

Primary health care in the South African context – medical students' perspectives

Draper CE, MA, PhD

Postdoctoral Research Fellow, UCT/MRC Research Unit for Exercise Science and Sports Medicine
Department of Human Biology, Faculty of Health Sciences, University of Cape Town

Louw G, DVSc

Associate Professor, Department of Human Biology, Faculty of Health Sciences, University of Cape Town

Correspondence to: Dr C E Draper, e-mail: catherine.draper@uct.ac.za

Abstract

Background

Both the South African Department of Health and the University of Cape Town (UCT) have committed to the primary health care (PHC) approach, which is best captured in the Declaration of Alma Ata. If medical students are to be trained in the PHC approach, it is important that they not only have a good understanding of this approach, but are also aware of the social, economic and political context that they will be working in when they have qualified, so that they can develop realistic expectations of their careers as doctors. From research that was conducted at UCT, this article covers UCT medical students' views of health care in South Africa, including their perceptions of the applicability and implementation of the PHC approach for South Africa, and their perceptions of how the South African government features in issues of health and the PHC approach.

Methods

Mixed-methods were used, but this article will focus on the qualitative data gathered. One hundred and seventeen medical students (years one to four) were purposively selected to be involved in focus groups and interviews. These focus groups were conducted between February 2004 and March 2005.

Results

Students acknowledged that the state of health care in South Africa needs to change and showed an awareness of the role that South Africa's history of apartheid has played in the state of health care in these areas and the existence of inequity. They however did not agree on the applicability of the PHC approach to the South African situation. The PHC approach is seen not to be working in South Africa because of various obstacles to its implementation and success, such as disorganisation within the health system, and a lack of infrastructure, finances and resources. There seemed to be a general understanding amongst the students that they will have been trained in the PHC approach but then will be working within a system that has possibly not undergone similar changes. Students agreed on the important role of government in PHC, some maintaining that the government should be at the forefront of its implementation, but were generally dissatisfied with the role the South African government is currently playing in health care.

Conclusion

It is encouraging that students are generally aware of the reality of health care in South Africa and of the fact that more change needs to take place. However, it may be that many students who have a limited understanding of the impact that apartheid had on health care provision in South Africa, and this could then impact on students' perceptions of the applicability of the current PHC approach for South Africa. Students' views that the PHC approach has not been fully implemented in South Africa are a concern, as it is these types of views that are likely to cause students to lose confidence in the PHC approach, and will most likely widen the disjuncture between theory of the approach and the reality of its implementation. Regarding the political dynamics of the PHC approach, students do need to be aware of political factors that can impact on the success of this approach. Discussion around and research into the social, economic and political context of health care and medical education has particular relevance for South Africa, and it is vital that students' views on these issues are acknowledged so that areas for change can be identified and addressed.

SA Fam Pract 2007;49(10):6-11

Introduction

As part of The White Paper for the Transformation of the Health System in South Africa in 1997, the South African Department of Health committed itself to the primary health care (PHC) approach as its strategy for working towards the

goal of "developing a unified health system capable of delivering quality health care to all our citizens efficiently and in a caring environment".¹ This commitment to PHC came three years after the voting in of South Africa's first democratically elected government. Prior to this, apart-

heid legitimated a system of segregation and inequality, allocating health care on the basis of power rather than need,^{2,3} leaving a mark on health care in South Africa that has yet to be erased.^{2,4}

The PHC approach is best captured in the Declaration of Alma-Ata (USSR),

which was developed at the International Conference on Primary Health Care in September of 1978.⁵ It is important that 'primary health care' be seen as an approach that goes beyond first-contact services.⁶ Referring to it as the PHC approach acknowledges that it is both a strategy as well as a philosophy. It is a strategy in the sense that it represents the manner in which health services need to be organised and delivered. The PHC approach is a philosophy as it requires traditional healthcare systems to institute considerable changes in both their structure and content; it emphasises the need for health and other sectors to work together at multiple levels to facilitate general social and economic development, of which PHC is a vital part; and it argues for a community-based and decentralised approach to health and health care, which is rooted in a drive for development and empowerment, and will ultimately make it possible for the kind of care to be supplied so that peoples' lives might be socially and economically productive.⁷

Implicit in this approach is the need to view health from more than just a biological perspective, but also from a 'biopsychosocial' perspective. This perspective acknowledges the biological, psychological and social dimensions of health and illness and aims to understand the whole patient rather than just the disease process.⁸

If medical students, both in South Africa and elsewhere in the world, are to be trained in the PHC approach, it is important that they not only have a good understanding of this approach, but are also aware of the social, economic and political context in which they will be working when they qualify so that they can develop realistic expectations of their careers as doctors. The aim of understanding these expectations is to better facilitate an alignment between medical education and the health system in which students are being prepared to work.

