or my supervisor on the details listed below. If you would like a copy of the final report, I would be happy to send it to you. If you have any concerns or complaints regarding the ethical procedures of this study, you are welcome to contact the University Human Research Ethics Committee (Non-Medical), telephone +27(0) 11 717 1408, email hrecnon-medical@wits.ac.za

Yours Sincerely,

Julia Allsop

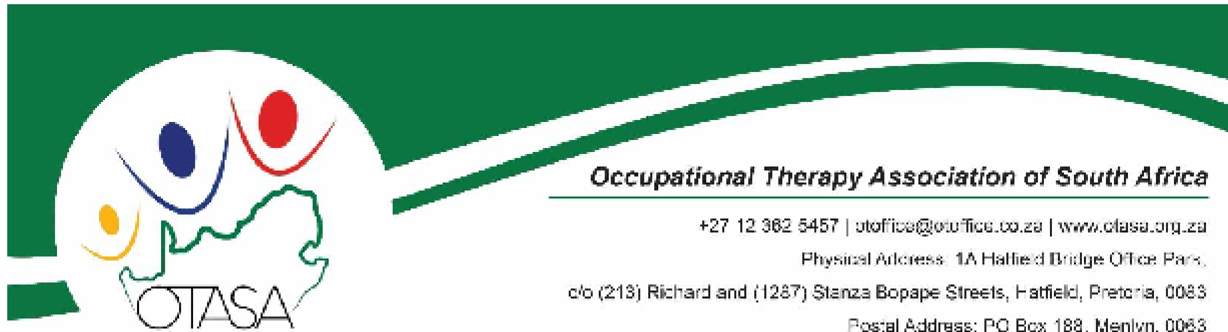
1612003@students.wits.ac.za

Dr Khetsiwe Masuku

Supervisor:

Khetsiwe.Masuku@wits.ac.za.

Appendix C 2: Permission letter received from the Occupational Therapy Association of South Africa



11 November 2022

Dear Ms Allsop

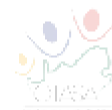
I acknowledge your email request to advertise and recruit participants within the OTASA platforms for your study on ***the experiences of rehabilitation healthcare professionals who have headed or managed their own department during the community service year in South Africa.***

This letter serves to confirm that; OTASA will be able to assist by advertising for participants for your study from our database platform.

Kind Regards,

El-lerisa Mahomed
OTASA Office Coordinator
Email: otoffice@otoffice.co.za
Cell & WhatsApp : 0794527274

NPO Number: 001-035-NPO | PBO Number: 930019148
Executive Committee: AE Manenzhe (President), Prof PA de Witt (Emeritus), A Ramlaul (COO), H Flieringa (Treasurer),
Vice Presidents: MOL Tau, Prof TG Mthembu, M Boaduo, J Craig



Appendix D 1: South African Association of Audiologists Permission Letter

Julia Allsop

University of The Witwatersrand

23 August 2022

South African Association of Audiologists

24 6th Street

Linden

Johannesburg 2194

Dear Cornella Naude,

RE: Permission to recruit participants of my study via your organisation

My name is Julia Allsop. I am Masters in Speech Language Pathology student registered with the University of Witwatersrand. In order to fulfil the requirements for my postgraduate degree, I am required to complete a research dissertation. I am therefore conducting a study on the experiences of rehabilitation healthcare professionals who have headed or managed their own department during the community service year in South Africa. The research study will be conducted under the supervision of Dr Khetsiwe Masuku.

I would therefore, like to ask for permission to advertise and recruit participates for my study through your organisation. I would particularly like to seek permission to share the study details included in the participant information letter with speech language pathologists and audiologists registered with your organisation. The information letter also consists of my details if potential participants are interested in participating in the study. Alternatively, potential participants interested in participating in the study can complete their details in the google form using the link below and the student researcher will contact them.

https://forms.gle/42pwkhTy7CnJCeBc7

Participants will be required to participate in an online interview via Microsoft Teams or Zoom where they will respond to questions about their experience of heading or managing a department when they were a community service therapist. The interview will be between 30-

45 minutes long and will be scheduled at a date and time that is convenient for them. Due to the interviews being online, they will require a stable internet connection and data.

