Training the primary health care team

Curriculum Vitae

Marietjie was born in Paarl and after matriculating at the Paarl Gymnasium, she spent a year at the South African Defence Force Women's college at George. She qualified as a medical doctor in 1980 at the University of Stellenbosch and then worked for three years at Tygerberg Hospital as intern and medical officer. Marietjie then joined a practice in Kuils River where she worked as partner from 1983 until 1988. She obtained her post-graduate qualification in Family Medicine/ Primary Care (MFamMed) cum laude at the University of Stellenbosch in 1988. In July 1988 she started a solo-practice in Mfuleni , a black township in the Eerste River area. During this time she was involved with several community initiatives including Sacla clinics in Khayelitsha, Masigcine Children's Home, Noluthando School for the deaf, and many others. She is currently appointed as Senior Family Physician/Lecturer at the Department of Family Medicine and Primary Care of the University of Stellenbosch responsible for the development of a vocational training programme for Family Medicine and Primary Care. She is also the co-ordinator of the Bishop Lavis Primary Health care project. Marietjie is the co-founder of the CME-group of the Academy of Family Practice/Primary Care for general practitioners of Cape Town's northern suburbs and also co-ordinates CME for the medical personnel of surrounding Community Health care at Tygerberg Hospital. She serves on the Hospital Board for the Community Health Services Organisation of the Cape Metropole and the Board of the Tygerberg-Boland branch of MASA. She has special interests in the field of community involvement in health, community-based education for health personnel, the development of primary health care personnel medical care for the indigent, and medical education in general. Marietjie is the SAAME council member for the University of Stellenbosch. Marietjie has recently taken up sky-diving and scuba diving.

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Summary

Health care reform and the needs of communities are forcing essential changes in the education of health personnel. Community-based training and multi-disciplinary education are strategies for training institutions to respond to this challenge. Furthermore, the health team concept as part of the comprehensive primary health care approach, needs to be reinforced. The Bishop Lavis Primary Health Care Project developed out of the urgent need to reorientate health care services and the training of students involved in primary health care. The project consists of a partnership formed by the Faculty of Medicine of the University of Stellenbosch, the Cape Metropolitan Council, the Provincial Administration of the Western Cape and the Bishop Lavis community. It aims to offer a comprehensive primary health care service to the community. A multi-disciplinary approach is used, including nurses, family medicine practitioners, a physiotherapist, an occupational therapist, a social worker, a dietitian and community workers. Community participation is an integral part of the project. Students and staff members work together with the community health committee and volunteer community workers in the fields of service, research and community development.

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S Afr Fam Pract

1996;17:111-117

KEYWORDS

Physicians, family;

Health care reform;

Team care;

Community health centre;

Health Plan implementation;

Interprofessional relations;

Education, medical;

Health professions;

Community participation.

INTRODUCTION

The need to provide quality primary health care services to all South Africans is among the top priorities of the Reconstruction and Development Programme (RDP). Appropriately trained health personnel is a prerequisite to deliver these services. Core teams must be established at every community

health centre (CHC) and clinic, and these health workers should be trained in the comprehensive primary health care approach.[1,2]

Academic health centres (AHCs) are traditionally associated with large, tertiary care, teaching hospitals. These centres have been highly successful in providing specialised, high-technology patient care. Social, economic and health care trends suggest, however, that AHCs need to re-evaluate their missions. AHCs have a duty to accept broad responsibility for the health of their communities.[3,4,5]

Therefore, despite their previously divergent missions, AHCs and CHCs are now becoming natural partners. It is the AHCs' need for sites to train primary health care workers, and the CHCs' need for personnel from these training programmes, that provide these two kinds of institutions with a common interest.[6]

Health care reform is also forcing essential changes in the education of health personnel.[7] Learning opportunities should be extended from the hospitals to the community. Furthermore, multiprofessional education needs to be introduced to endorse the health team concept.[8,9,10]

The aim of this article is to share our experience in introducing these concepts in a pilot AHC-CHC partnership. We describe training programmes that are conducted at the CHC, benefits and limitations of the project and propose strategies on how to improve AHC-CHC alliances.

BACKGROUND

The Bishop Lavis Primary Health Care Project consists of a partnership which includes the Faculty of Medicine of the University of Stellenbosch, the Cape Metropolitan Council, the Provincial Administration of the Western Cape and the community of the Bishop Lavis area.

The project is situated in Bishop Lavis, a peri-urban community on the Cape flats. It provides for multi-professional, community-based training for members of the primary health care team. The project adheres to the principles of providing comprehensive primary health care, together with the establishment of community partnerships in health.

RDP	=	**Reconstruction and Development Programme**
CHC	=	**Community Health Centre**
AHC	=	**Academic Health Centre**
CBR	=	**Community-based rehabilitation**
ICP	=	**International Collaborative Programme**
SAAME	=	**South African Association for Medical Education**

Academic departments and community health are now becoming natural partners.