It is also important for medical educators to acknowledge the social, economic and political factors that will influence students before, during and after their studies. The context to which students have been exposed before they begin their studies is likely to shape the image they have of medicine and doctors. Throughout their academic career, medical students will be in contact with the contextual factors of the country in which they are living, be it through interaction with communities, clinical exposure or exposure to various cul-

tures while they are training. In South Africa, qualified doctors will have to work within a South African context, at least for their internship and community service years.

Background

This research took place at the University of Cape Town (UCT), South Africa. In order to better coordinate the teaching of PHC in the Faculty of Health Sciences, UCT adopted a policy on the PHC approach in 1994. The Chair and Department of Primary Health Care were established in 1995, and the PHC Directorate was established in mid-2003. UCT also adopted a new MBChB (Bachelor of Medicine and Bachelor of Surgery) curriculum in 2002, which is largely problem based and underpinned by the principles of the PHC approach.

In their second semester of study, medical students at UCT are formally introduced to the PHC approach through the course 'Becoming a Health Professional'. Throughout this course, students are continually assessed on their ability to apply this approach to the South African health system. At the end of their fourth year, students undergo a multi-professional portfolio oral assessment, which includes examples of patient care that illustrate the relevance of PHC principles at the primary and secondary levels of care. In their fifth year, students complete a five-week elective block and are required to submit a report that includes their reflections on the principles of PHC during their placement.

Aim

The findings presented in this article form part of a broader set of findings for a PhD research study that aimed to qualitatively explore medical students' attitudes towards and perceptions of the PHC approach. Although other related issues emerged in the study's findings, this article will only be covering students' views of health care in South Africa, including their perceptions of the applicability for and implementation of the PHC approach in South Africa. What will also be dealt with in this article are students' perceptions of how the South

African government features in issues of health and the PHC approach.

Methodology

The study used a combination of quantitative and qualitative research methods, but this article will focus on the data gathered from qualitative methods, namely focus groups and semi-structured interviews. A questionnaire was also administered to first-year students in order to further validate the qualitative findings.

A total of 117 students (first-, second-, third- and fourth-year students) were involved in the focus groups (five to six students per group) and interviews, where guide questions were used as opposed to a structured questionnaire. Table I below outlines the details of the focus groups and interviews that were conducted. Purposive sampling was used to select participants. This is a type of non-probability sampling that selects specific individuals or groups because they match criteria that are necessary for the investigation of the phenomenon being studied. When interview and focus-group participants were selected, an effort was made to ensure, as far as possible, that all racial groups (White, Black, Coloured and Indian) and both genders were represented.

A content analytic approach was taken in the analysis of this data, performed by the principal researcher (CD). Qualitative content analysis is a process that involves the coding of interview and focus-group transcripts in order to organise data and identify categories according to content. A conceptual framework based on these categories was used to classify the data. This approach to data analysis helps to ensure that categories identified are those that emerge from the data, rather than organising data into pre-established categories. The conceptual framework then formed the basis for seven major themes, of which 'Medicine and PHC in the South African context' is one theme. The findings presented in this article form part of this theme.

Ethical approval for this research was obtained from the Research Ethics Com-

Table I: Interviews and focus groups

Set 1	Interviews	9	n = 9	1 st -year students	Feb 2004
	Focus groups	3	n = 16		
Set 2	Interviews	10	n = 10	1 st -year students	July 2004
Set 3	Interviews	8	n = 8	2 nd -year students	Jan 2005
Set 4a 4b 4c	Focus groups	6	n = 37	2 nd -year students	Jan / Feb 2005
	Focus groups	3	n = 11	3 rd -year students	Feb 2005
	Focus groups	5	n = 26	4 th -year students	Feb / Mar 2005

mittee of the Faculty of Health Sciences at UCT (REC REF: 324/2003).

Findings – Students' views

The applicability of the PHC approach for South Africa

There seemed to be general acknowledgement among the students that the state of health care in South Africa is not good, and that there is a need for change. Rural areas and townships were identified as being areas that were particularly in need of change, and students showed an awareness of the role that South Africa's history of apartheid has played in the state of health care in these areas and of the existence of inequity.