Their participation in the study will be voluntary and they will be required to complete a consent form. Confidentiality aswell as anonymity will be ensured as no identifying information will be included in the final report or conference presentations and publications that will emanate from the study. All data from the study will be safe guarded in the researcher's password protected computer, where only the researcher and the supervisor will have access to it. There are no risks or benefits to participating in the study. There will also be no penalties if participants choose to withdraw their participation or not to give responses to questions that they feel uncomfortable with.

Findings from the study will inform support structures that are needed to assist other rehabilitation professionals who are tasked with managing departments while they are in the community service year. Findings will also inform continued professional development courses or more formal training during undergraduate studies to prepare graduating rehabilitation professionals for management roles in the community service year.

If you have any questions at any point during the research or after please feel free to contact me or my supervisor on the details listed below. If you would like a copy of the final report, I would be happy to send it to you. If you have any concerns or complaints regarding the ethical procedures of this study, you are welcome to contact the University Human Research Ethics Committee (Non-Medical), telephone +27(0) 11 717 1408, email hrecnon-medical@wits.ac.za

Yours Sincerely,

Julia Allsop

1612003@students.wits.ac.za

Dr Khetsiwe Masuku

Supervisor:

Khetsiwe.Masuku@wits.ac.za.

Appendix D 2: Permission letter received from the South African Association for Audiologists

2 November 2022

To whom it may concern

Re: Permission to advertise and recruit participants for my study through SAAA

I, Lucretia Petersen, hereby give permission to Julia Allsop, to advertise and recruit participants for her masters study through the SAAA membership database as well as posting it on the SAAA Facebook page.

Please do not hesitate to contact Cornelle Naudé (SAAA Administrator) with any questions or concerns – 082 727 5977

Regards,

Lucretia Petersen (SAAA President)

+27 82 727 5977 | admin@audiologysa.com | www.audiologysa.co.za

Appendix F 1: The South African Speech Language and Hearing Association Permission Letter

Julia Allsop

University of The Witwatersrand

23 August 2022

The South African Speech Language and Hearing Association

PO Box 1690

Umhlanga Rocks

Durban, KwaZulu Natal 4320

South Africa

Dear Annaline Jack,

RE: Permission to recruit participants of my study via your organisation

My name is Julia Allsop. I am Masters in Speech Language Pathology student registered with the University of Witwatersrand. In order to fulfil the requirements for my postgraduate degree, I am required to complete a research dissertation. I am therefore conducting a study on the experiences of rehabilitation healthcare professionals who have headed or managed their own department during the community service year in South Africa. The research study will be conducted under the supervision of Dr Khetsiwe Masuku.

I would therefore, like to ask for permission to advertise and recruit participates for my study through your organisation. I would particularly like to seek permission to share the study details included in the participant information letter with speech language pathologists and audiologists registered with your organisation. The information letter also consists of my details if potential participants are interested in participating in the study. Alternatively, potential participants interested in participating in the study can complete their details in the google form using the link below and the student researcher will contact them.

https://forms.gle/42pwkhTy7CnJCeBc7

Participants will be required to participate in an online interview via Microsoft Teams or Zoom where they will respond to questions about their experience of heading or managing a department when they were a community service therapist. The interview will be between 30-45 minutes long and will be scheduled at a date and time that is convenient for them. Due to the interviews being online, they will require a stable internet connection and data.

Their participation in the study will be voluntary and they will be required to complete a consent form. Confidentiality aswell as anonymity will be ensured as no identifying information will be included in the final report or conference presentations and publications that will emanate from the study. All data from the study will be safe guarded in the researcher's password protected computer, where only the researcher and the supervisor will have access to it. There are no risks or benefits to participating in the study. There will also be no penalties if participants choose to withdraw their participation or not to give responses to questions that they feel uncomfortable with.