PROGRAMMES

1. A nursing education perspective

The primary health care nurse is ideally situated to assess the needs of the patient, act as health educator, appropriately treat or refer the patient, and manage the health care team.[11] Drastic changes in existing nursing education are urgently required to comply with the basic philosophy of the proposed Government Health Care Plan. The nurse must be able to operate independently in a clinic or a community health centre. One of her major responsibilities is to perform a full physical examination on a patient in any stage of life, assess and diagnose accurately, and manage the condition comprehensively.

A change of attitude towards underprivileged people by merely entering such a community.

Students following the Diploma and Certificate course in Clinical Nursing Science, Health Assessment, Treatment and Care, are trained at the Bishop Lavis CHC. They work under the supervision of mentors from the Nursing College and the CHC. The diploma students

must complete a research project which many of them conduct in the rural areas from where they originate.

2. Human nutrition

Nutrition is an integral part of comprehensive health care. No single element of primary health care is as important as nutrition in providing a promotive, preventative, curative and rehabilitative approach to health care. Nutrition is also one of the major determinants of health and disease in the individual, the family and the community at large.[12]

The students share in the tasks and responsibilities of the dietitian. These include diet therapy, preventative and promotive nutritional education, growth monitoring, nutrition support, home visits, research and community involvement. Other tasks of the dietitian are the continuing nutrition education of all health personnel at the centre, as well as support of the nutrition adviser. BSc Dietetic students from the University of the North are also accommodated at the CHC.

3. Rehabilitation

Community-based rehabilitation (CBR) has become one of the focus points in the empowerment of disadvantaged communities. It should indeed be regarded not only as an essential health service, but also as a philosophy towards the attainment of full human rights for the disabled.[13]

The aims of the CBR centre include the establishment of rehabilitation services in the community; the provision of community-based training to physiotherapy and occupational therapy students; the attainment of meaningful community participation in rehabilitation; and to provide an opportunity for the physiotherapist and occupational therapist to be an integral part of the multi-disciplinary primary health care team.

3.1 Occupational therapy

Occupational therapy students at the CHC are responsible for the treatment of individual clients and groups, the development and extension of the rehabilitation centres' services (eg support groups and home visits), and research. They are trained to shift the focus towards promotive and preventive strategies.

Physiotherapist treating a patient at home.

3.2 Physiotherapy

Physiotherapy aims to facilitate the individuals' rehabilitation as well as that of the community. The effective rehabilitation of the patient leads to improved quality of life for the client and cost-effectivity for the state.

The students' responsibilities include the treatment of individual patients, group exercises and treatment, home visits, and community education initiatives. Referral to other health care workers and liaison with the work environment of the patient are emphasised. The development and support of groups for the disabled, as well as the training of carers, plays an important role.

4. Family medicine and primary care

The primary care physician/family practitioner has a pivotal position in ensuring the delivery of comprehensive health care, as well as the optimal use of health resources. Also, escalating costs, the re-

Health care reform is forcing essential changes in the education of health personnel.

Success depends on co-ordination and team work.

A family medicine student and her patient.

emergence of the bio-psycho-social model, and the emphasis on prevention, are all powerful forces demanding more generalist doctors.[14, 15]

The Bishop Lavis CHC provides two training posts for the full-time Masters programme in Family Medicine and Primary Care. These doctors work in the CHC for one year and share in the normal duties of the medical officers of the CHC.

During this time they acquire experience in community-oriented primary care, ambulatory care, the care of families, continuity of care, and promotive, preventive and rehabilitative health care. They conduct clinics at the old-age home and take part in the activities of the community health committee.

THE PHC TEAM AND MULTI-DISCIPLINARY TRAINING

The effectiveness of any health care system depends essentially on co-ordination and team work. Only when a holistic approach with a multi-disciplinary team effort is adopted, will the health care needs of the community be effectively addressed.[11]