A conflict of opinion existed around the applicability of the PHC approach to the South African situation. Those who argued against it maintained that socio-economic issues, such as the low level of employment and education, made the PHC approach unfeasible in South Africa. There did seem to be many students who were in favour of implementing the PHC approach in South Africa, and who agreed that it was an important and relevant approach for South Africa as a developing country. Other students felt that, even if the PHC approach was a good one, it needed to be adapted more to the South African situation – *"...our country comes from a history of struggle, apartheid and everything ... we do need such a system or an approach that aims to target people that were previously disadvantaged..."* (third-year student).

Some students felt quite strongly that the PHC approach was less applicable in the poorer provinces and those provinces with large rural areas, and the justification for this was the lack of resources in these provinces. Related to this, some students pointed out the fact that there may be students who had a narrow view of the need for the PHC approach, and highlighted the need to raise awareness of the situation in rural areas.

Obstacles to and requirements for the implementation and success of the PHC approach

A number of students felt that the PHC approach was not seen to be working in South Africa. Various obstacles to the implementation and success of the PHC approach were pointed out, such as disorganisation within the health system, a lack of infrastructure, finances and resources, difficulties with manpower,

administration and logistics, government malfeasance, the lack of political cooperation, peoples' lack of awareness of the needs of others, as well as their motivations for wealth and comfort, which were perceived to run contrary to the philosophy of PHC.

Other obstacles mentioned were the lack of time that health professionals had with patients, a lack of belief, confidence or investment in the PHC approach on the part of health professionals, the lack of human resources, the low level of education in some areas and the fact that people in these areas have a different perception of health to the health professionals, the focus on major issues such as HIV, and the poverty gap.

Students also mentioned a number of factors that the PHC approach required in order to be implemented and to be successful. These included support of the government, support and commitment from sectors other than health, time, finances, resources and infrastructure. Global collaboration was also mentioned as a factor that could speed up the progress of the PHC approach.

The meeting of an old and new paradigm

There seemed to be a general understanding amongst the students that they would have been trained in the PHC approach but then would be working in a system that had possibly not undergone similar changes, making it difficult to reconcile the old and the new. This was a concern for some, as it could hinder the students' belief in the PHC approach. Students also felt that health professionals' awareness, understanding and views of the PHC approach could make the process of integration more difficult.

Some students expressed a more optimistic view of this meeting of the old and the new and argued that, in time, doctors who had been trained in the PHC approach would become more integrated into the healthcare system – *"...I think that it's a very good way to start by targeting the people that are studying and who are going to be working in the future years, so that at least by the time they do go out, the mindset is already there..."* (second-year student).

Government's role and responsibilities

Some students clearly stated their view that the government needed to not only

be aware of the PHC approach, but should be at the forefront of its implementation. Some went so far as to say that the approach relied on the government, which should be committed and hard working in this process. Some of the specific roles and responsibilities of the government mentioned were the prioritisation of health and health care, the provision of funding and resources to and support for the health sector, obtaining the support of the private sector, initiating and overseeing the integration of the various sectors, raising general awareness and increasing general knowledge about the PHC approach, and drafting relevant legislation.

Dissatisfaction with the South African government

Students' feelings towards the South African government were predominantly negative and were said to be fuelled by input from lecturers, the media, and the views of many of the general public. Some students felt that the government was exercising too much control over both the health services and health professionals. Other students felt that the government was not doing enough for the health situation in South Africa. One of the main concerns to do with this concerned funding, and especially the fact that the government did not seem to be allocating funds to the areas of need or to what the students considered and the government claimed to be important. Corruption and mismanagement were other issues within the government that promoted a lack of faith in the government – *"...spending money on arms and jets and things ... we haven't had a war for a while ... They're spending millions on inaugurations and birthday parties..."* (first-year student).

What the South African government is doing

A few students admitted that they did not actually know what the government was doing and, as a result of this, possibly feel less qualified to criticise or make suggestions. Other students felt that a reliance on the government to bring about change was somewhat futile. This is because of the extent of the change that needs to take place, the need for health professionals to take on some of the responsibility for change, and the fact that waiting over the long term can breed laziness and a sense of entitlement – *"...people keep saying 'it's the government's responsibility' ... But I*

feel like it's up to the people to help themselves, because we cannot all rely on the government..." (first-year student).

