The community involvement of nursing and medical practitioners in KwaZulu-Natal

Reid SJ, BSc(Med), MBChB, MFamMed
Centre for Rural Health, Nelson R Mandela School of Medicine, University of KwaZulu-Natal

Mantanga L
Nkabinde C
Mhlongo N
Mankahla N
Medical students
Centre for Rural Health, Nelson R Mandela School of Medicine, University of KwaZulu-Natal

Correspondence to: Prof. SJ Reid, email: reids1@ukzn.ac.za

Abstract

Background
The basis of the health system in South Africa is purported to be primary health care (PHC), as defined by the Alma Ata Declaration of 1978. This approach emphasises community involvement in all health-related activities, but it would appear that a very limited or selective PHC approach is actually being pursued in South Africa, without meaningful community participation or ownership. This study explores the involvement of exemplary medical and nursing clinical practitioners in non-clinical community-wide activities in terms of the primary health care approach, which demands a broader scope of practice than primary medical care.

Methods
The objectives of the study were to identify exemplary medical and nurse practitioners in primary health care, to document their practices and perceptions with regard to their community involvement, to analyse the common themes arising from the findings, and to present recommendations based on the findings. Seventeen primary care clinicians in KwaZulu-Natal, half of whom were professional nurses and the rest medical practitioners, were purposively selected through their district managers. A team of four medical students was trained to collect the data and interviewed the subjects in their places of work using open-ended questions. The interviews were recorded, translated where necessary, and transcribed. Content analysis was carried out as a team, with the identification of major and minor themes.

Results
The findings of this study were consistent with studies from other countries, with some interesting differences. The major themes that emerged from the data included the wide range of activities that subjects were involved in, the importance of relationships, the context of poverty, the frustrations of this kind of work, and the respondents’ motivations. These are illustrated by numerous verbatim quotes from the respondents. Minor themes were the roles that the respondents play in the community, the difficulty of obtaining funding, and experiences in starting up. Significantly, the fact that the role of clinicians in the community emerged as only a minor theme rather than a major theme in this study indicates the absence of expectation and policy in this area of practice in South Africa. In the light of the supposed centrality of the primary healthcare approach in the national health system, this is a serious gap.

Conclusion
The lack of a clearly defined role in the community outside of the clinical role that deals with the individual patient who presents for care is discussed in relation to the policy of the primary health care approach. The concept of community-oriented primary care provides a framework for a more systematic approach to community engagement, and this study serves as a basis for further research into the subject.

SA Fam Pract 2006;48(8):16

The full version of this article is available at: www.safpj.co.za  This article has been peer reviewed
Introduction
The basis of the health system in South Africa is purported to be primary health care (PHC), as defined by the Alma Ata Declaration of 1978. This approach emphasizes community involvement in all health-related activities and is delivered through the district health system. However, it would appear that a very limited or selective PHC approach is actually being pursued in South Africa, without meaningful community participation or ownership. Comprehensive PHC as envisioned in the Alma Ata Declaration is not actually being practiced, except in a few isolated projects. The more widely followed approach in practice is rather the medical model of health care with a more curative emphasis. Community-wide preventive health programs are funded at a much lower level than the curative services, and are often carried out by a completely separate group of health workers to the clinicians.

Bearing in mind that the majority of professional health practitioners are clinicians, it is essential for them to fulfill some non-clinical roles, particularly with regard to community involvement, in order for comprehensive PHC to be implemented. Nickson raises the question of whether community involvement should refer to the involvement of community representatives in the health services, or to the involvement of health workers in the activities of the community that they serve. In either definition, there is a clear need for health professionals’ involvement beyond the largely curative clinical role. However, there are no clear guidelines as to what this role is, and how it is expressed in concrete terms.

Pathman et al. described physicians’ involvement in each of the following four domains of community work: a) recognizing the socio-cultural aspects of patient care, b) coordinating a community’s health resources, c) identifying and intervening in a community’s health problems, and d) participating in a community’s organizations.

