

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.

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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 emphasises 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 practised, 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 preventative health programmes 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 fulfil 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.¹ 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:²

- a) recognising 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 organisations.

Oandasan *et al.* explored how primary care physicians respond to a community's needs and challenges in fee-for-service practices or community health centres in downtown Toronto, Canada.³ 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,⁴ 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 characterising the community, identifying and prioritising 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.^{5,6}

In North Carolina, Steiner *et al.* examined associations between physicians' current level of involvement in their communities and a range of prior educational experiences.⁷ 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.*² 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".²

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 interviewees underwent a one-day training session in open-ended interviewing techniques,

using role-playing and feedback, and an interview guide was drawn up. Before collecting any data, the interviewers 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 participant 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 transcribed 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 subjects 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 subjects' 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 practitioners from KwaZulu-Natal were identified as potential subjects, 21 were interviewed, 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 interviews 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' tearoom 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 information 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 importance following the ranking procedure used during the analysis. Verbatim quotations translated from isiZulu are given in brackets.

1. Activities

A wide variety of activities in the community was described. Some of these activities included organising a water supply for the community, to business, coordinating community steering committees, 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 Department 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, carpentry, and gardening among other things, to assist people with jobs."
- "I started a support centre, where there can be a more personal relationship 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-Lutho 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 professionals 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 patients. 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 importance 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 reasons 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 community."
- [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 community members.]

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 interventions in certain communities. Lack of funding also proved to be a frustration, and this has been identified as a minor theme in this research study.

- *“Oh!! I have so many challenges.”*
- *“I’m frustrated but I keep going.”*
- *“The commitment of the people you are helping, when you call them with your own money but only a few come, it’s bad.”*
- *“The very high crime rate because the youth are unemployed.”*
- *“Slow pace of government interventions in the area, they take too long to implement anything.”*

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.

- *“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.”*

Minor themes

The following themes were mentioned by some individuals as being significant to them, although they were not mentioned by all the respondents. They are arranged in order of importance.

Role

All of those interviewed clearly understood their role as extending beyond their consulting rooms or hospital, but this was assumed and not imposed: there was no mention of a predetermined or established expectation for this involvement.

- *“I am just a community somebody.”*
- *“Also I believe that in addition to my clinical role, I have an important community outreach agenda, which I’m hoping will meet people’s needs.”*

- *“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.*³: 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,⁸ 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.⁹ 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 lat-

ter, 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.

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