Some students mentioned examples of where the government's efforts were evident, such as the high expenditure on promotion and prevention strategies for HIV/AIDS, the provision of houses, water and land, and the building of hospitals.

Discussion

South Africa's rich and unique history of political change was alluded to at the start of this article. It should be noted that the majority of the students included in this study were between the ages of eight and ten years old when the new democratic government came into power in 1994. The implication of this is that most of these students have been exposed to gradually increasing degrees of racially integrated schooling in South Africa's process of political change, and have a more historical rather than experiential understanding of apartheid.

PHC in the South African context

It is encouraging that students are generally aware of the reality of health care in South Africa and the fact that, although improvement has occurred, more change needs to take place. However, it may be that many students have a limited understanding of the impact of apartheid on health in South Africa. This understanding could depend on the students' race and the advantage or disadvantage that has historically been associated with different race groups in South Africa. This exposure could then impact on the students' perceptions of the applicability of the PHC approach for South Africa. It should also be pointed out that arguments against the applicability of this approach for South Africa were based on misperceptions of the approach. For example, equating PHC with rural health and only the primary level of care, or using PHC as a label for the entire new MBChB curriculum.

Claims that the PHC approach needs to be adapted within the South African context are not necessarily faulty or unique to students, as Chen *et al.* argue that all countries should have a human resource structure that is appropriate for its circumstances and health needs.⁹ This applies equally to the PHC approach, since human resources are an integral part of its philosophy. Calls for adaptability could therefore actually indicate a better understanding of the South African context and the factors

within this context that could hinder the implementation and success of the PHC approach. They could also be an effort to help bridge the gap between the theory and reality of the approach by adjusting the theory of the PHC approach to match reality.

The implementation of PHC in South Africa – a success?

Students' views that the PHC approach has not been fully implemented in South Africa are not necessarily inaccurate, as Ntuli and Day maintain that South Africa has struggled to put an "impressive array of legislation, policies and guidelines to direct the provision of services" into practice.¹⁰ Others have also acknowledged the problems and difficulties regarding the implementation and success of the PHC approach in South Africa.^{6,7} However, the students' views remain a concern, as it is these types of views that are likely to make students lose confidence in the PHC approach and that will most likely widen the disjuncture between the theory of the approach and the reality of its implementation.

The fact that some students pointed out some of PHC's successes is also a true reflection of many of the positive changes that have taken place in South Africa with regard to health care. Van Rensburg backs this up by claiming that, despite the difficulties that have been encountered, progress has been made in implementing the PHC approach with respect to equity, accessibility, the reprioritisation of funding, building of health facilities, training of staff and future health professionals and the referral system.⁶ A few of these points were raised by the students.

Political dynamics of the PHC approach

Underlying the students' complaints about the government seems to be a feeling of unfairness about the way in which the government is prioritising its funds and energies, as it is probable that a number of the government's decisions are strongly impacting the health sector and it has been argued that students do need to have a greater awareness of the political factors that impact on the success of the PHC approach.¹¹

Regarding these political dynamics, it is necessary to consider whether or not they will ultimately prevent the full implementation of the PHC approach. Will political expediency and the government's private and public agendas stand in

the way of making the PHC approach a reality in South Africa? It is possible that there will always be other issues that will take priority over health in South Africa? As long as this is the case, the PHC approach will only be evident in bits and pieces throughout the health system, thereby pushing the ideals and theory of the PHC approach further away from the reality of their implementation.

Conclusion

Students acknowledged that the state of health care in South Africa needs to change and showed an awareness of the role that South Africa's history of apartheid had played in the state of health care and the existence of inequity. They did not, however, agree on the applicability of the PHC approach to the South African situation. The PHC approach is seen not to be working in South Africa because of various obstacles to its implementation and success, such as disorganisation within the health system and a lack of infrastructure, finances and resources. There seemed to be a general understanding amongst the students that they will have been trained in the PHC approach but then will be working in a system that has possibly not undergone similar changes. Students agreed on the important role of the government in PHC, some maintaining that the government should be at the forefront of its implementation, but were generally dissatisfied with the role that the South African government is currently playing in health care.

Health remains a priority in South Africa. The health system continues to confront issues such as HIV/AIDS and extreme drug-resistant tuberculosis, and works to prevent chronic diseases of lifestyle. It remains vital that medical students, the doctors of our future, are able to tackle these and other issues within the framework of the PHC approach and with an understanding of the factors contributing to these health issues.

Discussion on and research into the social, economic and political context of health care and medical education are relevant not only for a country such as South Africa, but also have international relevance for both developed and developing countries, which have a responsibility to train doctors who will be well prepared for the settings in which they will be placed as professionals. It is essential that students' views on these issues are acknowledged so that


areas for change can be identified and addressed.

Definitions used in this article

For the purposes of this research, 'White' refers to people of Caucasian or European descent, 'Black' refers to those of indigenous African descent; 'Coloured' refers to those of mixed race, and in this context would specifically include those classified as 'Cape Coloured'; and 'Indian' refers to those who are of Indian descent but are South African in nationality.

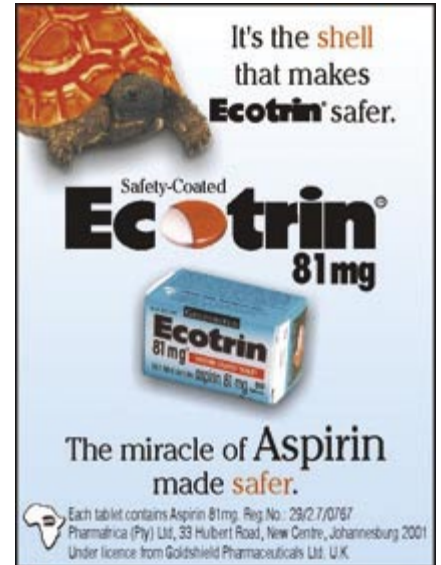
Acknowledgements

Dr Draper would like to acknowledge Prof. Graham Louw (UCT) and Dr David Taylor (University of Liverpool) for their supervision of this research project, Dr Judy Dick (Medical Research Council, South Africa) for her assistance in the area of qualitative research, and all those students who were participants in this project. Funding for this research was provided by the Medical Research Council (South Africa) and the Ernest Oppenheimer Memorial Trust. No conflict of interests exist.

 This article has been peer reviewed

References

1. Department of Health. White paper for the transformation of the health system in South Africa; 1997. Available: http://www.doh.gov.za/docs/policy/white_paper/healthsys97_01.html (Accessed 5/08/2005).
2. Van Rensburg HCJ. The history of health care in South Africa. In: Van Rensburg HCJ, editor. Health and health care in South Africa. Pretoria: Van Schaik; 2004. p. 51–108.
3. Van Rensburg HCJ, Fourie A, Pretorius E. Health care in South Africa: structure and dynamics. Pretoria: Academia; 1992.
4. World Health Organisation. Apartheid and health. Geneva: World Health Organisation; 1983.
5. World Health Organisation – United Nations Children's Fund. Declaration of Alma-Ata. International Conference on Primary Health Care; 1978 Sep 6–12; Alma-Ata, USSR. Available: http://www.int/hpr/NPH/docs/declaration_almaata.pdf (Accessed 5/08/2005).
6. Van Rensburg HCJ. Primary health care in South Africa. In: Van Rensburg HCJ, editor. Health and health care in South Africa. Pretoria: Van Schaik; 2004. p. 412–58.
7. Benatar S. Health care reform and the crisis of HIV and AIDS in South Africa. *N Engl J Med* 2004;351:81–92.
8. Bellet PS. Primary medical care education as an institutional endeavour. In: Knopke HJ, Diekelman NL, editors. Approaches to teaching primary health care. St. Louis: The CV Mosby Company; 1981. p. 15–27.
9. Chen L, Evans T, Anand S, *et al.* Human resources for health: overcoming the crisis. *Lancet* 2004;364:1984–90.
10. Ntuli A, Day C. Ten years on – have we got what we ordered? In: Ijumba P, Day C, Ntuli A, editors. South African Health Review 2003/04. Durban: Health Systems Trust; 2004. p. 1–10.
11. Cueto M. The promise of primary health care. *Bull World Health Organ* 2005;83:322–3.



It's the shell that makes Ecotrin safer.

Safety-Coated
Ecotrin[®]
81mg

The miracle of Aspirin made safer.

Each tablet contains Aspirin 81mg. Reg No: 29/2.7/0767
Pharmatrica (Pty) Ltd, 33 Hubert Road, New Centre, Johannesburg 2001
Under licence from Goldshield Pharmaceuticals Ltd, U.K.