Oandasan et al. explored how primary care physicians respond to a community’s needs and challenges in fee-for-service practices or community health centers in downtown Toronto, Canada. They used focus groups of 21 community family physicians and identified the following three major themes: they perform specific roles (collaborator, health educator, advocate, resource, and tailor of care); they face several challenges, including lack of funding and a dysfunctional healthcare system; and they share common beliefs about practising medicine. Whether current healthcare structures support physicians to actually carry out these roles in practice, however, is unclear.

The concept of community-oriented primary care, or COPC, has its origins in South Africa and has been developed and incorporated into mainstream family practice systems in other countries. The basic approach comprises a number of steps, beginning with defining and characterizing the community, identifying and prioritizing the health problems and planning interventions to address those problems, with monitoring of the outcomes. A number of authors have described an incremental approach to COPC that makes the process less daunting for the family physician, starting with defining a target population, and then developing activities that systematically address the health problems of that population.

In North Carolina, Steiner et al. examined associations between physicians’ current level of involvement in their communities and a range of prior educational experiences. The physicians described their community-related training experiences during medical school and residency through a nationwide mail survey. They also described their current involvement in each of the four domains of community work identified by Pathman et al. They found that physicians who received training in content relevant to a given community domain were significantly more involved in that domain as practicing physicians. Rotating in rural locations and having a mentor active in the community also were associated with greater current community involvement. They concluded that formal training experiences can influence how actively physicians later will interact with their communities, and that “we should provide medical students and residents with educational content in all four domains of community work, place them in carefully selected locations, and arrange mentor relationships.”

In summary, there is a need to understand what comprehensive PHC means in concrete terms for health professionals in clinical practice in our own context, using positive examples of practice. It appears that this phenomenon has not been documented in this country recently, and it is necessary to do so in the light of the importance of the implementation of comprehensive PHC in the South African context.

Methodology
The study was descriptive in design, using qualitative methods in the form of open-ended verbal interviews in order to explore the degree and types of involvement of medical and nursing practitioners in the communities that they serve as clinicians. For the purposes of this study, community involvement was defined as any health-related activity of a non-clinical nature that was undertaken in the local community, outside of a health facility. The objectives of the study were:

a) to identify exemplary medical and nurse practitioners in primary health care,
b) to document their practices and perceptions with regard to their community involvement,
c) to analyse the common themes arising from the findings, and
d) to present recommendation based on the findings.

Purposeful sampling was used to find clinicians who were known to be involved in their communities in some or other way beyond their clinical role. The district managers of the 11 districts in KwaZulu-Natal were contacted and asked to identify specific professional nurses and doctors known to them, and an initial list of 20 potential subjects was drawn up. When contacting them to invite their participation in the study, they were asked to identify others whom they knew to be suitable for the study, and in this way a final list of 25 was compiled. It was anticipated that a number of these nurses would be unavailable during the study period, or would refuse to participate for some reason, and an ideal number of 15 subjects was set as the target.

The data were collected by four medical students in their fourth year of study acting as research assistants, in pairs, with one conducting the interview and the other writing notes and tape-recording the interview. The interviewers underwent a one-day training session in open-ended interviewing techniques,
using role-playing and feedback, and
an interview guide was drawn up. Be-
fore collecting any data, the interview-
ers themselves were interviewed by
the principal investigator in order to record
what they expected to find in the study,
and thereby to document their individual
biases going into the study. Each par-
ticipant was contacted beforehand by
telephone, the study was explained
verbally, and an information sheet and
consent form was sent to each one. As
far as was possible, the interviews
were conducted in the setting of each
participant’s work environment, and the
signed consent forms were collected before proceeding with the interviews.

All the interviews were fully tran-
scribed from the recordings, and notes
and observations of the interviews were
added to these. Themes were identified
independently from the transcripts by
at least two research assistants, each
pair analysing the transcripts produced
by the other pair of assistants. Major
and minor themes were proposed and
justified from each transcript, and these
were debated with the researcher if
there was no initial consensus. Finally,
the major themes from all of the sub-
jects were ranked in order of priority
so that an overall picture of the results
could be presented.

Efforts were made to retain strict
confidentiality with regard to the sub-
jects’ personal data. Ethical approval
was given by the Biomedical Research
Ethics Committee of the University of
KwaZulu-Natal, and written approval
was obtained from the KwaZulu-Natal
Department of Health.