Findings from the study will inform support structures that are needed to assist other rehabilitation professionals who are tasked with managing departments while they are in the community service year. Findings will also inform continued professional development courses or more formal training during undergraduate studies to prepare graduating rehabilitation professionals for management roles in the community service year.

If you have any questions at any point during the research or after please feel free to contact me or my supervisor on the details listed below. If you would like a copy of the final report, I would be happy to send it to you. If you have any concerns or complaints regarding the ethical procedures of this study, you are welcome to contact the University Human Research Ethics Committee (Non-Medical), telephone +27(0) 11 717 1408, email hrecnon-medical@wits.ac.za

Yours Sincerely,

Julia Allsop

1612003@students.wits.ac.za

Dr Khetsiwe Masuku

Supervisor:

Khetsiwe.Masuku@wits.ac.za.

Appendix F 2: Permission letter received from the South African Speech Language Hearing Association

SASLHA
South African Speech-Language-Hearing Association

Local Tel : 0861 113 297
Address : P. O Box 1690 Umhlanga Rocks 4320
Email : admin@saslha.co.za
Web : www.saslha.co.za

10 November, 2022

Dear Ms Allsop

Permission granted to send research invitation to SASLHA members

Researchers: Julia Allsop
Title of study: The Experiences of Community Service Rehabilitation Professionals Who Managed Their Own Department in South Africa

On behalf of the SASLHA Research and Education Committee, I acknowledge receipt of your request to distribute your research invitation to SASLHA members via email. Your application has been reviewed and conditionally approved, subject to full ethical clearance and editorial changes on the Research Invitation Template. I permit the distribution of the survey link via email as soon as full ethical clearance has been obtained for the study and the editorial changes have been made.

Kind regards

Nola Chambers, PhD
Research and Education Committee
SASLHA

Appendix G 1: South African Society of Physiotherapy Permission Letter

Julia Allsop

University of The Witwatersrand

23 August 2022

South African Society of Physiotherapy

Unit 4

Parade on Kloof Office Park

Bedfordview, Johannesburg

Dear Thamsanqa Ncube,

RE: Permission to recruit participants of my study via your organisation

My name is Julia Allsop. I am Masters in Speech Language Pathology student registered with the University of Witwatersrand. In order to fulfil the requirements for my postgraduate degree, I am required to complete a research dissertation. I am therefore conducting a study on the experiences of rehabilitation healthcare professionals who have headed or managed their own department during the community service year in South Africa. The research study will be conducted under the supervision of Dr Khetsiwe Masuku.

I would therefore, like to ask for permission to advertise and recruit participates for my study through your organisation. I would particularly like to seek permission to share the study details included in the participant information letter with speech language pathologists and audiologists registered with your organisation. The information letter also consists of my details if potential participants are interested in participating in the study. Alternatively, potential participants interested in participating in the study can complete their details in the google form using the link below and the student researcher will contact them.

https://forms.gle/42pwkhTy7CnJCeBc7

Participants will be required to participate in an online interview via Microsoft Teams or Zoom where they will respond to questions about their experience of heading or managing a

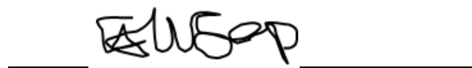
department when they were a community service therapist. The interview will be between 30-45 minutes long and will be scheduled at a date and time that is convenient for them. Due to the interviews being online, they will require a stable internet connection and data.

Their participation in the study will be voluntary and they will be required to complete a consent form. Confidentiality aswell as anonymity will be ensured as no identifying information will be included in the final report or conference presentations and publications that will emanate from the study. All data from the study will be safe guarded in the researcher's password protected computer, where only the researcher and the supervisor will have access to it. There are no risks or benefits to participating in the study. There will also be no penalties if participants choose to withdraw their participation or not to give responses to questions that they feel uncomfortable with.