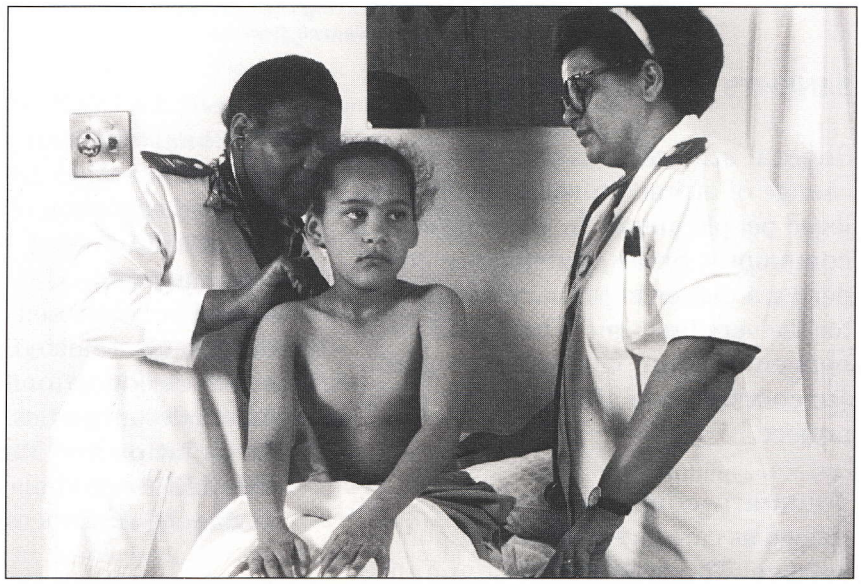
An in-service training programme is held at the CHC, alternating weekly between management meetings and academic discussions. The academic discussions are held in a multi-disciplinary manner, presented by the staff, according to adult education principles. At the management meetings the students are exposed to the practical management of the primary health care team. The meetings are minuted according to standard procedure. It provides a learning opportunity in participatory management for both staff and students. The students become familiar with community participation in health by taking part in the activities of the Community Health Committee and volunteer community workers.

Learning opportunities should be extended from hospitals to communities.

Planning together to do away with the 'them-and-us' mentality.

THE PHC TEAM AND RESEARCH

Reliable information is essential in planning strategies to solve the problems of communities.[16] One of the aims of the project is to conduct appropriate research in order to improve the health service and health status of the community.



Primary health care nurse practitioner student examining a patient with tutor.

All research proposals and outcomes are presented to the Community Health Committee at its monthly meetings. This ensures that appropriate research questions are formulated; co-ordination with staff and community is established; and that students, staff and community members are given the opportunity to learn from the research.

All research is presented to the full community health committee.

The Community Health Committee is currently conducting a multi-disciplinary community survey to assess the needs of the community. Community members were trained as fieldworkers and the fieldwork was co-ordinated by a community representative from the health committee.

Physiotherapy students addressing the Community Health Committee on research findings.

The health team concept needs to be introduced in the educational programme.

BENEFITS AND LIMITATIONS

Several students have expressed a change of attitude towards underprivileged people merely by entering such a community. Some students are considering a career in primary health care for the very first time. Three staff members enrolled in part-time post graduate courses soon after the start of the project.

Voluntary community workers are trained as care givers and to support the service. The training of community health workers and rehabilitation workers will commence in the near future.

Undergraduate medical students are unfortunately not yet formally involved in community-based education. Faculty curricular changes to facilitate community-based education for undergraduate medical students are currently in progress. Further involvement from social work students is also required.

STRATEGIES TO IMPROVE AHC-CHC ALLIANCES

According to the International Collaborative Programme (ICP) for Re-orientation of Medical Education,[8] and the Cape Town Declaration of the African Regional Conference on Medical Education held in April 1995, community-based education of health professionals is only one of several essential reforms required. Medical education should be addressed on a national level through co-ordinated planning by health sciences educational institutions and other relevant parties. The South African Association for Medical Education (SAAME) should play a leading role in facilitating this process.

A controversial issue is the redirecting

Drastic changes in nursing education.

of traditional curricula towards the problem-oriented approach.[17] This seems to be a major stumbling block in some established medical educational institutions. Research done on the problem-oriented approach should be consolidated to prove the value of the method. We should seriously guard against a 'quick fix' of merely continuing tertiary care vertical programmes in community-based facilities.

Also, students from health-related occupations should learn together during certain periods of their education in order to replace the competitive 'them-and-us' mentality with a team approach.[9, 10] Formal inter-departmental planning must be done to enhance multi-disciplinary training.

Lastly, health personnel should proactively strive towards health education of the community. The enhancement of health and prevention of disease are powerful mechanisms of community upliftment and empowerment.[18] Co-operative planning of community-based health education should be done by communities, AHCs and health service workers.

CONCLUSION

The long-standing imbalance between hospital-based and community-based teaching has had negative consequences. Students in the health sciences should develop an understanding of health and illness in the community within the framework of the comprehensive primary health care approach. Multi-disciplinary primary health care is a vital part of modern medicine, and community-oriented education for health personnel should be actively pursued. Health sciences educational institutions should aim to produce a community-oriented primary health care team that is able and willing to serve their communities and deal effectively with health problems at a primary level.

Now is the time for academic health centres to form partnerships with health service departments, community groups, and other social agents to address many of the underlying determinants of health. Today health sciences educational institutions should follow an approach, spearheaded by academic health centres without walls, to show that they are committed to respond to the changing demands of our time.[7]

Academic health centres have to take broad responsibility for the health of their community.

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Acknowledgement

The authors wish to thank the health services managers and staff of the Bishop Lavis Community Health Centre; the community of Bishop Lavis; and all university staff involved in the project. Without your participation this project would never have become the success it is today.