Results
A total of 25 medical and nursing practi-
tioners from KwaZulu-Natal were identi-
fied as potential subjects, 21 were inter-
viewed, and 17 interviews were used
for the analysis. The interviews were
conducted over a three-week period
at different rural sites around KwaZulu-
Natal, namely Port Shepstone, Ixopo,
Underberg, Ladysmith and Ingwavuma.
Five of the interviews were conducted
at a rural doctors’ annual conference,
and two were conducted telephonically.
Once the data were collected, four in-
terviews were rejected for analysis due
to a lack of information relating to the
research question, or due to technical
problems with the recordings.

Of the 17 interviews analysed, 12
were conducted with women and 5 with
men – 8 doctors and 9 professional
nurse practitioners. Only 3 of the 17
were involved in private practice, while
the rest were in the public sector. The
duration of the interviews ranged from
20 to 90 minutes, with an average
length of 35 minutes. The interviews
were conducted in different settings,
as the situation permitted, including
offices, outdoors, and in the doctors’
teatrroom at the hospital. Most of the
interviews were conducted in English,
with some in both English and isiZulu,
depending on the preferences of the
subjects. The interview guides helped
to direct the discussions, but after an
initial hesitance it was found that the
subjects gave all the relevant informa-
tion without having to use the interview
guide systematically.

Major themes
The following issues were raised by the
majority of the subjects and elaborated
upon: activities, relationships, context,
frustrations and motivations. These
themes are presented in order of impor-
tance following the ranking procedure
used during the analysis. Verbatim quo-
tations translated from isiZulu are given in
brackets.

1. Activities
A wide variety of activities in the com-

munity was described. Some of these
activities included organising a water
supply for the community, to business,
coordinating community steering com-
mittees, acting as home-based carers,
acting as training counsellors, providing
support to patients living with HIV/AIDS,
and involvement in feeding schemes.
The activities described far exceeded
the normal boundaries of health care.

- “In the community, with the Depart-
ment of Health, we were trying to
get a deeper understanding of what
the health needs and priorities are
in a very under-served area called
K…….”
- “We have a group of kids we sort of
take out on Sundays.”
- “We started a garden for destitute
people.”
- “Now we want to start a business
where we train people to build; car-
pentry, and gardening among other
things, to assist people with jobs.”
- “I started a support centre, where
there can be a more personal rela-
tionship with the patients.”
- “I’m the chairperson of the children’s
home.”

- “I helped start a victims’ support
[group] for rape survivors.”
- “I also helped start a pension office
in this district, before people had to
go to Pietermaritzburg to get their
pensions, or just not get it at all.”
- “I helped design and develop a
sanitation system called Phungo-Lu-
tho toilet, this was after some people
had died from falling into the pits of
the old toilets.”
- “We started a sewing club with
Mrs P……., called Sizanani club in
E……..”

2. Relationships
Relationships between the health pro-
fessionals and the community were
held to be important in respect of the
research question. The subjects felt
that, to be accepted by the members of
the community, they had to know them
on a deeper level than just as their pa-
tients. Some also felt that even the way
they dressed when they approached
the community was important, because
it had the potential of being a barrier to
good communication and this shows
the importance of respecting the culture
of that particular community. Some
practitioners also stressed the impor-
tance of strong relationships not just
with the community itself, but also with
the structures that support community
development.

- “I had left M……… in 2002, but
came back and one of the main rea-
sons for coming back was because of
the relationships that I had built in
this community with certain people.”
- “When you have good relationships
with people, your eyes just open to
what potential there can be, and to
what can happen.”
- “They see me as one who is truly
part of the community.”
- “When I’m referred to here by
people, I’m mostly not referred to as
doctor, but as brother or mfowethu
C……., which is what I have always
wanted.”
- “If I were to go back in time, I would
leave nursing and deal with the com-

munity.”
- “[When I arrive dressed the way I
am in the community, then I will be
a nurse, as a result when I go to the
community, I cover my head, I wear
a long skirt and all the rest that they
dress up in so that I may be part of
them. If I don’t do that, then there is
a barrier between me and the com-

munity members.]”

[This is the end of the document. The rest of the text may contain references or additional pages that are not included here.]
3. Context
Fifteen of the 17 interviewees described their community in similar terms, by noting that they were “deep” rural and poor, with a high unemployment rate, weak developmental structures, and some lacked even basic necessities for living. One of the major problems that the health professionals dealt with was the high prevalence of HIV/AIDS and its hampering of community development.

- [What I have noticed about this community is that the people from here are poor, and they have nothing.]
- “There is a mixture of very poor people and some affording people.”
- “Mainly farming community with a high unemployment rate.”
- “People cannot afford the basic necessities of living.”
- “It is a very sick community because of HIV/AIDS and TB.”
- “People in this community are united and they work hand in hand.”

4. Frustrations
A number of the interviewees spoke repeatedly of the frustrations of working or attempting to work in the community. Some were frustrated by time constraints due to too much work in the hospital, which meant that they could not find enough time to go out into the community. Some felt that the communities they were helping showed no commitment to the projects, even though the clinicians put a lot of energy into helping them. Crime also proved to be a threat to community development, and this was stated as being a result of unemployment. It was encouraging to find some health professionals who were persistent despite the frustrations because they believed there would be a change some day. The government was noted to be very slow in terms of interchange some day. The government was because they believed there would be a

- “I can’t carry on to see all these sick people and do nothing about it?”
- “[Christianity is] certainly a large influence of why I came to M………… in the first place.”
- “[I’m a person who loves to see another person succeed.]”
- “I’m passionate about this programme, I like to work with them. I communicate better with them. I want to take early retirement so that I can commit myself fully to the community.”
- “It is rewarding to be able to provide a service when there was nothing previously.”
- “At the end of the day, if you choose a difficult job and you get it done, then it’s very satisfying.”
- “I would probably get bored in my clinical work just dealing with coughs, colds, pneumonia, diabetes and arthritis, and doing nothing else.”
- “I’m not prepared to accept that he can’t do anything about issues he confronts every day, and yet still have a peaceful sleep at night.”

5. Motivation and personality
The motivations and personalities of the health professionals were important in determining the extent of their involvement. For many there was a religious commitment, but others were motivated by the relationships in the community and seeing the results of their involvement. Some practitioners were obviously passionate about their work and enjoyed working with the community, so it did not feel like a burden.

- “They see me as a somebody who can help with many things.”
- “They know I’m the one person who will take the message to everyone.”
- “My role in all of this was more of an advocacy role, involving some networking, facilitating, consultations and assisting where I can.”
- “My duty does not end in the hospital.”

Funding
Most of the respondents worked in poor communities and found funding-raising for community projects to be a constant challenge. Most of this work is done voluntarily, both on the part of the health professionals and on the part of the community members involved.

- “Those who work for us have no payments.”
- “There are so many people who have got the potential to do something, and really succeed, and it’s just a small amount of money and a few people with a little bit of clout that can open some doors for them that they struggle to open themselves, and this can really make a difference in one’s life.”

Women and youth
The burden of illness and deprivation in poor communities usually falls on women and children. Some of the health professionals, especially those who are women, have set their hearts on helping women in the communities by running programmes ranging from sewing to gardening.

- “We asked the youth what they wanted to do with their lives when they finish school, and we found that many of the kids were never asked that before, it was kind of like a shock to them that there were options.”
- “I also felt that a lot of problems with the youth in this community was that they were ashamed of who they were and where they come from, and this was responsible for a lot of apathy and helplessness and low self esteem, so we really tried to address these issues.”
- “[My heart was attracted to helping children and the elderly.]”

Starting up
Some of the health professionals began to get involved as a result of realising the need in their communities.
“Having realised that there was a need, I attempted to do something about it.”

“The outcome of the above start was very encouraging to me.”

Discussion

The aims of the study were achieved in that a number of appropriate clinicians were identified and the nature and scope of their involvement in their communities was explored and documented. The findings of this study were consistent with studies in other countries, with some interesting differences. The major themes identified in this study correlated most closely with the themes of Oandasan et al.; the specific roles of the clinician in the community were similar, the challenges of this kind of involvement related to the frustrations that were experienced, and the “beliefs” that drove the Canadian participants were directly comparable to the “motivations” theme of this study. One of the differences was that other studies focused on doctors only, whereas the respondents in this study were both doctors and nurses. It would appear that there are also differences in the degree and depth of interaction between the clinicians and the community: the role of the clinicians seemed to be more clinically based in other countries, whereas there appeared to be a more intimate and personal community involvement by the South African participants. This may be related to the particular group of participants who were identified, or it may be related to the common theme of poverty and need in the South African context in comparison with the urban communities in developed countries. This was certainly an important issue in motivating clinicians to become involved; as one put it, “I’m not prepared to accept that he can’t do anything about issues he confronts every day, and yet still have a peaceful sleep at night”.

It was clear that the clinicians had important and ongoing relationships with their communities, and this extended to a conscious decision to identify themselves as community members even by dressing appropriately. These relationships and networking are an essential part of family practice, referred to by Steiner et al. in terms of their fourth community dimension, as “assimilating and participating” in a community.7 McWhinney proposes that family physicians should not only understand the context of their patients’ illnesses, but ideally should share the same habitat as their patients.8 His principles of family medicine, namely being part of a network of health providers and being a manager of resources, are illustrated by the range of activities documented in this study, which also relate to Stenier’s more active dimensions of “coordinating” and “intervening”.6

Significantly, the fact that the role of clinicians in the community emerged as only a minor theme rather than a major theme in this study indicates the absence of expectation and policy in this area of practice in South Africa. In the light of the supposed centrality of the primary healthcare approach in the national health system, this is a serious gap. As Nutting and Green have noted, “community-oriented primary care remains an unrealized innovation in the delivery of primary care services. It has the potential to improve the quality of care and the health status of a defined population. Yet, there remains a general malaise among physicians and a remarkable lack of recognition by key decision makers concerning the great potential of COPC.”5 In South Africa, there is no imperative in the public service for clinicians to become involved beyond their clinical role, and the district health system is the poorer for their non-involvement. Similarly, there is no incentive in the private sector to engage with community-wide issues, with the exception of some managed care systems that deal with the health of a defined population, usually of employees of one company.

Gruen et al. provide a useful model for the level of engagement of physicians in health issues in the public arena.10 They identify a number of boundaries and domains of professional responsibility, diagrammatically represented by a number of concentric circles, with the innermost circle being that of individual patient care. Successive levels of responsibility, working outwards from this core obligation, include access to care, direct socioeconomic influences, broad socioeconomic influences and, finally, global health influences. They then argue that physicians should be responsible, beyond individual patient care, for access to care as well as those socioeconomic influences that have a direct impact on the health of their patients. Contributing to anti-smoking policy is given as an example of the latter, where the link between policy and health is clear. Beyond this level, where these links are less well defined and the feasibility or efficacy of interventions by physicians is less clear, they advocate a more elective approach, depending on the interests and situation of each physician. This conceptual model has relevance to the development of policy in this neglected field of practice and research.

In addition to policy, the community-oriented approach is important in the education of future health professionals. There is a need to expose medical and nursing students to community-wide approaches to health promotion, prevention and care that are integrated with personal primary care services in such a way that the linkages are made clear and are not seen as separate activities. If these connections are not made, the health status of the community is at risk of being disarticulated from personal clinical care, and there will be no significant impact on health status.

The limitations of the study include the small sample and the fact that the results are not generalisable, which is in the nature of qualitative studies and the purposive sampling method. The data were collected by four medical students in their fourth year of training who were able to interview the subjects in the language of their choice, using an interview guide and in appropriate settings, and there is no reason to doubt the validity of the data. The results differed from what the interviewers expected to find (as recorded before they collected any data), indicating that their individual bias was minimised. Furthermore, there was significant consensus on similar themes by the different participants, which strengthened the validity of the information collected.

Conclusion

An expanded scope of the practice of primary care clinicians, to include the community beyond the individual patient using a population-based approach to complement an individual patient service, is a component that is largely missing in primary health care. The examples documented in this study illustrate the type of activities and issues that are engaged in by a few exemplary community-oriented clinicians in contemporary South Africa, and give an idea of what is possible. Clinical practitioners need to better under-
stand the context and the community in which they work, with an emphasis on relationships and networks. This study serves as a basis for further research into the subject, with a view to promoting the field of community-oriented primary care as a core function of primary care practitioners in South Africa.

References