Findings from the study will inform support structures that are needed to assist other rehabilitation professionals who are tasked with managing departments while they are in the community service year. Findings will also inform continued professional development courses or more formal training during undergraduate studies to prepare graduating rehabilitation professionals for management roles in the community service year.

If you have any questions at any point during the research or after please feel free to contact me or my supervisor on the details listed below. If you would like a copy of the final report, I would be happy to send it to you. If you have any concerns or complaints regarding the ethical procedures of this study, you are welcome to contact the University Human Research Ethics Committee (Non-Medical), telephone +27(0) 11 717 1408, email hrecnon-medical@wits.ac.za

Yours Sincerely,



Julia Allsop

1612003@students.wits.ac.za

Dr Khetsiwe Masuku

Supervisor:

Khetsiwe.Masuku@wits.ac.za.

Appendix G 2: Permission letter received from the South African Physiotherapy Association

POSTAL
PO Box 752378
Gardenview
Johannesburg
2047

PHYSICAL
Unit 4
Parade on
Kloof Office Park
1 The Parade
Bedfordview
2007

CONTACT
+27 11 615 3170
085 559 8237
www.saphysio.co.za
info@saphysio.co.za

NPO
106 - 154
VAT No
4390268409

07th November 2022

Dear Ms Allsop

I acknowledge your email request to advertise and recruit participants within the SASP platforms for your study on ***the experiences of rehabilitation healthcare professionals who have headed or managed their own department during the community service year in South Africa.***

This letter serves to confirm that; the SASP will be able to assist by advertising for participants for your study on our SASP platforms.

Regards;

Thamsanqa Ncube

National Operations Manager

World Physiotherapy
MEMBER ORGANISATION

The Difference is in Our Hands®

Appendix H 1: Interview Guide

The Experiences of Community Service Rehabilitation Professionals Who Managed Their Own Department in South Africa

Interview Guide:

Question:
Section A: Demographics
Age
Gender
What is your profession?
Province where community service was completed
Type of healthcare facility where community service was completed
Section B: Readiness for Community Service
What aspects of managing a department were you exposed to during your undergraduate studies? Probes: • Theoretical • Practical • Placement • Day to day running of a department (tenders, ordering supplies etc)
In terms of being prepared to manage a department, what do you wish you had been exposed to during your undergraduate studies?
Section C: Management of a department during community service
What structures were in place to assist in planning for future needs that may arise throughout the year?
What duties were you expected to complete as a department head?
What forms of collaboration with other managers were made available to you?
In what way would the different departments interact with each other to assist with management duties?
What measures were in place to help you reflect on tasks done?

What measures were in place to assist you in better preparing for future tasks?
What support structures were offered to you whilst heading a department during your community service year?
How did you find the support structures available to you to be beneficial?
What other additional support structures do you wish could have been made available to you?
Section D: Challenges faced during community service
Describe challenges related to managerial duties that you faced during your community service year. Probes: • Assistance • Theoretical • Emotional • Practical
Describe any additional challenges you had during your community service year.
What suggestions do you have on how to improve these challenges?

Appendix I 1: Ethical Clearance Certificate

Research Office

HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL)
R14/49 Allsop

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER: H22/09/01**
PROJECT TITLE	The Experiences of Community Service Rehabilitation Professionals Who Managed Their Own Department in South Africa
INVESTIGATOR(S)	Miss E Allsop
SCHOOL/DEPARTMENT	Human and Community Development/
DATE CONSIDERED	16 September 2022
DECISION OF THE COMMITTEE	Approved Risk Level: Minimal
EXPIRY DATE	27 October 2025

DATE 06 December 2022 **CHAIRPERSON**
(Professor J Watermeyer)

cc: Supervisor : Dr K Masuku

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University. Unreported changes to the application may invalidate the clearance given by the HREC (Non-Medical)

I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to submit an amendment of the protocol to the Committee. **I agree to completion of a regular progress report. For Minimal and Low studies, this is due annually on 31 December. For Medium and High Risk studies, this is due twice annually on 30 June and 31 December.**

Signature

07 / 12 / 2022
Date

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES