AN ANALYSIS OF THE PERCEPTIONS OF EXIT COMPETENCIES OF MEDICAL GRADUATES TO IMPLEMENT THE NATIONAL HEALTH SYSTEM AT DISTRICT LEVEL : A SELECTIVE CASE - STUDY OF THE WESTERN CAPE.

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CONTENTS PAGE

1. BACKGROUND TO THE PROBLEM 2

2. LITERATURE REVIEW 6

3. OBJECTIVES 28

4. METHODOLOGY 29

5. RESULTS 34

6. DISCUSSION 53

7. IMPLICATIONS OF THE OUTCOMES OF THE STUDY 61

8. CONCLUSION 62

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1. BACKGROUND TO THE PROBLEM

In 1978, the Declaration of Alma - Ata was signed with 134 countries as signatories. The Declaration included a specific clause on the training of health personnel: "Primary health care ...relies, at the local and referral levels, on health workers...suitably trained - socially and technically - to work as a health team and to respond to the expressed health needs of the community" (WHO / UNICEF, 1978, para viii).

In examining the international and local literature, it is apparent that medical educators have for a long time recognised some of the shortcomings in the training of medical doctors. In 1988 the world's leading medical educators met in Edinburgh to examine, on a global scale, issues in medical curricula. The outcome of these deliberations was the Edinburgh Declaration of 1988, which in its preamble states :

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"Thousands suffer and die every day from diseases which are preventable, curable or self - inflicted, and millions have no ready access to health care of any kind. These defects have been identified for a long time, but efforts to introduce greater social awareness into medical schools have not been notably successful. Many improvements can be achieved by actions within the medical school itself, for example to : Complement instruction about the management of patients with increased emphasis on promotion of health and prevention of disease " (Edinburgh Declaration, 1988, pp 8). Furthermore, the Declaration proposed 12 reforms in medical education, of which competency - based learning is an integral component.

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The area of human resource development in South Africa is at a critical stage. In October 1995 the National Minister of Education, Minister Sibusiso Bengu, appointed a Committee for Development Work on the National Qualifications Framework (NQF). The NQF is defined as a framework for providing lifelong learning opportunities utilising nationally recognised levels. The main brief of the committee was to formulate proposals which will serve as guidelines on developing a curriculum framework which will underpin the NQF (Report of the Ministerial Committee for Development Work on the NQF, February 1996). The NQF essentially involves outcomes - based education and training, where curriculum developers work backwards from agreed desired outcomes and clearly state what the learner should be able to demonstrate an understanding of, and show an ability to apply appropriately. Competence, as defined by the NQF, involves the integration of a number of specific outcomes. Furthermore the National Commission on Higher Education endorses the role of a National Qualifications Framework of higher education in the health sciences (A Future Organisational and Financial Model for the Health Sciences - National Commission on Higher Education, Task Group Five, Working Document, April 1996). In this study we have used a more precise definition of competence to be the "...attributes necessary for job performance to the appropriate standards" (NOOSR, 1993;5). The "attributes" as used in this study include the knowledge, skills and attitudes required to perform a task or function to a required standard.

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Another important aspect to consider when examining the area of competencies is that the Department of Health (DOH) in South Africa is actively engaged in restructuring the health system of this country in order to redress the social and economic injustices of the past.

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The DOH aims to do this through the establishment of district health systems, which will become the smallest functioning unit of the health system in South Africa.

It is envisaged that a district will provide comprehensive health care through clinics, community health centres, community hospitals and community - based programmes. This will be provided within certain geographical boundaries (A Policy for the Development of a District Health System, 1995). Although the district health system is not yet in place, adequate preparations need to be made for its implementation. This must also include an examination of the training needs.

Recent assessments of the human resource capacity in the health sector in South Africa have highlighted the inappropriateness of training provided by training institutions for meeting the service imperatives of the National Health System (National Assembly Portfolio Committee on Health Report on Vocational Training October 1996; Health Care Personnel Audit , October 1996; Final Draft National Human Resource Development Policy, 1996). In the health arena in South Africa, the Interim National Medical and Dental Council of South Africa (INMDC) has proposed a two year vocational training period for medical graduates upon completion of their course. This proposal has subsequently been withdrawn and has been replaced by a proposal from the Minister of Health for a one year period of community service upon completion of the internship period. However, neither of these two proposals have been based upon an objective assessment of competencies that medical graduates ought to display at the end of their training period.

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in February 1995, the Western Cape Provincial Ministry of Health published a Provincial Health Plan, which aims to restructure health care delivery in this province. The integration of health and

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development in this province will be characterised by, amongst others, “its provision for human resource advancement and development while being responsive to the need for historical redress” (Draft Provincial Health Plan, 1995 pp iv).

The Plan goes further to state that “the overwhelming proportion of undergraduate training at the two Western Cape medical schools is hospital - based (third level hospitals) and much of it is provided by sub - specialists” (pp 183). At the same time, and in contrast to the hospital - based undergraduate training, the Plan notes that the “disease patterns of the Western Cape are a manifestation of a combination of the worst consequences of poverty, social instability and industrialisation” (pp i) . The establishment of the district health system will require staff with the skills and knowledge to perform a range of tasks and functions as part of a multi - disciplinary health team. Although the district health system is not yet in place, adequate preparations need to be done for its implementation. This must also include an examination of the training needs.

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The purpose of this study therefore, is to provide an analysis of the appropriateness of the exit competencies of doctors who have completed their basic training for the implementation of the National Health System at district level.

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2. LITERATURE REVIEW

Before examining the issue of competency - based issues in the medical curriculum, it would be useful to look at various models of medical education. These range from the more traditional eg. subject - centred curriculum to to the more innovative such as the 'spices model'.

MODELS OF MEDICAL EDUCATION

1. Subject - Centred Curriculum

This is the most wide - spread model for medical education. Generally this includes 2 - 4 years of didactic instruction in basic and pre -clinical science; followed by several years instruction in the clinical disciplines. Scientific fact and theory form a large part of the medical course, together with instruction in research methodology. Contact with patients occurs only after proficiency in these basic sciences is demonstrated. The subject - centred curriculum can best be demonstrated by figure 1 described below , with verticalisation of subjects within the curriculum.

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Problems that can be encountered with this approach include: it emphasises factual knowledge of independent medical speciality areas, patient contact occurs without direct responsibility for patient care, and there is an unbalanced focus on human disease and pathology instead of a more comprehensive view of the humanistic aspects of illness.

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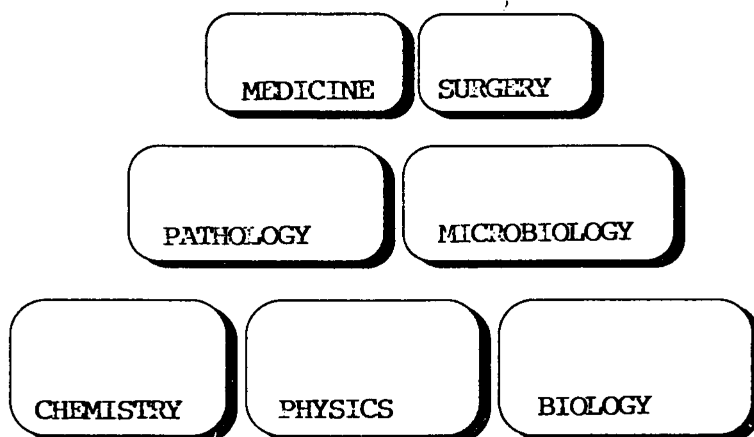

FIG. 1

In looking at curricular responses to these issues, according to Cox, separate departments of community medicine have often been created at medical schools which has compounded, rather than addressing the problems with medical education. These departments of community health then have to compete for curriculum time and space within the separate worlds of academia, the health care system and the needs of the community (Cox, 1984).

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2. The Integrated Curriculum

This model attempts to fuse independent disciplines into a more unified whole. Development of this model is based on the assumption that medical learning and teaching have greater perceived relevance when didactic courses and clinical experience are brought together.

This fusion of elements of the medical curriculum into a conceptually meaningful structure provides a more appropriate context for learning about medicine and can be represented by fig. 2 below.

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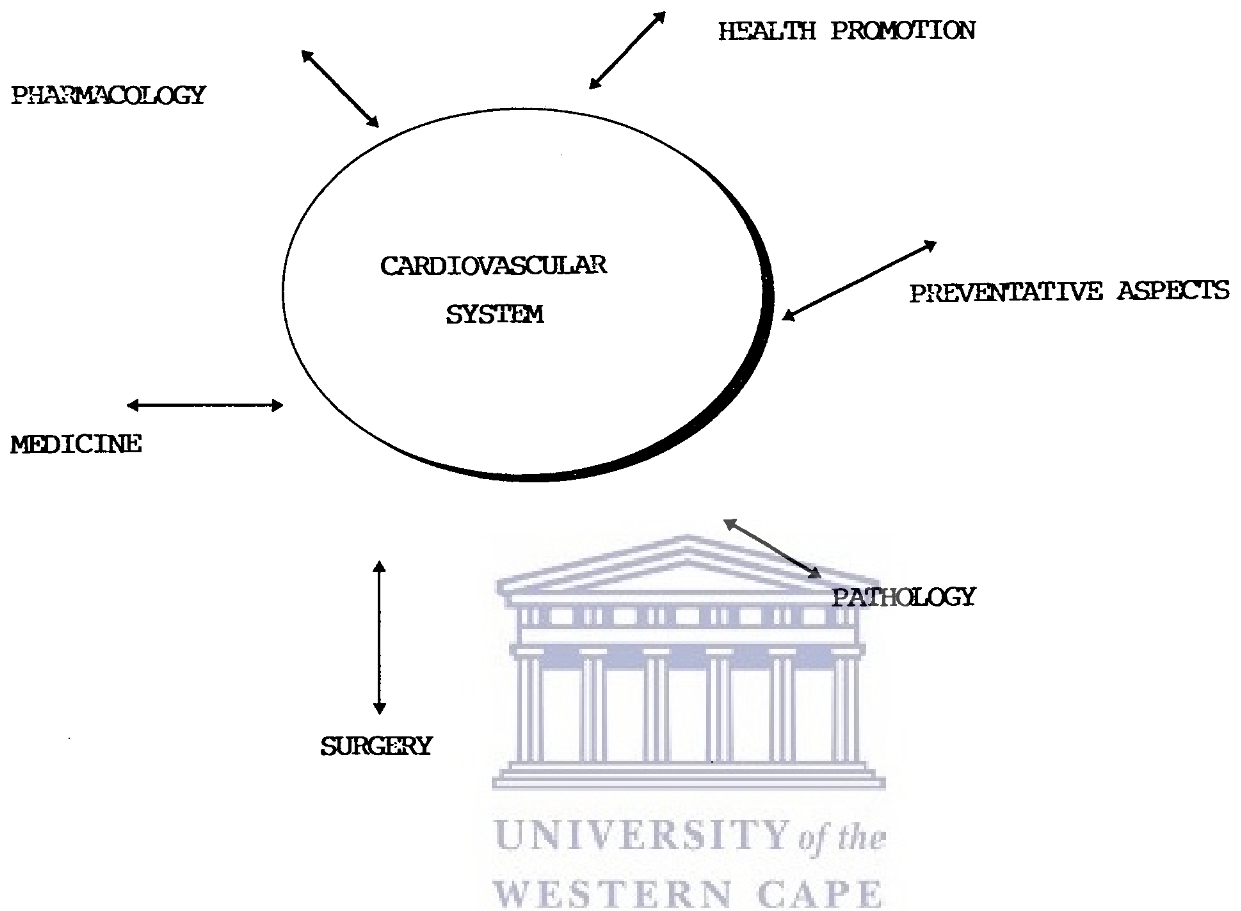

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FIG. 2

3. Multiprofessional Education

The concept of multiprofessional education recognises that health care is performed by a team of providers drawn from diffferent disciplines. These providers usually belong to a wide range of health related vocations and through the sharing of a common core of learning experiences, the graduate receives a more holistic and comprehensive education.

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Multiprofessional education often uses a problem - solving approach, with the emphasis on being able to demonstrate an acquired competence. The skills that are required must relate to congruence of objectives, thus optimising efficiency and effectiveness. The ultimate objective is to develop skills in health care providers that would enable them to deliver comprehensive health care.

For multiprofessional education to be effective, it has to relate to the pertinent health problems of the community and should therefore be mostly community - based. This is a radical shift away from the prevailing situation at most medical schools, wherein most of the training of health professionals revolves around a predefined and predesignated institutional framework (Bajaj, 1994).

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4. Portfolio - Based Learning

The term portfolio - based learning, derived from the arts, has come to mean the collection of evidence that learning has taken place. This means the accumulation of a variety of materials that illustrate professional growth of the student. Some of these can include : written accounts of interactions with patients (case studies), critical reviews of articles read , teaching sessions attended, video clips, personal reflections in the form of a diary etc. This type of learning is a more mature approach and uses different teaching methods to enhance professional growth This method could also be used as a means of assessing competence in students. (Snadden et al, 1996).

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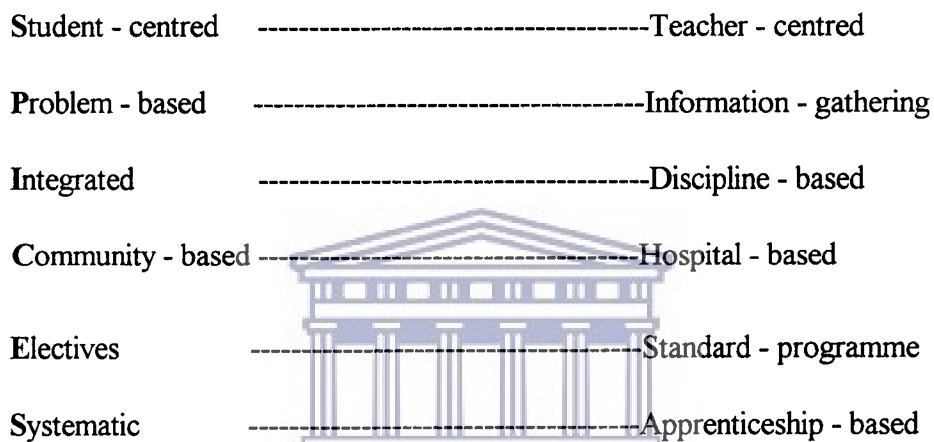
5. The Spices Model

In looking at general principles guiding the medical curriculum, the **SPICES** model proposed by Harden, Sowden and Dunn, is an informative and innovative approach .

Six education strategies have been identified relating to the curriculum in a medical school. Each of the six education issues can be represented diagrammatically. Each issue is presented as a spectrum between two extremes and can be presented schematically as follows:



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The newer innovative medical schools are mostly to the left of the model whilst the more traditional schools are to the right of the spectrum. The concepts embodied in the SPICES model take cognisance of the changing needs of society and ensures that the fledgling doctor is capable of dealing with these changing needs (Harden et al, 1984) .

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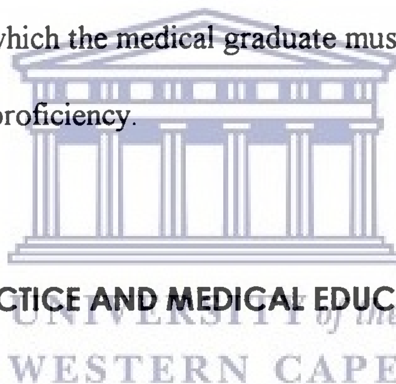
6. Competency - Based Curriculum

A curriculum based upon competencies is organised around knowledge and skills required for the practice of medicine in a specified setting. According to the WHO document on competency - based curriculum , it is grounded in the principle that students at medical schools, when given appropriate instruction, can master the basic prescribed performance objectives.

"The intended output of a competency - based programme is a health professional who can practise medicine at a defined level of proficiency, in accord with local conditions, to meet local needs" (McChagie et al, 1978). These competencies include a broad range of knowledge, attitudes and skills which the medical graduate must acquire in order to provide health care at a defined level of proficiency.



INTERLINKING MEDICAL PRACTICE AND MEDICAL EDUCATION

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In order to produce doctors for today's world, the relationship between medical practice and medical education needs to be reviewed. The traditional 'binomial' model of medical practice - medical education, has limitations in that it assumes a linear relationship between an educational intervention and an effect on the learner's behaviour. This is often not the case, as in many instances graduates do not demonstrate mastery of all the skills that health authorities and health care consumers expect. There is not always a linear relationship between an educational intervention and an effect on the learner's behaviour.

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Charles Boelen of the WHO in Geneva, proposes a new definition of medical education : "It is the art and science of (1)preparing future medical graduates to function properly in society and (2) influencing the environment in which these graduates will work, to the greatest satisfaction of the health consumers, the health authorities and the graduates themselves" (Boelen, 1994).

Furthermore the author identifies 5 functions that the medical practitioner will have to play in our changing society:

* Assess and improve the quality of care by responding to the patients' total health needs with integrated preventive, curative and rehabilitative services.

* Make optimal use of new technologies, bearing in mind ethical and financial considerations and the ultimate benefit of the consumer.

* Promote healthy lifestyles by means of communication skills and the empowerment of individuals and groups for their own health protection.

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* Strike a balance between patient's expectations and those of society at large.

* Work efficiently in teams both within the health sector and intersectorally.

It is imperative that these functions of the medical practitioner serve as a link between medical education and medical practice and that these are not divorced from the environment in which medical graduates practise.

In the process of redefining what he believes medical education to be, the author has identified basic functions or competencies which he believes medical graduates ought to demonstrate a mastery of.

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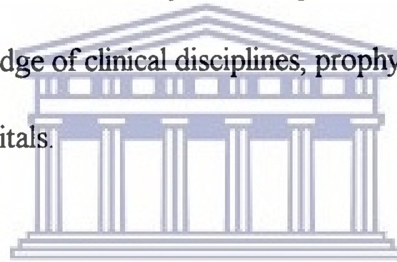
COMPETENCY - ORIENTED MEDICAL EDUCATION

In examining competency - based issues in medical curricula, it would be useful to firstly have a look at the general medical curriculum. The European Union directives (EEU/75/362, EEU/ 75/363, EEU/93/16) outline the competencies for the medical course which students must achieve in 5500 hours, or 6 years (Garcia - Barbero, 1995). This is seen in many countries as a framework for future achievements during which students must acquire : an adequate knowledge of the sciences on which medicine is based; the scientific method; a sufficient understanding of the structure, function, and behaviour of both healthy and sick persons; physical and social surroundings; an adequate knowledge of clinical disciplines, prophylaxis, diagnosis and therapy; and suitable clinical experience in hospitals.



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The Directives do not however define expressions such as 'adequate knowledge', 'sufficient understanding', 'suitable clinical experience'. They do however, further specify an exhaustive course content for the medical curricula which should include:

support sciences (physics, biomathematics, general biology, embryology), human morphology, molecular biology, functional human biology, cellular and molecular pathology, behavioural sciences, introduction to clinical methodology, laboratory, diagnostic pathology, image diagnosis, preventive medicine & public health, system pathology & human illness (integrated approach between internal medicine and surgery), clinical pharmacology and therapeutics, paediatrics including physical and psychological development, gynaecology, obstetrics and reproduction,

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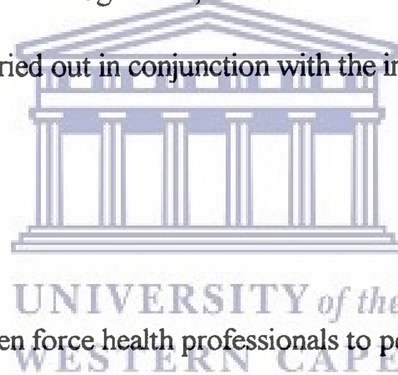
medical and surgical specialities, health and illness of the human mind, clinical trials and community medicine. Mechanisms are also identified which allow students to specialise in any one of the above areas.

Furthermore, the Edinburgh Conference also highlighted the importance of a social dimension and community / public health approach to the training of medical doctors and indeed all medical personnel. Since the Edinburgh Declaration, the World Federation for Medical Education (WFME) has embarked upon numerous global attempts to refine the concepts expressed therein; an example being the Global Curricula Programme, which is reviewing all subjects being taught in the medical curriculum. This is carried out in conjunction with the international specialist bodies (WFME, 1993).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Changes in health care systems often force health professionals to perform new tasks; which include meeting community health needs, promoting health, considering socio - cultural differences, adjusting to new situations, solving problems, working in teams, and using managerial skills. There needs to be a dynamic link between these changes in the health care system and the continuous development of medical curricula.

In a study by Walker in the United Kingdom, seventy five students at the end of their final year, responded to a postal questionnaire designed to assess their views on their medical curriculum. A Lickert - type rating scale was used which required the respondent to indicate his / her opinion by circling one of the following - “strongly agree”, “agree”, “disagree” or “strongly disagree”.

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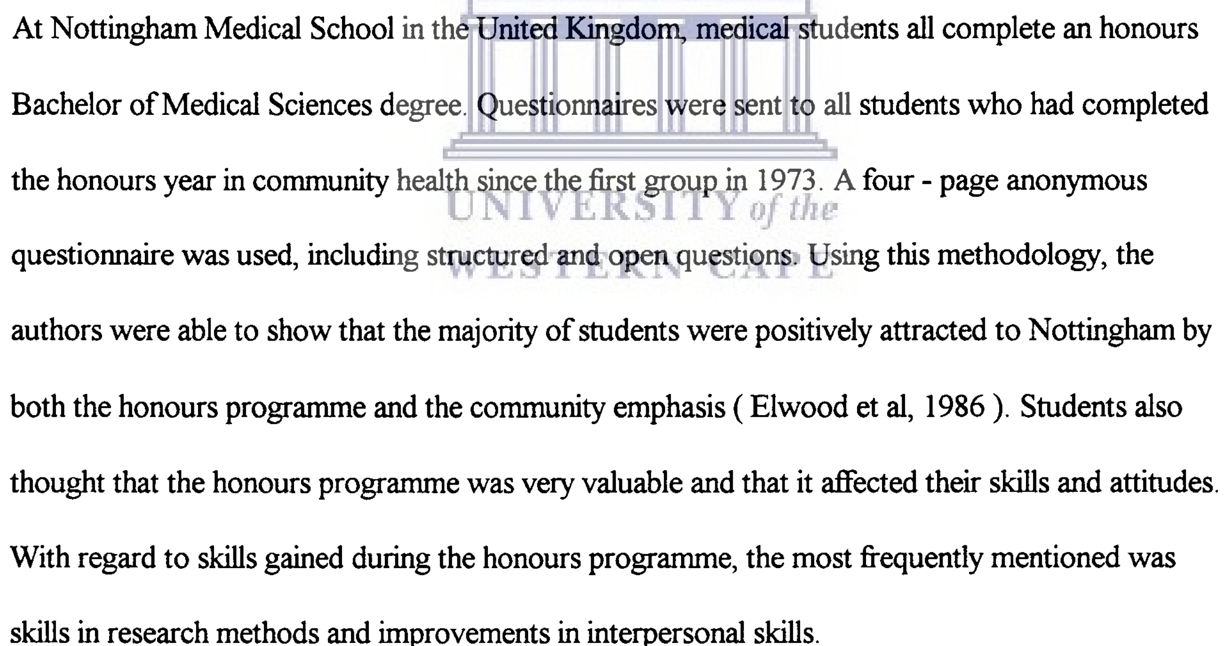
With respect to the curriculum itself, 66 % of respondents believed that the scientific aspects of medicine, as opposed to the human ones, had been over - emphasized. The breadth of the curriculum was also questioned by a number of respondents; just over a third considered that the curriculum offered too restricted an education for the modern doctor.

This study also assessed staff attitudes. It was felt by 51 % that staff who taught medical students had not been sufficiently interested in staff - student relationships. Furthermore, 45 % felt that staff had been insufficiently accessible for advice and guidance on clinical and academic teaching matters (Walker et al, 1981).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At Nottingham Medical School in the United Kingdom, medical students all complete an honours Bachelor of Medical Sciences degree. Questionnaires were sent to all students who had completed the honours year in community health since the first group in 1973. A four - page anonymous questionnaire was used, including structured and open questions. Using this methodology, the authors were able to show that the majority of students were positively attracted to Nottingham by both the honours programme and the community emphasis (Elwood et al, 1986). Students also thought that the honours programme was very valuable and that it affected their skills and attitudes. With regard to skills gained during the honours programme, the most frequently mentioned was skills in research methods and improvements in interpersonal skills.

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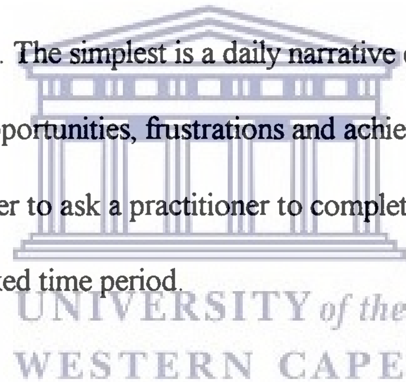
METHODS OF ASSESSING COMPETENCE

The following section examines various methods that are used to assess competence and draws on the WHO document "Competency - Based Curriculum Development in Medical Education" (MacCaghie et al, 1978).

1. Self - Reports

Self - reports are the most direct way to collect functional data as it involves physicians in the analysis of their own performance. The simplest is a daily narrative diary, which can provide enlightenment about problems, opportunities, frustrations and achievements. However, for analytical purposes it is much easier to ask a practitioner to complete some standard form after each encounter with a patient over a fixed time period.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2. Observation

This usually provides more reliable data than self - reports an involves using trained observers and an observational guide and checklist. While the presence of an observer may have some influence upon a practitioner's behaviour, the gain in reliability of what is described is probably worth the small potential loss in validity.

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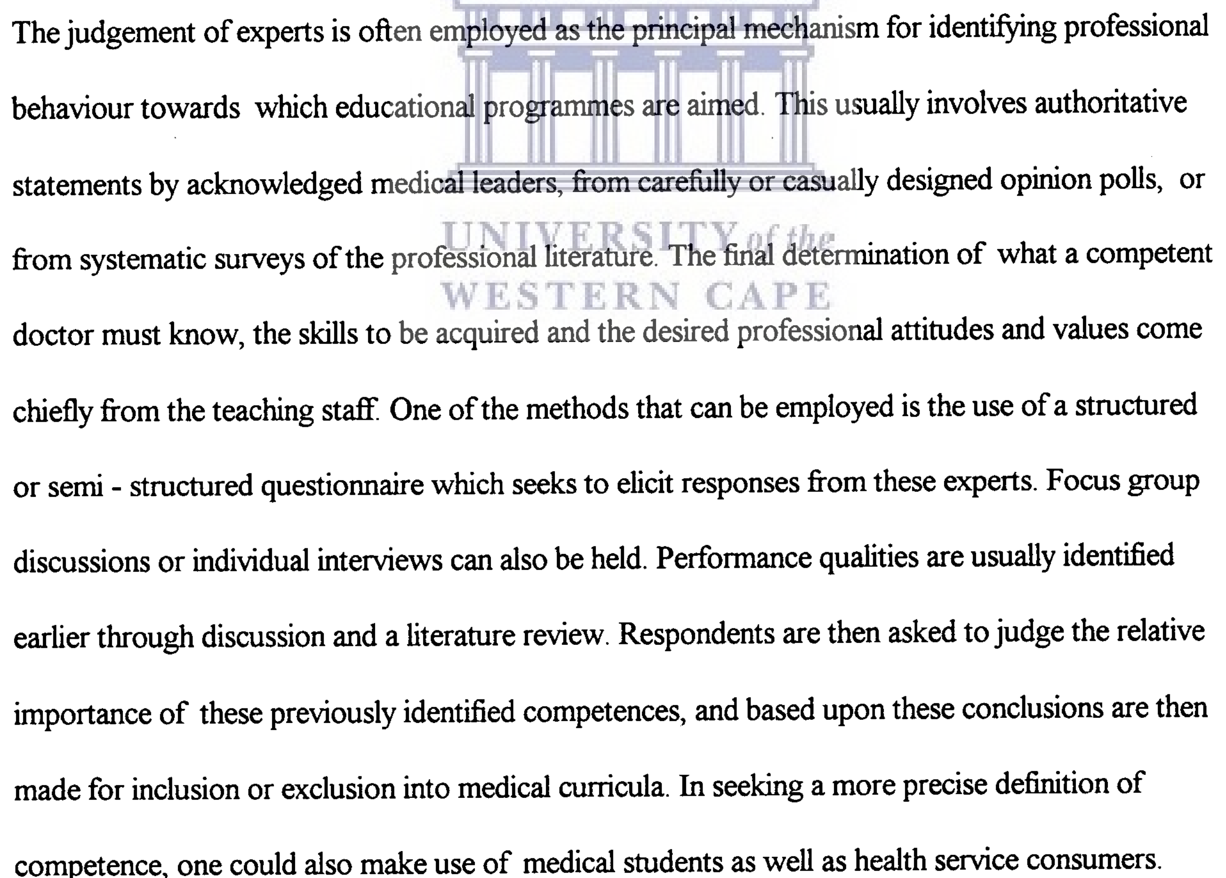
3. Critical Incidents

This is where qualified individuals are asked to describe incidents of medical care which they have observed and judged to reflect superior or poor performance. The judgement requested is of the incident not of the individual. Each description includes the setting in which the event took place, exactly what occurred, an account of the outcome, and why it was judged to be effective or ineffective. As the number of individually described incidents grows larger they begin to fall into clusters and a detailed description of competence begins to emerge.

4. Expert Judgement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The judgement of experts is often employed as the principal mechanism for identifying professional behaviour towards which educational programmes are aimed. This usually involves authoritative statements by acknowledged medical leaders, from carefully or casually designed opinion polls, or from systematic surveys of the professional literature. The final determination of what a competent doctor must know, the skills to be acquired and the desired professional attitudes and values come chiefly from the teaching staff. One of the methods that can be employed is the use of a structured or semi - structured questionnaire which seeks to elicit responses from these experts. Focus group discussions or individual interviews can also be held. Performance qualities are usually identified earlier through discussion and a literature review. Respondents are then asked to judge the relative importance of these previously identified competences, and based upon these conclusions are then made for inclusion or exclusion into medical curricula. In seeking a more precise definition of competence, one could also make use of medical students as well as health service consumers.

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THE INTERNATIONAL LITERATURE ON SPECIFIC COMPETENCIES

The competencies of health workers are influenced by many factors, such as: the socio - political and economic climate of the country, practice setting, types of patients and types of health problems and the availability of resources. In assessing competencies of medical graduates, ratings by clinical supervisors using prepared rating scales have been widely used to evaluate intern performance. Rating scales still remain one of the most practical ways of obtaining assessments and providing feedback to junior doctors (Rolfe et al, 1995).

The competencies identified by Adjou - Moumouni that graduates in the developing nations in Africa for example must achieve, are very different from their counterparts in Europe. Of the 13 competencies identified by Adjou - Moumouni, only 3 involve the diagnosis and treatment of particular complaints in individual patients (McCaghie et al , 1978). These competencies, note that the physician graduate should be able to:

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- Detect the major communicable diseases in a community, treat individuals or groups affected by these diseases.
- Recommend or organize measures for preventing such diseases from spreading.
- Identify the social or economic significance of communicable or non - communicable disease prototypes and suggest appropriate social measures.
- Diagnose and treat organic and functional disorders affecting the major body systems, analyse the consequences.
- Analyse the consequences of disease on the individual life and family and take the necessary action to minimise the sequelae of the disease.

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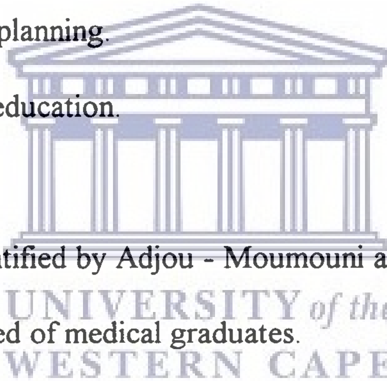
- Analyse the influence of social, economic, and environmental factors on the health status of individuals and groups, and suggest appropriate measures for their correction.
- Collaborate with governmental and private organizations to provide a healthful environment, good food, and better use of available resources to meet the health needs of the community.
- Obtain community participation in solving health problems.
- Lead the health team, supervising their activities, supporting their morale, and helping to solve their problems.
- Use record systems to supply information to upper levels.
- Participate in national health planning.
- Pursue his own professional education.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Many of these competencies identified by Adjou - Moumouni are often not seen as part of the 'traditional competencies' required of medical graduates.

A study by Leonard Finocchio et al in 1991, selected 300 physicians randomly as representative of the physician population in the United States who were asked to rate: (1) the importance of formal undergraduate training in each of 16 competencies - previously identified by the broadly representative Pew Health Professions Commission, and (2), the adequacy of their own undergraduate training in the competencies.

The sample population was drawn from 3 cohorts: 1960-1969, 1970-1979,1980-1989. The information needed was obtained using a telephone survey. The competencies identified were

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derived from the skills, attitudes, and behaviours defined by the Pew Health Professions Commission as necessary for the nations' health care practitioners to meet the changing health care needs in the United States. For each identified area, the following was asked: "Based on your own experience in your residency and your practice, how important is it for medical schools to provide formal training ?". Physicians answered using a four point scale: "very important", "somewhat important" , "slightly important" and "not important". Physicians were then asked to rate how well they were prepared in these areas by their professional education. Response options were "excellent" , "good" , "fair" , "poor" and "unsure".

In evaluating competencies in the undergraduate curriculum more than 75 % thought it "very important" to include the 5 competencies involving skills traditionally valued in medical practice: diagnosis and treatment, effective communication with patients, problem solving, lifelong learning and medical ethics.

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More 50% of the physicians thought that 12 of the 16 competencies were "very important" to include in undergraduate training. These competencies are: health promotion and preventive medicine, involvement of the patient and his family in the treatment, management of large volumes of information, appropriate use of technology, working in a team with other health professionals, and consideration of cost factors in clinical decision making. More than 50% thought it "very important" that curricula include some competencies which reflect the changing dynamics of health care delivery.

In rating their own training, more than 50% felt well prepared in the 5 traditional competencies identified above. However, a majority felt their training was only "fair" or

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"poor" regarding the involvement of patients and their families, evaluation of the appropriateness of costly technology, consideration of cost implications in their decision making, and understanding and supporting the community's role in health care (Finocchio et al, 1995).

In New South Wales, Rolfe et al, used a clinical supervisors' rating form addressing 14 competencies, to assess intern performance one year after qualification in NSW. The original instrument comprised 13 competencies, each rated on a 10 - point Lickert rating scale ranging from 1 which was "unsatisfactory" to 10 which was "outstanding".

The competencies identified in this study include : clinical clerking, diagnostic skills, clinical judgement, procedural skills, approach to patient management, understanding of basic disease mechanisms, communication skills, relationships with patients and families, relationships with other professionals, self - directed learning, reliability and dependability, initiative, enthusiasm and teaching abilities.

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Data from 485 interns (97.2 % response rate) showed that graduates from the problem - based medical school were rated significantly better than their peers with respect to their interpersonal relationships (i.e. relationships with patients, their families and other health professionals), were more reliable and were better self - directed learners. Interns from one of the traditional medical schools were rated significantly better than graduates from other institutions on the competencies: understanding of the basic disease mechanisms and were also better teachers and diagnosticians (Rolfe et al, 1995) .

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In his paper entitled: "Certification in post- graduate education", Dr. Kenneth Calman looks at some of the *practical issues* relating to the certification of specialists. This includes the assessment of competence and the need for public involvement. Although the specifics relate to specialists, the concepts are applicable to basic and undergraduate programmes as well. These practical issues are important to factor into the design of any curriculum and deserve special consideration.

According to Calman, certification should be based on an assessment of competence and should not be defined by a length of time. In the United Kingdom, the General Medical Council (GMC) has also increased public participation in matters relating to the Council; this will ensure that public opinion on certification and competence will also be taken into account. A portfolio - based approach will be used to decide on whether specialists are competent or not. This may include: log books, practical tasks and personal reviews. Core competencies amongst the specialities should include: ability for self - learning, problem - solving and research. Other competencies will include some of the public's concerns such as : attitudes, communication skills and teamwork (Calman; 1995).

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Continuing education and lifelong learning are also integral to the maintenance of professional competence. Undergraduate and postgraduate training cannot guarantee the competencies of trainees throughout their professional lives. Health professionals will constantly need new roles and therefore educational programmes should focus on the achievement of professional competence, not the retention and recall of information.

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Problem - solving skills, self - learning habits, and teamwork approach must be greatly encouraged in the emerging health professional. It is equally important that educators draw a distinction between education and training; the former is broad and has a clear value base; whilst the latter is concerned with the acquisition of particular skills.

APROACHES TO MEDICAL EDUCATION IN SOUTH AFRICA

The training of medical graduates in the South African context is occurring within a milieu of unprecedented reform in the health sector. Benatar's description of our health system reflects the situation that the Ministry of Health is trying to move away from: "Our current health care system can be accurately described as maldistributed, poorly funded and co - ordinated, fragmented and duplicated, discriminatory on a racial basis, hospital - based, and supported by very poorly developed ancillary services" (Benatar, 1990). Furthermore in an article by Volmink, the author states that the teaching of medical students is biased towards urban, tertiary and high technology medicine and that most of the teaching is done by specialists many of whom have never practised outside of a teaching hospital. He also states that doctors emerging from medical school have been exposed mainly to rare and life - threatening conditions (Volmink, 1992).

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Whereas there are no studies in South Africa which examine the issue of competency based curricula and their relevance for practice at the district level, there have been numerous studies which have critically examined medical education in terms of its content, process and appropriateness within the South African context.

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In terms of the local situation, Lazarus identifies 5 major problems of the graduate delivered by South African medical schools. These include: the emphasis on high technology hospital medicine, specialist orientation of the graduate, a strong focus on academic rather than on humanistic criteria, graduates do not benefit from a broader university education and lastly, that medical education is geared towards curative rather than preventive medicine.

According to Lazarus, the bias towards high technology hospital medicine is partly responsible for the maldistribution of medical practitioners within South Africa thus "resulting in a saturation of health care amongst advantaged urban populations and consequent poor health care for disadvantaged rural populations" (Lazarus, 1988). Furthermore, the author states : "the unfortunate result of these problems is that medical graduates are unappropriately trained to meet the health care needs of our population".

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These views are supported by Sparks, who further identifies the lack of patient education and the need to stress holistic aspects of care in the teaching of undergraduate medical students. This should encompass physical, psychological, social and spiritual aspects of health as well. In analysing the content of medical undergraduate training, Sparks comments : "students are shown patients with rare diseases and are provided with theoretical training which is often inappropriate" (Sparks, 1988).

Examining the various obstacles to the need for curricular change, Ross looks more closely at the concept of community - based medical education. According to Ross, conventional medical educational systems make change difficult, and thus it may be necessary to create alternative

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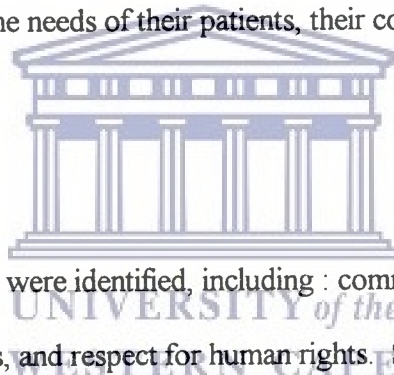
pathways in medical schools for a community - orientated education. This is in line with an important aspect of the policy of the World Health Organisation (WHO), namely the development of training programmes which are more responsive to the needs of the community served than are the vast majority of current programmes for the training of physicians (Ross, 1988).

In April 1995 the African Regional Conference on Medical Education met in Cape Town in order to re - examine the issue of education of medical graduates in the African context. The Conference comprised 240 delegates from 35 African countries and reaffirmed its commitment to medical education reform in Africa. Such reform was designed to produce doctors who are appropriately trained and motivated to service the needs of their patients, their communities and their fellow health care providers.



Specific attributes to be promoted were identified, including : community - based orientation, ethical awareness, progressiveness, and respect for human rights. Specific knowledge to be promoted include : relevant basic medical sciences, epidemiology, maternal and child health, mental health, rehabilitation, diagnostic skills, medico - legal issues, social and cultural anthropolgy, ecomics of health care, management of resources, and the humanities. Specific skills that should be promoted include: clinical medicine, epidemiology, preventive and promotive medicine, generalist competence, scientific, managerial, educational, learning, interpersonal and communication skills, computer literacy, community capacity building, and a multi - sectoral approach fostering work in multi - disciplinary teams.

This conference also proposed that particular emphasis should be placed on learning which is

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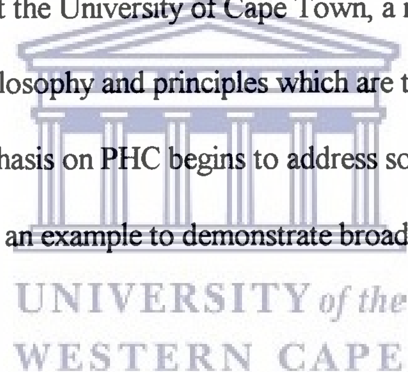
student - centred, problem - based, patient - orientated and community based. It was felt that preference should be given to community - based education, shifting from curative to comprehensive health care, and should be orientated towards producing generalists rather than specialists (World Summit on Medical Education, April 1995).

A renewed emphasis on primary health care

In the present medical curriculum at the University of Cape Town, a renewed emphasis has recently been placed upon PHC philosophy and principles which are taught during the first, fourth and sixth years. This renewed emphasis on PHC begins to address some of the inadequacies identified above and will be used as an example to demonstrate broad curricular changes that many medical schools are undergoing.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In the first year of medicine , a recently introduced course under the auspices of the Department of Primary Health Care entitled "Health and Society" serves as an introductory course to orientate students to the factors that influence health and disease including an introduction to the concepts of PHC, community participation as well as the sociology of health. It is an interdisciplinary course which medical students have to register for along with occupational therapy and physiotherapy students.

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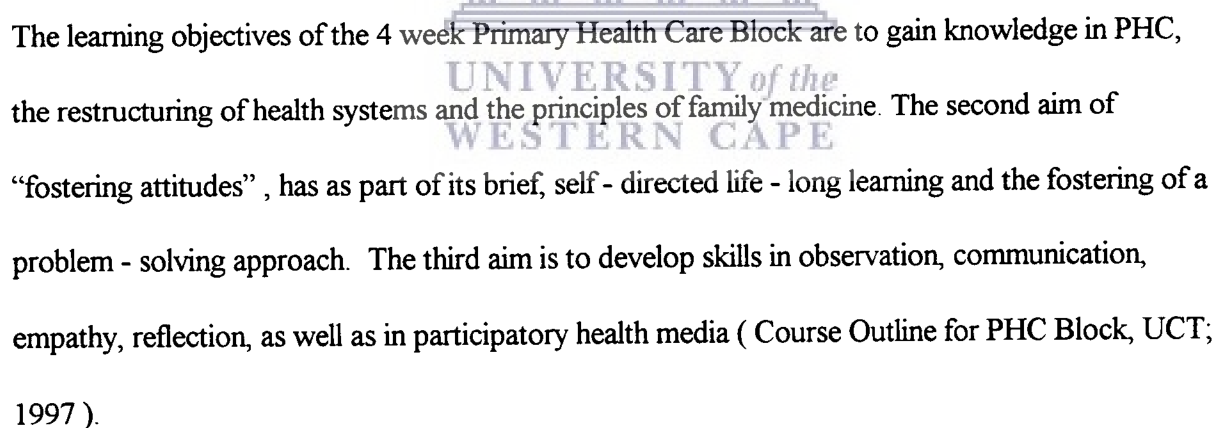
As from 1996, the fourth year community health component was changed to include 4 weeks of primary health care as well as 4 weeks of teaching in community health. During 1996 , the Department of Community Health underwent a process of curriculum review and redefined the aims and objectives of the community health component of the 8 week block. The stated aims are to contribute to the development of students who have a community orientation, population perspective of health and comprehensive approach to health care.

This should include an inter - disciplinary and intersectoral approach; as well as looking at a critical approach to future medical practice and an understanding of the health care system and its goals (Curriculum Review , Fourth Year, Department of Community Health, UCT; 1996).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The learning objectives of the 4 week Primary Health Care Block are to gain knowledge in PHC, the restructuring of health systems and the principles of family medicine. The second aim of "fostering attitudes" , has as part of its brief, self - directed life - long learning and the fostering of a problem - solving approach. The third aim is to develop skills in observation, communication, empathy, reflection, as well as in participatory health media (Course Outline for PHC Block, UCT; 1997).

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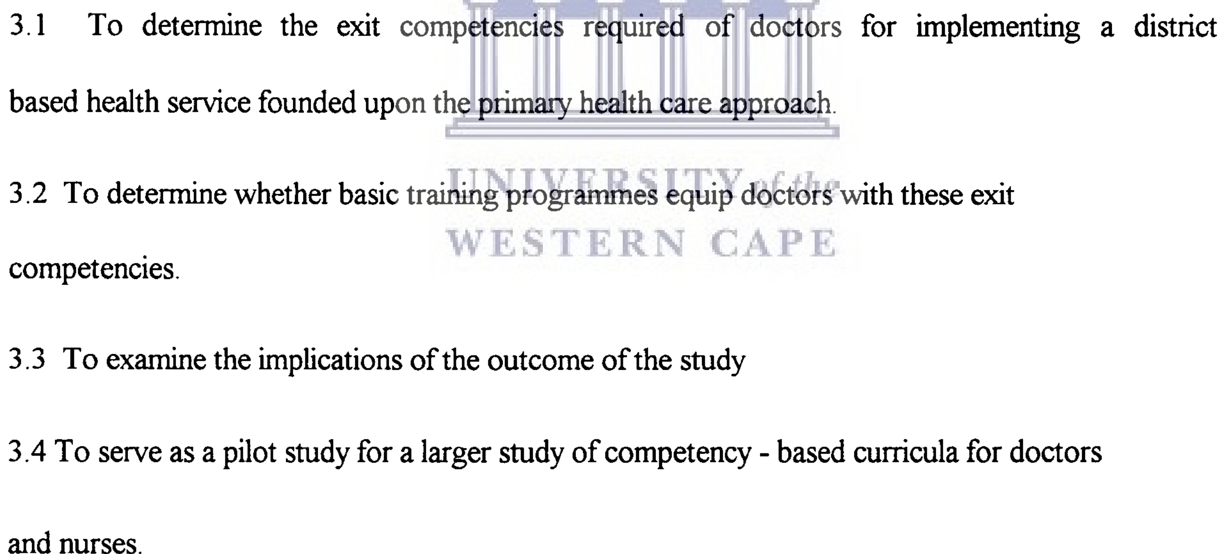
During their sixth year, students spend 2 weeks seeing patients at a Community Health Centre (CHC) in the Cape Town area and another 2 weeks in a rural setting. The aim of the block is for students to learn to assess patients "using a biopsychosocial perspective and manage their care appropriately in a primary care environment" (Faculty of Medicine Student Handbook , UCT, 1997).

3. OBJECTIVES



3.1 To determine the exit competencies required of doctors for implementing a district based health service founded upon the primary health care approach.

3.2 To determine whether basic training programmes equip doctors with these exit competencies.

3.3 To examine the implications of the outcome of the study

3.4 To serve as a pilot study for a larger study of competency - based curricula for doctors and nurses.

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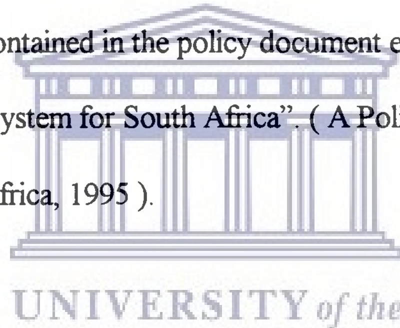
4. METHODOLOGY

4.1 DEVELOPMENT OF THE INSTRUMENTS

4.1.1 Developing the Working Framework

A "working framework" was developed of the Primary Health Care (PHC) competencies required of doctors to comprehensively deliver services at the district level of the national health system. The working framework was based upon the priority competencies required to meet the health functions ascribed for districts as contained in the policy document entitled : "A Policy for the Development of a District Health System for South Africa". (A Policy for the Development of a District Health System for South Africa, 1995).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In order to develop this framework of the knowledge, attitudes and skills that are required upon completion of the medical course, a series of workshops and informal discussions were held with people who are knowledgeable about competencies required at the district level of health care. Because many of the competencies required of doctors and nurses would be generic, it was felt that the development of the working framework should remain generic and applicable to both doctors and nurses. A small working group consisting of members of the Public Health Programme at UWC, drew up a list of people who were considered to be knowledgeable about competencies required at the district level of health care. This list included academics, service providers, as well as policy makers. These people were then invited to participate in a workshop together with members of the Public Health Programme of UWC and the researcher.

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This was an important initial step in the process and allowed the researcher to develop more fully the methodology to analyse the exit competencies. It was felt that a tool needed to be developed that could be used to perform an analysis of the exit competencies required of health personnel. Using these initial workshops and based upon discussions with experts in the field, available literature, and the policy document "A Policy Document for the Development of a District Health System for South Africa", a draft working framework of competencies was constructed.

A second workshop was then held where this draft was presented to participants (also from various backgrounds as in the first workshop), discussed and any changes made that were deemed necessary. The total number of participants of these workshops was twenty and included medical and nursing personnel. The result of this process was the "Working Framework of Competencies Required of Nurses and Doctors in order to Implement a District Based Health System" document. The overall feeling was that the exit competencies developed as the working framework, was an extensive and generic list that could be applicable to all health professionals not only to doctors an nurses.

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4.1.2 The information - gathering instrument

A semi - structured questionnaire was developed using the working framework and the district document described above. This served as the information - gathering tool and was organised into 14 different areas based upon the competencies identified in the working framework.. In addition, questions of an exploratory nature were included in order to gain a more thorough understanding of the responses.

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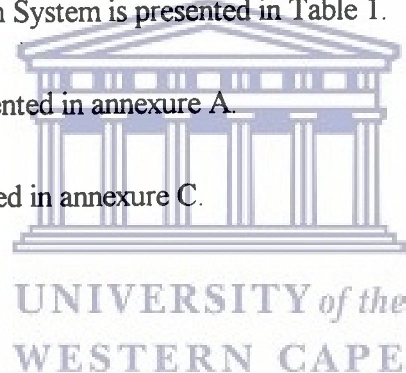
It was also felt that a more in - depth understanding of the issues would be obtained by asking the recent graduates to respond to questions posed around a **case scenario**. This scenario "Joseph" was designed around a clinical case that would be typical of the Western Cape; that of a patient with tuberculosis.

4.2 DESCRIPTION OF THE INSTRUMENTS

4.2.1 The Working Framework of Competencies Required of Nurses and Doctors In Order to Implement a District Based Health System is presented in Table 1.

4.2.2 The questionnaires are presented in annexure A.

4.2.3 The case scenario is presented in annexure C.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4.3 STUDY SUBJECTS

Convenient sampling was used in the study. The information gathering tools, a questionnaire and a "case scenario" was applied to a sample consisting of three groups:

1. Graduates: four recent graduates; two from the University of Cape Town (UCT) and two from Stellenbosch University. It was felt important to interview graduates from both the medical schools in this province.
2. Educators: four educators who are considered to be knowledgeable in this field. Two of these educators are from a University Community Health Department (one is also attached

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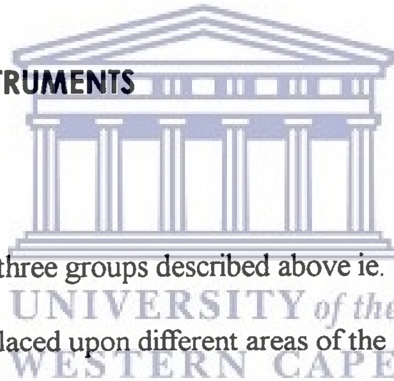
to a Primary Health Care Department) attached to a University since they teach much of the material related to the relevant competencies. One educator was selected who is actively involved in teaching students within a district setting; and one tutor was selected who teaches students within a hospital setting but maintains a strong focus on the district level of care.

3. Service providers / managers: two. Managers were selected who are involved with the day to day management of graduates in a district setting. These two districts are the pilot districts in the Western Cape Province for the implementation of the district health system.

4.4 APPLICATION OF THE INSTRUMENTS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The questionnaire was applied to the three groups described above ie. graduates, educators and managers. Different emphases were placed upon different areas of the questionnaire for each of the three groups and the questionnaire modified accordingly. Notes were kept by the interviewer and the interview recorded in order to serve as corroborating data.

4.4.1 The main focus for the graduates was to assess whether, in their opinion, the curriculum equipped them with the competencies identified by the working framework. The case scenario was applied to the graduates.

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4.4.2 The main focus for the educators was to assess whether, in their opinion, the curriculum covered the areas of competence identified in the working framework.

4.4.3 The main focus for the mangers was to assess whether, in their opinion, graduates exhibit these competencies.

The information gathered was used to discuss the implications of the outcome of the study and also compares the identified competencies with those ideally required of the graduate.

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TABLE 1.

WORKING FRAMEWORK OF COMPETENCIES REQUIRED OF NURSES AND DOCTORS IN ORDER TO IMPLEMENT A DISTRICT BASED HEALTH SYSTEM

KNOWLEDGE	ATTITUDES	SKILLS
Understanding of policies of public health & the district-based health system	Commitment to public health policy (primary health care)	Ability to implement public health policy
1. Knowledge of the most common causes of ill-health in a community	Commitment to addressing important/priority public health problems	Ability to assess, diagnose & institute comprehensive, cost-effective management of these conditions, making appropriate use of available technology
2. Understanding of counselling methods in various health care contexts	Belief in the value of counselling & the importance of caring	Ability to counsel effectively and appropriately & to communicate effectively
3. Knowledge of social dynamics & structures of a community	Acknowledge the role of social dynamics & community structures in determining health	Ability to diagnose community problems, including basic research skills (monitoring & evaluation)
4. Understanding of preventive and promotive health issues within a community	Acceptance of the importance of health promotion in the context of primary health care	Ability to facilitate health promotion activities, in particular, advocacy & lobbying about public health & development within communities
5. Understanding of patterns of referral & existing channels	Acceptance of the need for a referral network to optimise patient care (as senders & recipients of patients)	Ability to make effective & appropriate use of referral networks
6. Understanding of the functioning of the team in a district setting	Acknowledgement of the importance of each team member	Ability to contribute and participate in the health team

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KNOWLEDGE	ATTITUDES	SKILLS
7. Understanding the web of roleplayers that influence health and how they influence health	Belief in the importance of intersectoral collaboration in achieving & optimising health within communities	Ability to interact & collaborate with other roleplayers, including collaboration with traditional healers & non-western health providers
8. Recognition & understanding of the dynamics of conflict	Acknowledgement of the importance of conflict resolution in optimising the functioning of the health team	Ability to resolve conflict as it arises
9. Understandingof the importance of the ethics of health care & its influence on professional practice	Consistent consideration of the ethical implications of practice	Ability to identify ethical issues & address them in the management of a patient
10.Understandingof the role of lifelong learning in professional development	Acknowledgement of the need to continually upgrade professional competence	Ability to regularly make use of facilities for ongoing education
11.Understanding of the basic principles of management	Acknowledgement of the management/supervisory component of his/her duties	Ability to successfully manage an effective district health team

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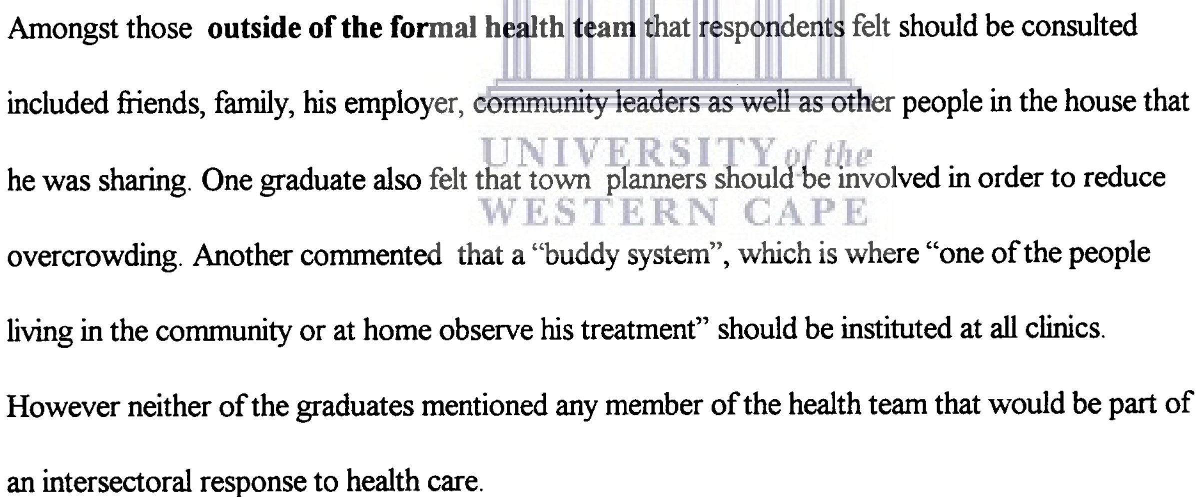
One graduate also commented that Joseph's financial situation makes it impossible for him to miss his work.

In examining **the factors that contributed to Joseph developing TB**, the respondents felt that these were largely problems of a socio - economic nature. These included: poverty, overcrowding, poor nutrition, and also as one respondent said "he needs to be educated about the disease". It was felt that it is mostly the responsibility of the doctor or the community health nurse to educate Joseph; something which was lacking in the case scenario. Educating patients about their disease is often a neglected part of the holistic management of patients. This is often due to the pressure on staff at clinics especially in terms of the volume of workload.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Amongst those **outside of the formal health team** that respondents felt should be consulted included friends, family, his employer, community leaders as well as other people in the house that he was sharing. One graduate also felt that town planners should be involved in order to reduce overcrowding. Another commented that a "buddy system", which is where "one of the people living in the community or at home observe his treatment" should be instituted at all clinics. However neither of the graduates mentioned any member of the health team that would be part of an intersectoral response to health care.

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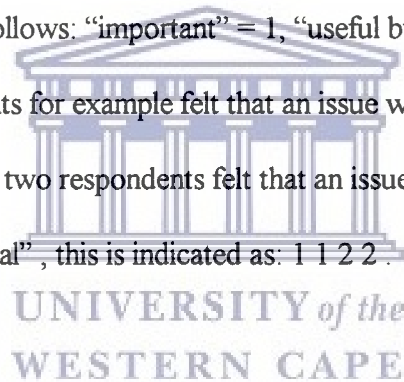
RESPONSES TO THE QUESTIONNAIRE

The responses to the questionnaire are organised in the 14 different areas that were used in the questionnaire. For each question, the relative importance is discussed first for all three groups, followed by how well these areas are covered in the curriculum. Specific examples or other comments follow. Comments from the respondents are quoted throughout.

The results presented below are also shown in tabular form in annexure B. An indication is also given of the relative importance of these competencies in terms of a rating scale. The importance of each of the responses is rated as follows: "important" = 1, "useful but not essential" = 2, "unimportant" = 3. If four respondents for example felt that an issue was "important", this is indicated as : 1 1 1 1. If for example two respondents felt that an issue was "important", and two felt that it was "useful but not essential", this is indicated as: 1 1 2 2 .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1. PUBLIC HEALTH POLICY

In response to the first question "how important is knowledge of **public health policy?**" all ten respondents felt that it was "important".

The four educators and three graduates felt that the curriculum did not cover these issues enough, the other graduate felt that it was covered "adequately". One manager felt that recent graduates did not demonstrate an understanding of public health policy at all, the other felt it was not covered enough.

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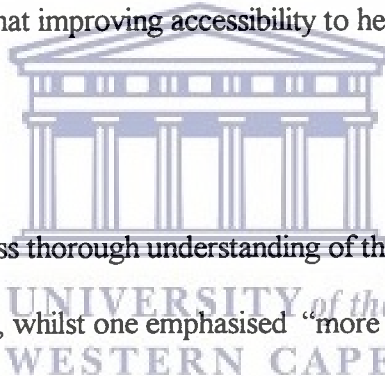
The point was also made that these policies were new and that although the fourth year curriculum at UCT had been newly revised to include many of the public health policy aspects, these students, as one manager commented, “haven’t come through (graduated) yet”.

Three educators mentioned the move to primary health care and the move towards equity as central in their **understanding of the National Health Plan.** The one educator expanded further by adding issues such as the “establishment of districts, overcoming fragmentation of the health system and establishing a national social health insurance system”. Another felt that it also incorporated decentralised management which will “enable people to make decisions at the level where it makes a difference”. One educator also felt that improving accessibility to health services was a key factor in the National Health Plan.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The four graduates showed a much less thorough understanding of the National Health Plan, citing the move towards primary health care, whilst one emphasised “more clinics” and also “a greater focus on prevention”. One graduate commented “the general move in health care is to look at the principles of primary health care and no longer in terms of the curative Western methods”. Another graduate showed very little understanding of the National Health Plan: “I know what I read in ‘Die Burger’ (a local newspaper) and that’s basically it”.

2. THE DISTRICT HEALTH SYSTEM

Knowledge of the **district - based health system** (DHS) was felt by all ten respondents to be “important”.

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Respondents differed in opinion however on how well the curriculum covered these issues. Two educators felt that it was covered "adequately", whilst two others felt that it was not covered well enough. The four graduates also differed in opinion, one felt that it was covered "adequately", two felt that it was "not covered at all", whilst the fourth felt that it was not covered well enough. The two managers both felt that graduates in their employ did not display enough knowledge about the district health system.

In their understanding of what a district health system is, the educators had similar opinions. Three agreed that there should be one single authority which as one educator put it, would "co - ordinate and provide health care ...which would include public and private (sectors of health care)" .
Other aspects that were mentioned were that the district should cover a specific geographic area, with specific boundaries which would provide "comprehensive health services", will promote equity, develop better infrastructure especially in the rural areas.
One educator felt that in undergraduate training, medical students were justified in complaining about rural areas which did not have the necessary infrastructure to support them.
Another educator felt that community participation in the district health system should be a statutory regulation. Another felt that problem - based learning in elements of the DHS was essential "I don't think we will succeed until we move to a problem - based approach".

One of the graduates responded that the DHS is a specific geographic area with a community health centre in each district which would provide specific services such as maternal, child and women's health, treatment of TB patients. Another two graduates however, demonstrated a paucity of knowledge on this issue, the only response from one graduate being that it implied

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"better primary health care and the building of clinics", whilst the only response from another graduate was "we are only taking patients from certain districts…that's basically what I know about it".

On asking the managers "how well do recent graduates reflect an understanding of the district - based health system?", one response was "not at all"! The other manager felt "it's more seen to be addressing needs of a particular kind of community or set - up". Such firm responses from the manager is cause for concern in that the issue of the district health system is not adequately addressed in curricula, especially seeing that many of the graduates are likely to work in primary care settings after graduation.

3. THE MOST COMMON CAUSES OF ILL HEALTH

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In response to the question "how important do you think knowledge of **the most common causes of ill - health** is for your work? " the four graduates felt that this was "important".

One graduate felt that the curriculum covered the common causes of ill - health "adequately" whilst another felt that it was covered "very well". The other two graduates felt that it was not covered well enough.

However, they differed on what the three most common causes of ill - health were: three felt that

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they were more clinical, such as TB, pneumonia, gastro-enteritis, HIV; whilst the fourth felt that the causes were more general such as nutritional status, living conditions and poor levels of education.

This question was not asked of the educators or managers as it was felt that it may have been superfluous.

4. COUNSELLING METHODS

All the respondents thought that an understanding of **counselling methods** was important.

Three educators felt that the curriculum did not cover counselling methods well enough whilst one thought that this area was covered adequately, citing some counselling courses offered by the Aids Training Information and Counselling Centre (ATICC). The graduates differed in how well they thought the curriculum covered counselling issues. One felt that these were covered "very well" whilst one concurred with the educators in that they were not covered well enough, and two thought that it was not covered at all. Both managers also felt that recent graduates were not well enough prepared to counsel patients.

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Comments from the educators on various counselling techniques included both general and specific issues. One educator felt that it would mostly be "talking to a patient about the disease, its consequences" whilst another felt it should include "communication skills, brief interventional techniques (behavioural changes), simple counselling around psycho - social skills".

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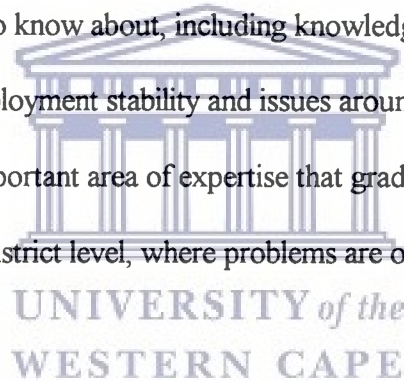
Another comment was that whilst no specific method would be used for teaching students about counselling methods, "informational issues such as stigma and self - image, establishing support systems" should be taught. It was pointed out that the present second year curriculum at UCT had a week of afternoon sessions on counselling that would also cover different methods of counselling.

The graduates had similar views on counselling techniques in that they agreed that an explanation is needed around the causative factors of the disease, its implications, how it is spread, and also how to modify behaviour. One graduate had had extensive experience in counselling, having worked with the Students Health and Welfare Organisation (SHAWCO). In addition to these points above, he pointed out other factors to know about, including knowledge about numbers of sexual partners, use of barrier methods, employment stability and issues around confidentiality. Knowledge about counselling skills is another important area of expertise that graduates ought to know about, especially if they are to work at the district level, where problems are often of a psychosocial nature.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5. SOCIAL DYNAMICS AND COMMUNITY STRUCTURES

Nine respondents concurred on the "importance" of the next section of the questionnaire i.e. the relationship between health and **social dynamics and community structures.** One graduate felt that the issue was useful but not essential.

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Two educators thought that this issue was "adequately" covered in the curriculum and two thought that it was not covered well enough. Two graduates felt that the issue was not covered enough in the curriculum, whilst two felt that it was not covered at all.

One manager also felt that graduates in his service did not demonstrate an adequate enough understanding of the relationship between health and social dynamics in the service, whilst the other felt that graduates did not address this issue at all in their practice.

In looking at the ways in which social dynamics and community structures impact on health, one educator separated the two issues in that community structures "are largely political issues that impact on policy and planning" and that social dynamics were more the "basic services like water, sanitation, educational levels". Another educator felt that social dynamics represented more the interests of "one social group vs. the interests of another social group".
It was also felt that there is a need to look at leadership within societies and that use should be made of certain theories, such as social mobilisation.

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Two recent graduates both felt that the impact on the health of the patient was directly related to poverty, nutrition, overcrowding and sanitation. As one graduate stated "it is a breeding ground for bugs". Another commented "if you understand how they (communities) perceive health in their own terms, then you understand why they seek health care".

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6. PREVENTIVE AND PROMOTIVE HEALTH ISSUES

In response to the importance of **preventive and promotive health issues**, there was a unanimous "important" response.

One educator felt that the issues were "adequately" covered in the curriculum whilst three others thought that this area was not covered well enough.

It was also pointed out that in the newly revised fourth year curriculum at UCT "there is a significant health promotion study that students have to do as part of their 8 week community health block" and as another educator commented "the primary health course is now better than before".

Graduates differed on this issue. One thought that the curriculum covered these issues "very well" whilst three others thought that it was not covered enough. The UCT graduates however, had not experienced the new curriculum being taught at UCT.

Both managers felt that graduates could not practically apply these issues well enough in the communities on a more practical application level. As one manager commented: "there's a lot of one - on - one in the chronic diseases of lifestyle clinics" as it was felt that "you want lifestyle changes to take place".

In looking at the content area of preventive and promotive health issues, the educators gave remarkably similar answers. They divided the question into two main areas: the "broader population - based health programmes" such as cervical screening for example, and a greater focus on

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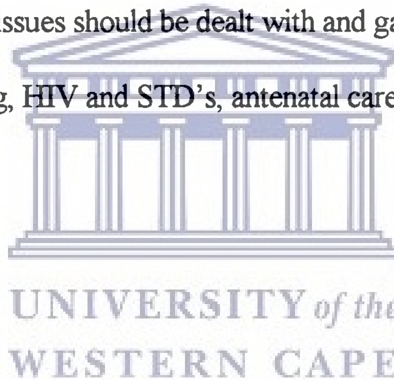
"individual lifestyle issues .....such as smoking, sexual behaviour". Health promotion should not only "look at diseases of the poor, but should also look at diseases of affluence". It was also felt that students should have a basic understanding of the Ottawa Charter and should also be taught policy and legislative matters as part of health promotion. An example of policy and legislative matters around an anti - smoking campaign were cited.

The graduates were less forthcoming with their responses to the content area. One graduate also stressed the individual aspect such as lifestyle habits, nutrition; another thought the focus should rather be on social circumstances, promotion of employment and education. Two of the graduates pointed out that the important health issues should be dealt with and gave examples such as "TB, gender empowerment, family planning, HIV and STD's, antenatal care and children".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7. REFERRAL PATTERNS

In terms of knowledge of **referral patterns** for patients, all respondents felt that these were important.

Three educators felt in general that the curriculum does not cover patterns of referral adequately enough, whilst one felt that it was not covered at all. As one educator commented: "because students still train in tertiary centres where patients are referred to them instead of the other way around". Another responded by saying that it should be looked at holistically and that it should also deal with accessibility to health services, counselling and dealing with employers.

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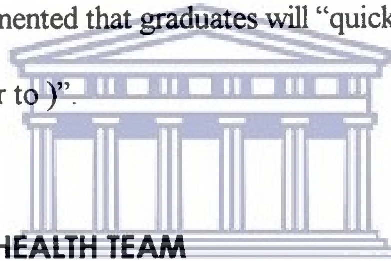
One graduate felt that the curriculum covered patterns of referral adequately, another felt it did not cover patterns of referral at all and two felt that is was not covered well enough. The two managers felt that graduates did not display any knowledge about referral patterns.

All respondents agreed in general that a patient with multiple drug resistant TB needs to be referred to some sort of specialised centre. In terms of the actual pattern of referral one educator commented that "from the clinic they should be referred to the regional hospital and then to the tertiary hospital". An interesting comment from the manager on asking "how well graduates make use of referral networks? " commented "I would say not at all" although it was felt that this is the fault of the educators. The other commented that graduates will "quickly find out from the senior doctor and senior staff (where to refer to)".



8. FUNCTIONS OF THE DISTRICT HEALTH TEAM

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Eight of the respondents felt that an understanding of the **functions of the district health team** is important. However, one graduate and one educator felt that this issue was "useful but not essential".

This was qualified by the educator who said that because the district health system is not yet in place, the educators are teaching theory but this is not being related to the reality of the situation. Furthermore one educator pointed out that the functions of the district health team were "appallingly covered" in the curriculum.

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When asked "how well the undergraduate curriculum covered the functions of the district health team", three educators responded "not at all" and the other by saying "somewhere between not at all and not enough". All four graduates felt that the functions of the district health team were not covered well enough in the curriculum. The two managers also felt that graduates did not display any understanding of the functions of the district health team.

On the constitution of the district health team the graduates felt that it should broadly consist of doctors, nurses, physiotherapists , district nursing sisters as well as community representatives. Two graduates felt that the doctor should not necessarily head the team but rather, as one graduate put it, "someone with managerial skills" whilst the other graduate felt a local community leader should be the head of the team.

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9. INTERSECTORAL DYNAMICS

On the importance of the **knowledge of the web of roleplayers that influence health**, eight of the respondents thought that it was "important" whereas one educator and one graduate felt that it was "useful but not essential".

All four educators responded "not enough" when asked about how well they thought the curriculum covered this web of roleplayers. Two graduates responded "not enough" whilst two others responded "not at all" to this issue. Both managers also felt that the graduates did not interact with the web of roleplayers at all.

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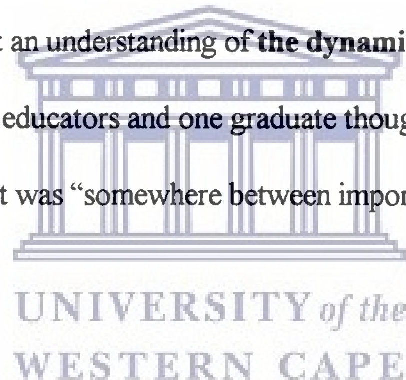
When asked to expand on who they thought these roleplayers should involve, two educators mentioned the role of local and provincial health authorities as these were the main roleplayers where, for example job creation, environmental issues were dealt with; all of which impact directly on health. Education, housing and engineering services were also mentioned as part of the intersectoral approach to health care. Graduates also mentioned broader intersectoral areas such as teachers, parents, sports stars.

10. CONFLICT RESOLUTION

Eight of the respondents thought that an understanding of **the dynamics of conflict resolution** were important to know about. Two educators and one graduate thought that it was "useful but not essential" and one graduate said it was "somewhere between important and useful but not essential".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All four educators felt that the issue of conflict resolution was not covered at all by the curriculum. The graduates differed in how well they thought this issue was covered in the curriculum, one said that it was covered "adequately" whilst three others said that it was not covered at all. Both managers felt that recent graduates did not handle conflict situations well enough.

In looking at an example of a conflict situation between a doctor and a nurse, one educator responded by saying that it would be important to understand the other person's perspective. This was very similar to the response by two of the graduates as well.

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One of the graduates gave an interesting example of where a nurse refused to give a patient treatment, at the request of the doctor, because as the nurse put it "that's the sister's job". Conflict situations often arise between doctors and nurses and usually it boils down to a matter of authority - who is really in control of the situation. As one graduate commented "in my opinion, doctors are usually guilty of always wanting to be the final decision - maker and tend to act paternalistically towards the nursing staff instead of empowering them". A comment from one of the managers was that "the doctor learns not to react, she becomes a listener in a conflict situation".

11. ETHICAL ISSUES

All respondents thought that knowledge of ethical issues was important to know about.
All four educators felt that the curriculum did not cover these issues enough. The graduates differed in opinion; one felt that it was covered adequately, another felt that it was not covered at all and two others felt that it was not covered well enough. Both managers felt that graduates in the service did not address ethical issues in health care well enough. Comments from one educator were that this was a "major gap in students teaching". Another commented that there were four ethical principles that he taught which included "do no harm.....the good should outweigh the harm", but was embarrassed that he could not remember all of them.

One educator felt strongly that there is often no relationship between ethical issues and human rights issues. He felt strongly that it was "decontexualised" in the teaching course, had no practical application and that it was "not based on reality". Another commented that basic guidelines should be used such as the Constitution and the Bill of Rights.

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Two graduates felt that the curriculum did not cover the basic principles of management at all: one graduate had had the experience of attending a course in management arranged by the university by an outside private firm and hence responded "not enough" to this issue, and the fourth graduate also responded "not enough" to this issue. The managers felt that graduates reflected no understanding of the basic principles of management and supervision.

13. TIME SPENT IN HOSPITALS

It was felt by seven of the respondents that during the **practical portion of the undergraduate training,** too much time is spent in secondary / tertiary hospitals. Two of the graduates thought that "enough" time was spent in these hospitals, one felt that too little time was spent in tertiary hospitals. Eight respondents however , felt that too little time was spent in community health centres or primary health care environments, one educator thought that enough time was spent at community health centres (CHC), and one graduate also felt that enough time was spent at CHC's. It is interesting to note that the same graduate who felt that too little time was spent in tertiary hospitals also felt that enough time was spent at CHC's. Both managers felt that too little time was spent at CHC's.

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14. ROLE MODELS

In the last section of the questionnaire, all four educators saw it as part of their duty to serve as a **role model** for their students. As one stated "often students are inspired in choosing a career by a particular role model". However, one of the educators felt that he only wanted to mentor students

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"who are going to contribute ... I don't want to waste my time with students who are not interested". This was confirmed by one of the graduates who intended becoming a surgeon and in doing so to emulate her role model who "always has time for his patients". Another graduate commented : "I admire people with good clinical skills with a big emphasis on being human".

GENERAL COMMENTS

Some interesting general comments were made by interviewees on the questionnaire outline and layout that will impact on the design of the questionnaire for the broader study. These comments were made throughout the interviews but are synthesised here in one section to gain a better understanding of all the comments.

- It was felt that the question "what do you understand by the National Health Plan?" was ambiguous in that it did not specify which National Health Plan. This will need to be specified as there are indeed different National Plans available such as the African National Congress's National Health Plan for South Africa, the National Health Insurance document, the recently introduced White Paper for the Transformation of the Health System for South Africa. and the National Health Bill for South Africa.

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- The sequence of questions needs to be reviewed. As an example it was mentioned that question no 4 on counselling methods does not logically follow on from the district health system (question no 3). Question 8 (functions of the district health team) follows on more logically from question 3.

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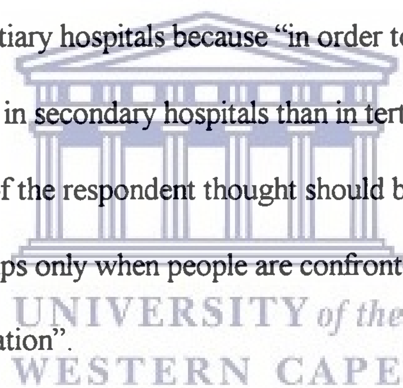
- Question 5 on social dynamics and community structures was not clear. There could be many different ways of interpreting social dynamics. It must be clarified what is meant by social dynamics. Three respondents had made similar comments on this question.

- The question on the dynamics of conflict and conflict resolution was thought by one educator to be too specific. He thought that it would be better to "focus more on the broader category of interpersonal and interstaff relations".

- One educator thought that there should be a separate question focusing on secondary and a separate question focusing on tertiary hospitals because "in order to learn hospital medicine students *should* spend more time in secondary hospitals than in tertiary hospitals" .



- An additional question that one of the respondent thought should be included was a question on health informatics. "It is perhaps only when people are confronted with problems that they realise we don't have any information".

- The manager felt that it would be essential to include the sort of qualitative questions that were asked of the graduates and educators as it is as important for managers to know about these issues. "It is important to assess how well they understand these issues". He did not think that it would take up too much time in the questionnaire.

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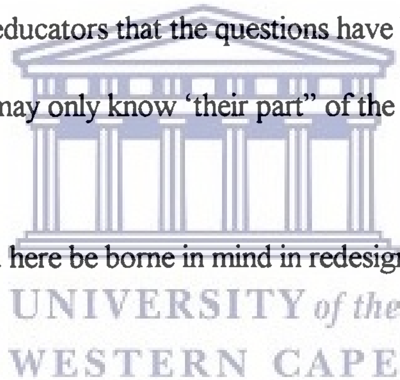
- It was felt by one of the educators that the use of TB was a bad example in the question on referral as it is a strong vertical programme in this province. A better example to have used would rather have been child abuse or a farm worker with a medical problem, as these are more complex and require knowledge about general referral principles.

- Two of the educators felt that interviewees should have been allowed the opportunity to make recommendations as to what they think should happen for each of the question asked. Thus the research can be more meaningful.

- It was pointed out by one of the educators that the questions have been designed to address the entire curriculum, but educators may only know 'their part" of the curriculum.



It is important that these points raised here be borne in mind in redesigning the questionnaires for the broader study.

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6. DISCUSSION

Health science training institutions in South Africa are concentrated in the Western Cape, Gauteng and KwaZulu - Natal. The Western Cape is particularly significant in that it produces approximately one third of the country's human resources in health (Draft Provincial Health Plan, 1995). Thus an enquiry into the nature of health science education in a well resourced province such as the Western Cape, has a bearing on a far wider population than just that of the Western Cape.

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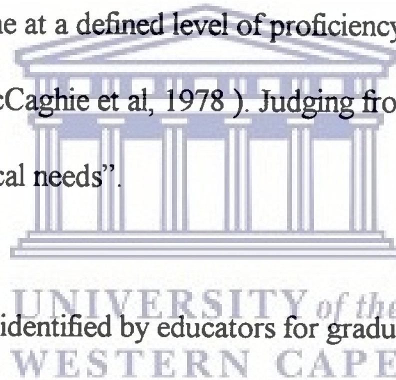
Changes in health care systems are dynamic and often force health professionals to re - examine their role and tasks in order to meet community needs. The present restructuring of the health system in South Africa with an emphasis in the district level of care, will require staff with the competencies to be able to render effective health services at the primary level of health care. The "working framework" document that has been developed, includes a comprehensive list of competencies that are required in order for health professionals to meet these needs. Judging from the responses to the questionnaires however, there seems to be a gap between what is expected of health professionals at the primary level of care and what competencies graduates actually possess. If one looks at the definition of the output of competency - based education as being "a health professional who can practise medicine at a defined level of proficiency, in accord with local conditions, to meet local needs" (McCaghie et al, 1978). Judging from these responses, graduates are not well equipped to meet the "local needs".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Comparing the competencies that are identified by educators for graduates in first - world countries to possess, are also very different from those that graduates in developing nations should possess. From the literature, it is apparent that the emphasis in developed nations lies more with clinical clerking and diagnostic skills. On the other hand, for medical graduates from developing nations as identified by Adjou - Moumouni, the emphasis is more comprehensive and includes administrative leadership, intersectoral liason, social research and consumer education. Only three of the competencies identified by Adjou - Moumouni involve the diagnosis and treatment of particular complaints in individual patients. Of the eleven competencies identified in this study for working at district level of care, only two pertain directly to clinical and diagnostic skills. These two competencies include (1) the ability to assess, diagnose and institute comprehensive, cost -

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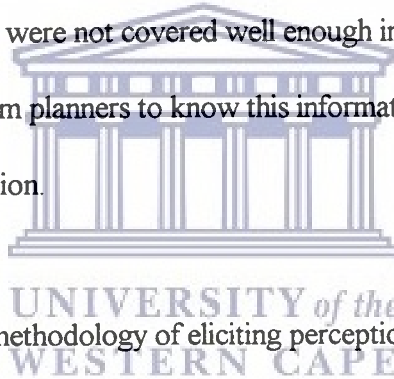
effective management of the most common causes of ill - health and (2) the ability to counsel effectively and appropriately and also to be able to communicate effectively.

It must also be borne in mind that the three groups of respondents in this study are at different points of time in relation to the study question: the managers reflecting on training as it was some time ago; the recent graduates reflect on the immediate past; the teachers also have the perspective and plans for the immediate future in mind.

Whilst the educators have a thorough understanding of what the issues are, most respondents from the three groups, felt that these issues were not covered well enough in the curriculum. It is important for educators and curriculum planners to know this information and incorporate it into the educational strategy of the institution.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It was felt that the most appropriate methodology of eliciting perceptions of exit competencies would be the "expert judgement" method discussed in the literature review.
As no previous data exist in the South African literature on specific competencies at the district level of health care, these had to be developed through the process of workshopping with academics, service providers and managers. Not only did this "working framework" serve as a good baseline for developing the questionnaire, but it represents the knowledge, attitudes and skills that medical, nursing and other health workers need to possess in order to function effectively at a district level of health care.

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On the whole, ten areas of the curriculum were felt not to have been covered well enough by all three groups in the curriculum or at least to some degree of success. These include, knowledge of public health policy, knowledge of the district health team, counselling, preventive and promotive health issues, referral patterns, knowledge of the web of role players that influence health, conflict resolution, social dynamics and community structures, ethical issues, management and supervision and too little time spent in community health centres.

These issues are areas that have been highlighted as not having been covered well enough in the medical graduates curriculum and represent opportunities to be able to improve the knowledge of graduates in these critical areas.

Two critical areas in the present restructuring of health delivery in South Africa are the general principles contained in the National Health Plan and the district health system. Although these policies are new and, as one educator said "they (the graduates) haven't come through yet", it is important that graduates must be taught the basic principles outlined in these policies such as primary health care, comprehensive health care, intersectoral collaboration.

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Two educators had also stressed the issue of community participation. The government has recently released a draft Bill, the Hospital Boards Facilities Bill, which will in fact make the establishment of community health committees a statutory requirement. The functions of the district health team were well understood by educators but graduates displayed a paucity of knowledge in this area.

The question on the most common causes of ill - health seems not to have been properly understood. Only one graduate felt that general socio - economic status impacted greatly on well -

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being; three graduates named more specific illnesses such as TB, pneumonia. These diseases are more the consequences of poor socio - economic conditions. The question must be clarified when redesigning the questionnaire for the broader study.

Although graduates displayed some knowledge about counselling skills, these were patchy and had not been part of a structured course during their training. It is important that this should be an integral part of the undergraduate training of medical students especially with the rising epidemics of HIV / AIDS and STD's.

Graduates were also not very familiar with preventive an promotive health issues. This is one of the main pillars of primary health care and represents an area of the curriculum that needs to be covered in greater depth. The educators as expected were well versed in these issues.

Graduates also displayed poor knowledge about intersectoral dynamics. With the ever - changing political and social climate and renewed emphasis on primary health care, knowledge of intersectoral dynamics will greatly benefit graduates especially at the primary / local level.

With regard to ethical issues, the fact that graduates seem to be using their own principles to guide their decision - making due to inadequate coverage of these issues in the curriculum, is of great concern. This should also be an area of greater focus in the curriculum of undergraduates.

On the issue of management, even though graduates will not immediately find themselves in management positions upon completion of their course, it is important to at least provide basic skills in management issues to undergraduates. With the proposed establishment of the district

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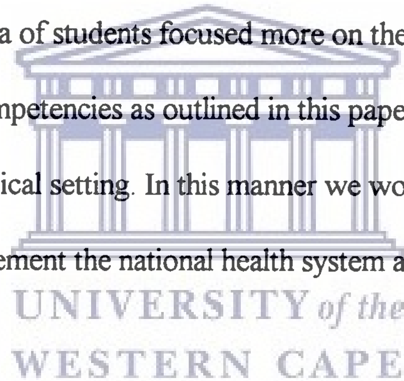
health system and the devolution of functions and authority to the district level, health workers will increasingly find themselves in management positions.

Most respondents felt that too little time was spent in community health centres and too much time was spent in secondary and tertiary environments. If medical schools are going to equip doctors with the necessary skills to work at a primary level of health care, then it is imperative that students spend more of their teaching time in these environments. An interesting comment was made from one educator there should be a separate question focussing on secondary hospitals as he said: "in order to learn hospital medicine, students should spend more time in secondary hospitals than in tertiary hospitals". If the training arena of students focused more on the primary health care environment, then the teaching of competencies as outlined in this paper would be an easier task as students can relate the theory to practical setting. In this manner we would also train health personnel more appropriately to implement the national health system at district level.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There were also a number of positive responses in terms of the contents of graduates' responses: knowledge of the most common causes of ill health were good, and one graduate also displayed sound knowledge of counselling techniques, two graduates also showed a good understanding of the district health system. The relation between poverty and ill health was also well understood by graduates and is evident from their responses to the case scenario "Joseph". The case scenario further demonstrated that the diagnostic skills of graduates were good in that they identified most of the important issues in the diagnosis and treatment of the patient with tuberculosis. Although referral patterns were felt not to have covered well enough in the curriculum, graduates understood the basic concepts as shown in their understanding of the case scenario.

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It is also encouraging to note that at least two graduates attended courses outside of their 'normal' curriculum requirements; one having an ATICC counselling course and another a management course. Graduates need to be encouraged to attend more of these courses offered by various institutions as it would increase their knowledge of general issues relating to medicine tremendously.

The method of teaching graduates also has a profound effect on what competencies graduates display. From the literature review it is apparent that graduates from medical schools employing a problem - based approach were better self - directed learners and take more cognisance of the changing needs of society. Graduates from medical schools employing traditional teaching methods were better diagnosticians and understood basic diseases mechanisms better.

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LIMITATIONS OF THE STUDY

1. The main limitation of the study is that the opinions expressed are personal opinions only and hence the study cannot make reference to a particular institution. The conclusions that can be drawn from the study as a result are therefore limited.

2. It is important to bear in mind that the three groups of respondents are at different points in time in responding to the questionnaires. The managers reflects on training as it was some time ago, recent graduates reflect on the curriclum of the immediate past, whilst the teachers have the perspective and plans for the immediate future in mind.

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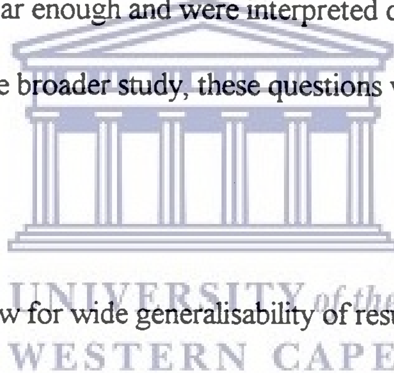
This may have a relation on the responses received and may explain why, for example, recent graduates are more familiar with the curricula and have different perspectives compared to the managers.

3. The study did not corroborate the responses of the participants by observing graduates in their daily practice. There were many difficulties which made this impractical including : there is no standard measurement tool by which to measure the level of competence of graduates for the areas of competence identified and the influence of observer bias cannot be ruled out.

4. Some of the questions were not clear enough and were interpreted differently by respondents. In re - designing the questionnaire for the broader study, these questions will have to be phrased clearer.



5. The small sample size does not allow for wide generalisability of results and the conclusions drawn need to be suitably gaurded.

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7. IMPLICATIONS OF THE OUTCOMES OF THE STUDY

The working framework of competencies that was developed by experts knowledgeable in the field represents the core competencies that health personnel should possess in order to implement a district - based health system in the province. Although the clinical pattern of disease may vary from province to province throughout South Africa, these competencies represent the basic knowledge, attitudes and skills that district level health personnel should possess using the Western Cape as a case study. The challenge now would be to ensure that graduates have achieved these core competencies upon completion of their respective courses.

Further areas of research could include: replicating the study on a broader scale nationally, performing a similar study to determine the exit competencies for other levels of care, for example, secondary and tertiary levels of care. It would be interesting if this study were repeated once the first graduates complete the courses at medical schools that are being redesigned with a stronger emphasis on primary health care. Although the study examined the exit competencies for medical graduates, it needs to be determined whether these competencies are adequate for other health workers as well eg. physiotherapists, occupational therapists.

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8. CONCLUSION

Human Resource Development for the National Health System in South Africa is still very much in its infancy stages. There have been numerous assessments of the human resource capacity in the health sector which have highlighted the inappropriateness of training provided by medical institutions.

Recent documentation on the National Qualifications Framework has identified an outcomes - based education framework where curriculum developers work backwards from agreed desired outcomes and clearly state what the learner should be able to demonstrate an understanding of and apply appropriately. Competence then results from the integration of a number of specific outcomes. This study builds onto this process, in that it identifies specific competencies which represent the core competencies that medical graduates should be able to demonstrate upon completion of their basic training in order to provide health care at the district level.

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It is also important that medical schools need to look at where they locate themselves in relation to the continuum of teaching; from the traditional to the more innovative approaches. With the changing needs in society it is clear that traditional teaching methods do not adequately equip doctors with the necessary skills and competencies in order to meet the challenges of health care. This would ensure that medical graduates are suitably qualified and appropriately trained in order to meet the continuously changing health needs of the people of this country.

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ANNEXURE A1

AN ANALYSIS OF THE EXIT COMPETENCIES REQUIRED BY HEALTH PERSONNEL, WHO HAVE COMPLETED THEIR BASIC TRAINING, TO IMPLEMENT THE NATIONAL HEALTH SYSTEM AT DISTRICT LEVEL.

QUESTIONNAIRE: RECENT GRADUATES

Where did you complete your undergraduate / basic training?______________________________

When did you graduate? _________ When did you start working here? _________

Scenario introduction
A. Would you have managed Joseph differently? *If yes, how would you have managed him?*
B. Identify the factors that you think contributed to Joseph developing TB.
C. Who, outside of the immediate health team would you need to liaise with in order to manage Joseph's case?

The following questions have been designed to ascertain the nature of your undergraduate health science programme.

1. Public health policy
How important do you think knowledge of public health policy is for your work?

important	useful, but not essential	unimportant

How well did your undergraduate curriculum cover policies of public health?

very well	adequately	not enough	not at all

What do you understand by the National Health Plan?______________________________

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2. The district-based health system
How important do you think knowledge of the district-based health system is for your work?

important	useful, but not essential	unimportant

How well did your undergraduate curriculum cover the district-based health system?

very well	adequately	not enough	not at all

What do you understand by the District Health System? ______________________________

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3. Common causes of ill-health
How important do you think knowledge of the most common causes of ill-health is for your work?

important	useful, but not essential	unimportant

How well did your undergraduate curriculum cover the most common causes of ill-health?

very well	adequately	not enough	not at all

State the three most common causes of ill-health in the Western Cape.

____
____
____

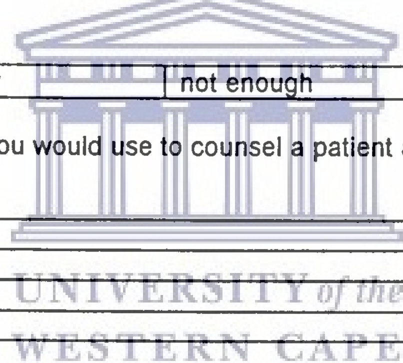
4. Counselling methods
How important do you think knowledge of counselling methods is for your work?

important	useful, but not essential	unimportant

How well did your undergraduate curriculum cover the methods of counselling required in health care?

very well	adequately	not enough	not at all

What are the various methods that you would use to counsel a patient about HIV, both prior to and after testing?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5. Social dynamics & community structures
How important do you think knowledge of the relationship between health and social dynamics and community structures is for your work?

important	useful, but not essential	unimportant

How well did your undergraduate curriculum cover the relationship between health and the social dynamics and structures of a community?

very well	adequately	not enough	not at all

What, in your opinion, are the most significant ways in which social dynamics & community structures impact on health? ____
____
____
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6. Preventive & promotive health issues
How important do you think knowledge of preventive and promotive health issues is for your work?

important	useful, but not essential	unimportant

How well did your undergraduate curriculum cover preventive and promotive health issues in communities?

very well	adequately	not enough	not at all

In your daily work, what are the most important promotive & preventive health issues that arise & how can they best be dealt with by the district health team (with respect to Joseph)?

____
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____
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7. Referral patterns
How important do you think knowledge of referral channels for patients is for your work?

important	useful, but not essential	unimportant

How well did your undergraduate curriculum cover patterns of referral?

very well	adequately	not enough	not at all

How would you deal with a patient who has a persistent cough that is unresponsive to treatment (MDRTB)? ______________________________
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8. Functions of the district health team
How important do you think knowledge of the functions of the district health team is for your work?

important	useful, but not essential	unimportant

How well did your undergraduate curriculum cover the functions of the district health team?

very well	adequately	not enough	not at all

What is the constitution of the district health team? ______________________________
____
____

Who should head the district health team & why? ______________________________
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9. Intersectoral dynamics & collaboration
How important do you think knowledge of the web of roleplayers that influence health is for your work?

important	useful, but not essential	unimportant

How well did your undergraduate curriculum cover the web of roleplayers that influence health, in particular those outside the formal health system?

very well	adequately	not enough	not at all

Identify significant roleplayers outside the formal health system who have influence over the health of the communities that you serve?

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10. Conflict: dynamics & resolution
How important do you think knowledge of the dynamics of conflict & methods of conflict resolution is for your career?

important	useful, but not essential	unimportant

How well did your undergraduate curriculum cover the dynamics of conflict & methods of conflict resolution?

very well	adequately	not enough	not at all

Give an example of a conflictual situation that you have experienced between a doctor & a nurse. How did you deal with it then and how would you deal with it now? ____________
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11. Ethics
How important do you think knowledge of the ethical dimensions of health care is for your work?

important	useful, but not essential	unimportant

How well did your undergraduate curriculum cover ethical issues in health care?

very well	adequately	not enough	not at all

What principles guide your ethical decision-making? ____________
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ANNEXURE A2

AN ANALYSIS OF THE EXIT COMPETENCIES REQUIRED BY HEALTH PERSONNEL, WHO HAVE COMPLETED THEIR BASIC TRAINING, TO IMPLEMENT THE NATIONAL HEALTH SYSTEM AT DISTRICT LEVEL.

QUESTIONNAIRE: MANAGERS

Where did you complete your undergraduate / basic training?____________________

When did you graduate? __________

How long have you held a management position for? __________

1. Public health policy
How important do you think it is for recent graduates working in your service to understand public health policy?

important	useful, but not essential	unimportant

How well do the recent graduates in your service demonstrate an understanding of public health policy?

very well	adequately	not enough	not at all

2. The district-based health system
How important do you think it is for recent graduates to understand the district-based health system?

important	useful, but not essential	unimportant

How well do recent graduates reflect an understanding of the district-based health system?

very well	adequately	not enough	not at all

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3. Counselling methods
How important do you think an understanding of counselling methods is for recent graduates?

important	useful, but not essential	unimportant

How well are recent graduates in your service able to counsel patients?

very well	adequately	not enough	not at all

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4. Social dynamics & community structures
How important do you think it is for recent graduates to have an understanding of the relationship between health and social dynamics and community structures?

important	useful, but not essential	unimportant

How well do you think recent graduates take account of the relationship between health and the social dynamics and structures of a community?

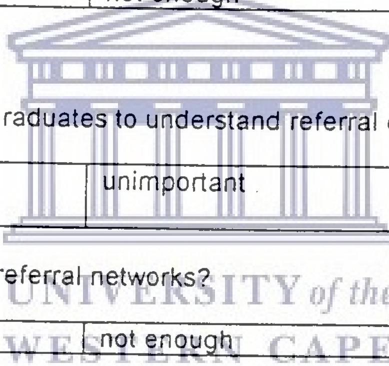
very well	adequately	not enough	not at all

5. Preventive & promotive health issues
How important do you think knowledge of preventive and promotive health issues is for recent graduates in your service?

important	useful, but not essential	unimportant

How well do recent graduates address preventive and promotive health issues in communities?

very well	adequately	not enough	not at all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6. Referral patterns
How important do you think it is for recent graduates to understand referral channels for patients?

important	useful, but not essential	unimportant

How well do recent graduates make use of referral networks?

very well	adequately	not enough	not at all

7. Functions of the district health team
How important do you think an understanding of the functions of the district health team is for recent graduates?

important	useful, but not essential	unimportant

How well do recent graduates reflect an understanding of the functions of the district health team?

very well	adequately	not enough	not at all

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8. Intersectoral dynamics & collaboration
How important do you think knowledge of the web of roleplayers that influence health is for recent graduates?

important	useful, but not essential	unimportant

How well do recent graduates interact with the web of roleplayers that influence health, in particular those outside the formal health system?

very well	adequately	not enough	not at all

9. Conflict: dynamics & resolution
How important do you think an understanding of the dynamics of conflict & methods of conflict resolution is for recent graduates?

important	useful, but not essential	unimportant

How well do recent graduates deal with conflictual situations?

very well	adequately	not enough	not at all

What measures exist to deal with situations of conflict that arise in your service, e.g. between a nurse and a doctor?

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10. Ethics
How important do you think an understanding of the ethical dimensions of health care is for recent graduates in your service?

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important	useful, but not essential	unimportant

How well do recent graduates address ethical issues in health care?

very well	adequately	not enough	not at all

11. Management & supervision
How important do you think knowledge of the basic principles of management & supervision is for recent graduates?

important	useful, but not essential	unimportant

How well do recent graduates reflect an understanding of the basic principles of management & supervision in health care?

very well	adequately	not enough	not at all

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12. Settings of training

During the practical portion of their undergraduate programmes, do you think

too much	enough	too little

time is spent in ***secondary / tertiary hospitals***?

During the practical portion of their undergraduate programmes, do you think

too much	enough	too little

time is spent in ***community health centres / primary health care environments***?

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ANNEXURE A3

AN ANALYSIS OF THE EXIT COMPETENCIES REQUIRED BY HEALTH PERSONNEL, WHO HAVE COMPLETED THEIR BASIC TRAINING, TO IMPLEMENT THE NATIONAL HEALTH SYSTEM AT DISTRICT LEVEL.

QUESTIONNAIRE: HEALTH SCIENCE EDUCATORS

The following questions have been designed to ascertain the nature of your undergraduate health science programme.

1. Public health policy

How important do you think it is for your graduates to understand public health policy?

important	interesting, but not essential	unimportant

How well does the undergraduate curriculum cover policies of public health?

very well	adequately	not enough	not at all

What do you understand by the National Health Policy? ____________________

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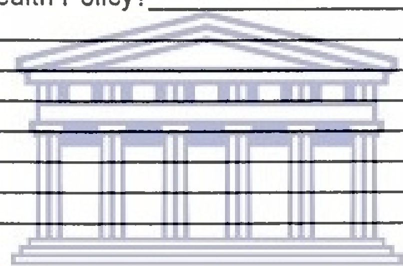

2. The district-based health system

How important do you think it is for your graduates to understand the district-based health system?

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important	interesting, but not essential	unimportant

How well does the undergraduate curriculum cover the district-based health system?

very well	adequately	not enough	not at all

What do you understand by the District Health System? ____________________

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3. Counselling methods

How important do you think an understanding of counselling methods is for your graduates?

important	interesting, but not essential	unimportant

How well does the undergraduate curriculum cover the methods of counselling required in health care?

very well	adequately	not enough	not at all

What are the various methods that you would advise a student to use when counselling a patient about HIV, both prior to and after testing?

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4. Social dynamics & community structures

How important do you think an understanding of the relationship between health and social dynamics and community structures is for your graduates?

important	interesting, but not essential	unimportant

How well does the undergraduate curriculum cover the relationship between health and the social dynamics and structures of a community?

very well	adequately	not enough	not at all

What, in your opinion, are the most significant ways in which social dynamics & community structures impact on health? ______________________________

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5. Preventive & promotive health issues
How important do you think knowledge of preventive and promotive health issues is for your graduates?

important	interesting, but not essential	unimportant

How well does the undergraduate curriculum cover preventive and promotive health issues in communities?

very well	adequately	not enough	not at all

What are the most important promotive & preventive health issues that you equip students to deal with? ______________________________

6. Referral patterns
How important do you think it is for your graduates to understand referral channels for patients?

important	interesting, but not essential	unimportant

How well does the undergraduate curriculum cover patterns of referral?

very well	adequately	not enough	not at all

How would you advise a student to make use of their referral networks when presented with a patient who has a persistent cough that is unresponsive to treatment (MDRTB)? ______________________________

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7. Functions of the district health team
How important do you think an understanding of the functions of the district health team is for your graduates?

important	interesting, but not essential	unimportant

How well does the undergraduate curriculum cover the functions of the district health team?

very well	adequately	not enough	not at all

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8. Intersectoral dynamics & collaboration
How important do you think knowledge of the web of roleplayers that influence health is for your graduates?

important	interesting, but not essential	unimportant

How well does the undergraduate curriculum cover the web of roleplayers that influence health, in particular those outside the formal health system?

very well	adequately	not enough	not at all

Who, in your opinion would be the most significant roleplayers outside the formal health system who have influence over the health of the communities that your graduates serve?

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9. Conflict: dynamics & resolution
How important do you think an understanding of the dynamics of conflict & methods of conflict resolution is for your graduates?

important	interesting, but not essential	unimportant

How well does the undergraduate curriculum cover the dynamics of conflict & methods of conflict resolution?

very well	adequately	not enough	not at all

How are students advised to handle conflictual situations, for example between a doctor & a nurse?

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10. Ethics
How important do you think an understanding of the ethical dimensions of health care is for your graduates?

important	interesting, but not essential	unimportant

How well does the undergraduate curriculum cover ethical issues in health care?

very well	adequately	not enough	not at all

What the guiding principles that students are taught to use in their ethical decision-making?

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11. Management & supervision

How important do you think knowledge of the basic principles of management & supervision is for your graduates?

important	interesting, but not essential	unimportant

How well does the undergraduate curriculum cover basic principles of management & supervision in health care?

very well	adequately	not enough	not at all

12. Settings of training

During the practical portion of the undergraduate programme, do you think

too much	enough	too little

time is spent in ***secondary / tertiary hospitals***?

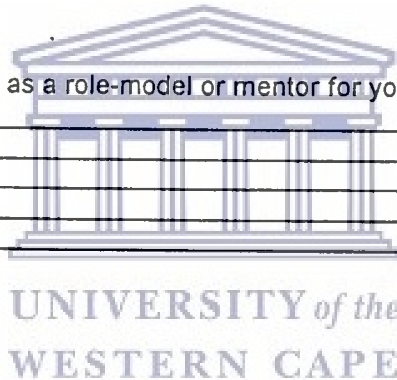
During the practical portion of the undergraduate programme, do you think

too much	enough	too little

time is spent in ***community health centres / primary health care environments***?

13. Role models

Do you see it as part of your duty to serve as a role-model or mentor for your students?



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ANNEXURE B

TABLE OF ANALYSIS OF INTERVIEWS - GRADUATES

1. PUBLIC HEALTH POLICY

Importance	Covered in Curr	Comments
1 1 1 1	2 3 3 4	♦ the general move in health care is to look at principles of primary health care and no longer in terms of western methods ♦ I know what I read in the Burger and that's basically it ♦ if the clinics have these problems they send them to secondary hospitals ♦ unless you are interested to find out about them (public health issues) they are not covered fully ♦ it basically puts health into a broader perspective ♦ its the move to PHC, more clinics, a greater focus on prevention

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2. DISTRICT - BASED HEALTH SYSTEM

Importance	Covered in Curr	Comments
1 1 1 1	2 3 4 4	♦ we are only taking patients from certain districts ♦ it prepares you conceptually for how the system works but not practically ♦ you can only learn in the district you are placed ♦ the Western Cape has been divided into health districts and there is s referral system within the districts ♦ it is specific geographic areas with a community health centre (CHC) in each district

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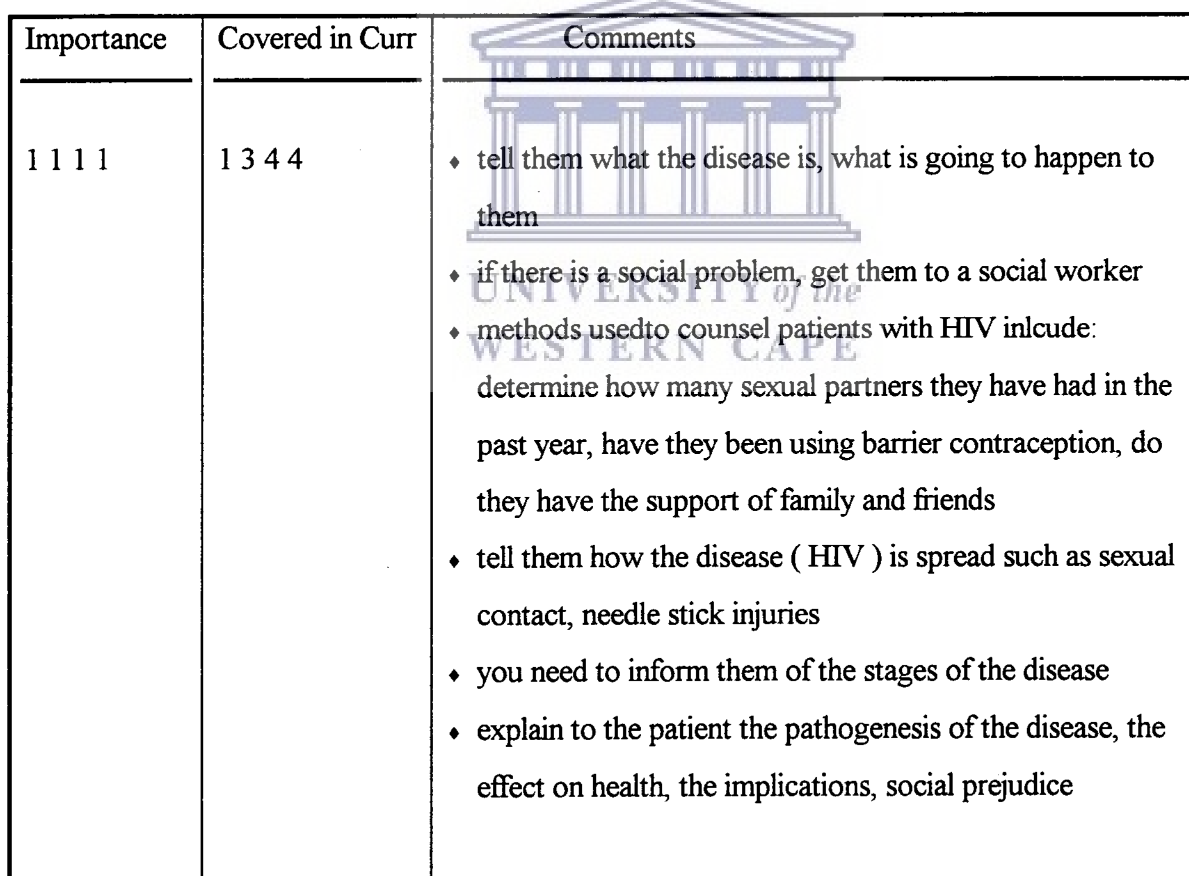
3. COMMON CAUSES OF ILL HEALTH

Importance	Covered in Curr	Comments
1 1 1 1	1 2 3 3	♦ TB, HIV, gastro ♦ STD's ♦ asthma ♦ poor nutriition, living conditions and levels of education

4. COUNSELLING METHODS



Importance	Covered in Curr	Comments
1 1 1 1	1 3 4 4	♦ tell them what the disease is, what is going to happen to them ♦ if there is a social problem, get them to a social worker ♦ methods usedto counsel patients with HIV inlcude: determine how many sexual partners they have had in the past year, have they been using barrier contraception, do they have the support of family and friends ♦ tell them how the disease (HIV) is spread such as sexual contact, needle stick injuries ♦ you need to inform them of the stages of the disease ♦ explain to the patient the pathogenesis of the disease, the effect on health, the implications, social prejudice

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5. SOCIAL DYNAMICS AND COMMUNITY STRUCTURES

Importance	Covered in Curr	Comments
1 1 1 2	3 3 4 4	♦ you need to have knowledge of the extended family (on asking what the impact of social dynamics is on health) ♦ if yoy understand how they perceive health in their own terms then you understand why they seek health care ♦ poverty, nutrition, overcrowding, poor sanitation...these things impact on the health of the patient ♦ if people are poor or unemployed and live in poverty with poor sanitation, its a breeding ground for bugs

6. PREVENTIVE AND PROMOTIVE HEALTH ISSUES

Importance	Covered in Curr	Comments
1 1 1 1	1 3 3 3	♦ (need to) improve social circumstances / promote employment, educate people around TB issues ♦ counselling, lifestyle habits, good nutrition ♦ presenting early if you are note well ♦ things like pamphlets, posters must carry messages about the major diseases such as HIV / TB ♦ community structures should not be forgotten ♦ some important health issues to deal with include : gender empowerment, family planning, HIV / STD's, education of women, children

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7. REFERRAL PATTERNS

Importance	Covered in Curr	Comments
1 1 1 1	2 3 3 4	♦ (referral patterns are) essential to know about ♦ referral systems have already been established this year ♦ the patient would go from the local clinic after a few days treatment to the TB hospital ♦ they go from the clinics to the day hospital to the TB hospital, then they refer to tertiary care ♦ you don't get taught this kind of thing (at medical school) ♦ you need to protect the staff against TB as well

8. FUNCTIONS OF THE DISTRICT HEALTH TEAM

Importance	Covered in Curr	Comments
1 1 1 2	3 3 3 4	♦ (the district health team) it should really consist of doctors, nurses, physiotherapists, dieticians ♦ it should not only be medical people, like school head masters must be there, churches ♦ someone like a "burgemeester" (mayor), someone like a community leader (should head the district health team) ♦ the team should consist of doctors, nurses, paramedics, physio's, occupational therapists, district sister ♦ someone with managerial skills should head the team; not necessarily a doctor or nurse; a community leader can also head the team ♦ The team should have a broad vision in health issues and the things that impact upon them

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9. INTERSECTORAL DYNAMICS AND COLLABORATION

Importance	Covered in Curr	Comments
1 1 1 2	3 3 4 4	• people like sports stars, school headmasters could have an influence over the health of the communities that you serve • people like engineers, teachers and parents (could influence communities) • church people, people at the school, district sisters and personnel • I don't understand the question, it is not clear

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10. CONFLICT DYNAMICS AND RESOLUTION

Importance	Covered in Curr	Comments
1 1 2 2	2 4 4 4	• (an example of a conflict situation) it's especially with older nursing staff... when they feel they have more experience. • I would deal with the situation by keeping calm ...you listen to her and give her time to explain her reasons...and you explain yours • I have asked the nurse to fetch glucagon, and she responded by saying "that's not my job, the sister in the patient's ward must get it". I responded by telling her she must be able to treat all patients • you learn alot about things after you graduate

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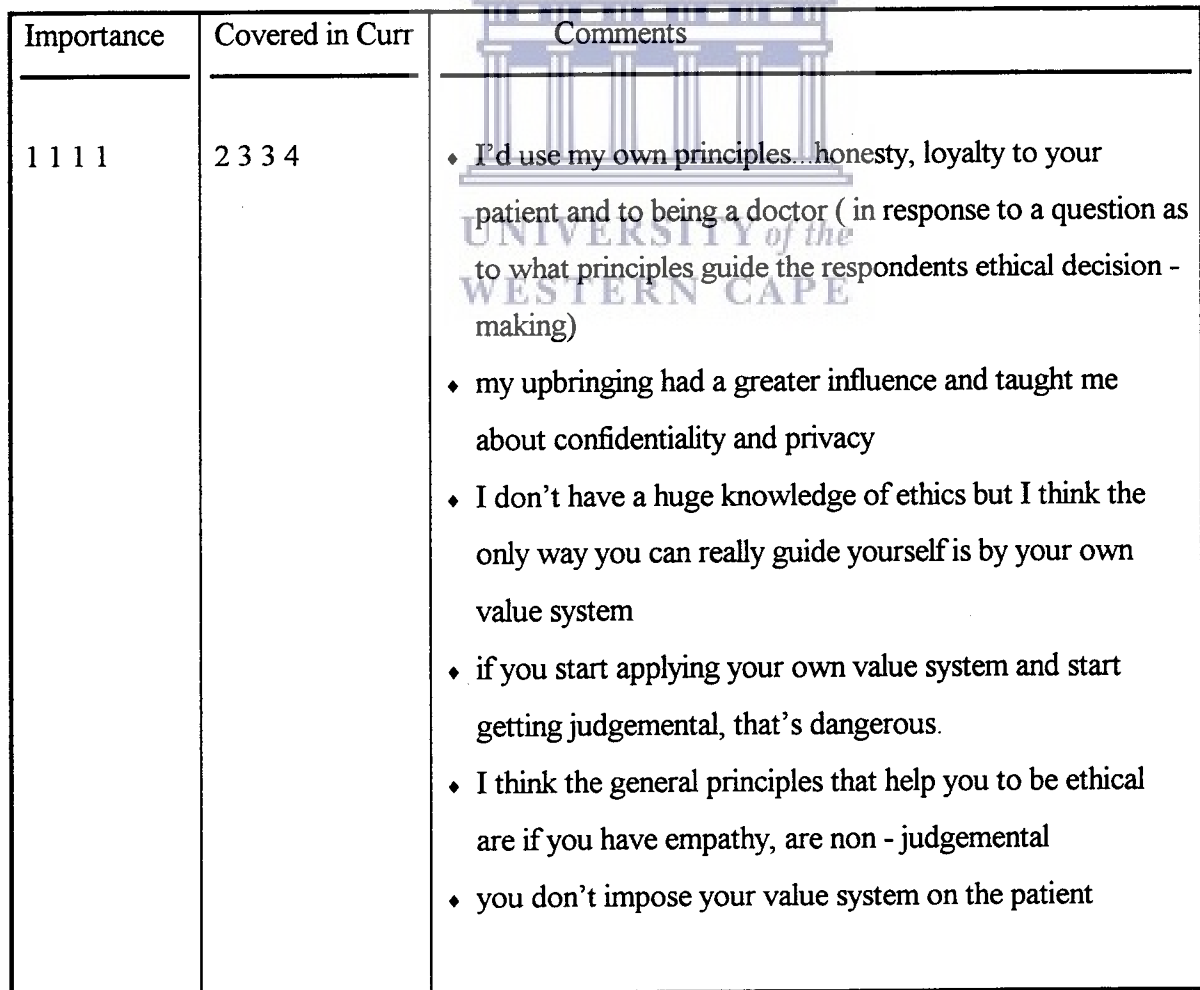
		♦ I ordered an antibiotic without motivation, ; as this was not strictly according to policy, the pharmacist responded by becoming verbally abusive ♦ (in order to deal with conflict) it depends on who the person is and the power relationship ♦ you must tell people if they are being unprofessional eg swearing and laziness ♦ you must understand the other person's point of view

11. ETHICS



Importance	Covered in Curr	Comments
1 1 1 1	2 3 3 4	♦ I'd use my own principles...honesty, loyalty to your patient and to being a doctor (in response to a question as to what principles guide the respondents ethical decision - making) ♦ my upbringing had a greater influence and taught me about confidentiality and privacy ♦ I don't have a huge knowledge of ethics but I think the only way you can really guide yourself is by your own value system ♦ if you start applying your own value system and start getting judgemental, that's dangerous. ♦ I think the general principles that help you to be ethical are if you have empathy, are non - judgemental ♦ you don't impose your value system on the patient

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12. MANAGEMENT AND SUPERVISON

Importance	Covered in Curr	Comments
1 2 2 2	3 3 4 4	♦ it should be covered in the curriculum ♦ I would have liked more information ♦ Coopers and Lybrand (auditing firm) gave us a two week course in management things

13. SETTINGS OF TRAINING

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- Secondary / tertiary : enough: 1 1 1 ; too much 1
- primary: too little: 2 ; enough : 1

14. ROLE MODELS

- consultants that infleunced me: neurology specialist
- qualities that are required ....the ability to teach you things, not only academic but to remember that there is a person behind the disease
- I admire people with good clinical skills with a big empahsis on being "human"
- because he (the head of the cardiac department) always has time for his patients ...and addresses any problems that they may have

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TABLE OF ANALYSIS - EDUCATORS

1. PUBLIC HEALTH POLICY

Importance	Covered in Curr	Comments
1 1 1 1	3 3 3 3	♦ basic principles are to model health system on the primary health care ♦ vehicle is through the district health system ♦ redistribute resources in an equitable way, improve access, enable to make decisions at a level where it makes a difference ♦ basic principles are those of equity, access, appropriate levels of care , primary health care approach ♦ it's overcoming fragmentation of the health system and establishing a national social health insurance system

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2. DISTRICT - BASED HEALTH SYSTEM

Importance	Covered in Curr	Comments
1 1 1 1	2 3 3 3	♦ it is not integrated with sixth year disciplines which are all hospital based ♦ need a problem based learning as students are reluctant to focus on any area that does not develop clinical skills despite finding exposure to PHC meaningful . I don't think we will succeed until we move to problem - based approach

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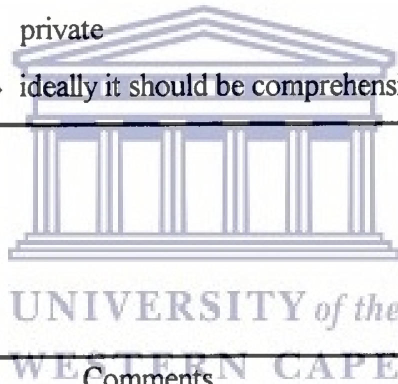
		♦ the district health system promotes equity ♦ it is a geographically defined area with a defined population, single management ♦ there should be statutory community participation ♦ intersectoral participation is important ♦ it is difficult to practice as the district health system has not yet been set up , this impacts directly upon curriculum development ♦ the best way to teach about the district health system is to work in it ♦ there should alot of devolution to a single management to co - ordinate and provide health care, both public and private ♦ ideally it should be comprehensive health services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3. COUNSELLING METHODS

Importance	Covered in Curr	Comments
1 1 1 1	2 3 3 3	♦ mostly talking to the patient about the disease, its consequences ♦ counselling can be a range ...from a brief 10 minute encounter to full psycotherapy ♦ the fundamental principles would include communication skills, brief interventional techniques, motivational skills, ♦ look at informational issues such as stigmatisation, self - image ♦ establish support systems, material issues

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4. SOCIAL DYNAMICS AND COMMUNITY STRUCTURES

Importance	Covered in Curr	Comments
1 1 1 1	2 2 3 3	• with regard to community structures, these are largely political issues that impact upon policy and planning; there are also NGO's ...they can have a major impact on health because they are community based and theoretically have closer links with the community • basic services like water, sanitation ... all impact on health • it's kinda the interests of one group vs. the interests of another social group • I'm having trouble with the words 'social dynamics'.. this question is not clear • you need to clarify this question • there are courses that they get in their first year (which look at these issues) • it's difficult to integrate general aspects of development such as gender with the curriculum • you need to understand the composition of communities • use different theories, such as social mobilisation which divides society into 5 different structures • there is a need to look at leadership within societies

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5. PREVENTIVE AND PROMOTIVE HEALTH ISSUES

Importance	Covered in Curr	Comments
1 1 1 1	2 3 3 3	• There is a significant health promotion study that students have to do (at UCT)

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		♦ There are two main areas usually not enough attention is given to population - based health programmes, for example cervical screening. The other main area is a focus on an individual level... more lifestyle change and behavioural change. ♦ There are two things: the broader population issues in relation to housing, water ... and then there are individual lifestyle issues like smoking, sexual behaviour etc. ♦ There should be some focus on environmental health and occupational health ♦ students need to have a basic understanding of the Ottawa Charter; they need to understand the planning cycle and the setting of goals and objectives. ♦ We should look at health promotion not only as diseases of the poor but also looking at diseases of affluence eg. hypertension, diabetes ♦ Issues such as policy, legislation, eg. smoking ... and the importance of involving the community.

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6. REFERRAL PATTERNS

Importance	Covered in Curr	Comments
1 1 1 1	3 3 3 4	♦ I'd say not enough... because students still train in tertiary centres ... where patients are referred to them instead of the other way around. ♦ (a patient with multiple drug resistant TB) will require referral to a specialised centre ♦ Students don't work outside of hospital enough in the community. From the clinic the person must be referred to a regional hospital and then to a tertiary hospital

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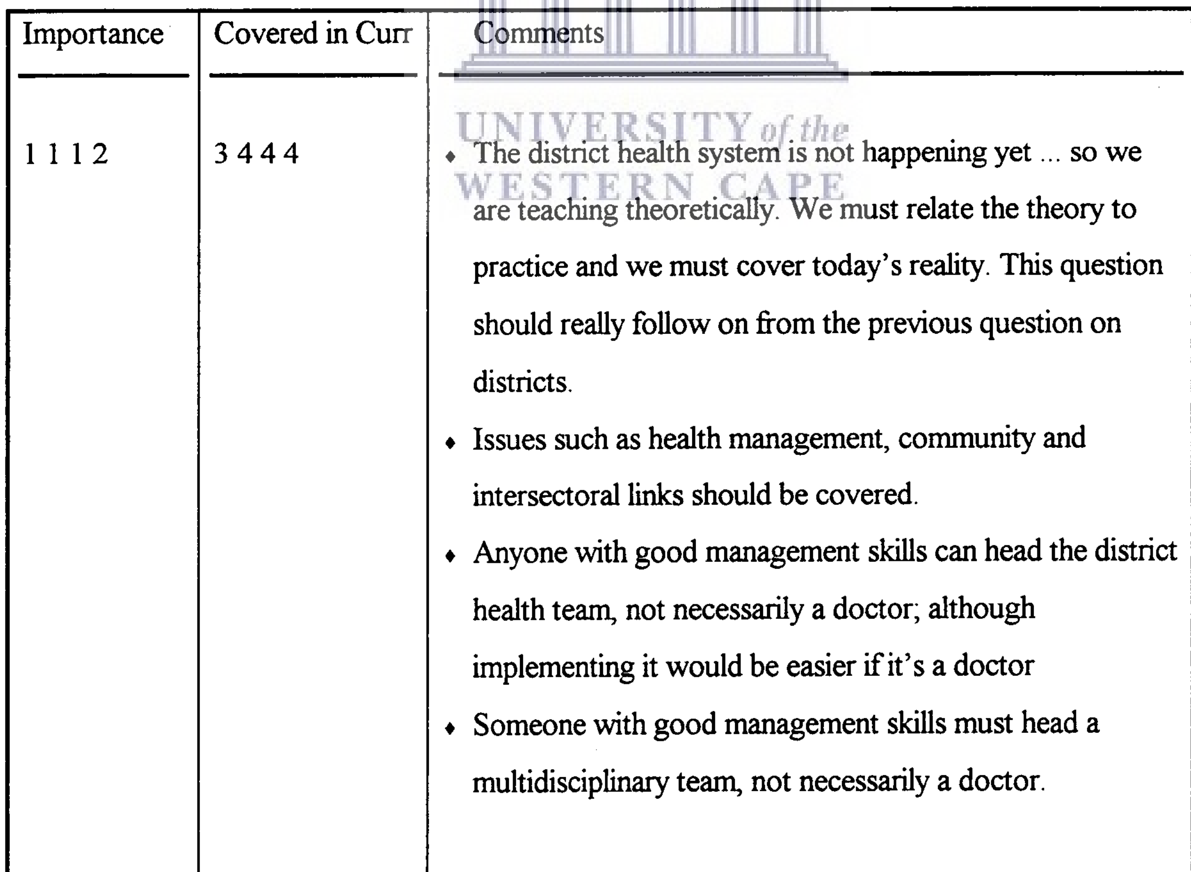
		♦ The role model the student sees is a registrar who writes a referral letter for a CVA (cerebrovascular accident) patient to the day hospital but they will receive zero follow up. ♦ TB is a bad example for this questionnaire (in response to referral patterns) because it is fairly definite. A better example would have been a farm worker or the area of child abuse. ♦ You need to look at it holistically... poor housing conditions, access to health services, stigma and counselling, dealing with employers, ensure compliance

7. FUNCTIONS OF THE DISTRICT HEALTH TEAM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Importance	Covered in Curr	Comments
1 1 1 2	3 4 4 4	♦ The district health system is not happening yet ... so we are teaching theoretically. We must relate the theory to practice and we must cover today's reality. This question should really follow on from the previous question on districts. ♦ Issues such as health management, community and intersectoral links should be covered. ♦ Anyone with good management skills can head the district health team, not necessarily a doctor; although implementing it would be easier if it's a doctor ♦ Someone with good management skills must head a multidisciplinary team, not necessarily a doctor.

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8. INTERSECTORAL DYNAMICS AND COLLABORATION

Importance	Covered in Curr	Comments
1 1 1 2	3 3 3 3	♦ The local authorities, provincial government (in response to a question who would be the most significant role players outside of the formal health sector) ♦ It is with these structures that job creation, environmental, water etc... are the main intersectoral agents ♦ NGO's, private commerce, industry are the main role players ♦ Sectors like agriculture, education, welfare, public services such as housing, and electricity all impact on health ♦ Students from these disciplines should be involved re their impact on health issues eg. poor housing can cause the spread of TB ♦ It is important to resolve the issue governance of the districts

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9. CONFLICT DYNAMICS AND RESOLUTION

Importance	Covered in Curr	Comments
1 1 2 2	4 4 4 4	♦ This needs to be a focus in future curricula ♦ There is a need to get an outside facilitator as these conflicts are often about power ♦ Doctors are often perceived as "all powerful" but nurses as "passive resistors"

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		• An example : a doctor knew a patient with cancer who was being neglected by a nurse. He was hesitant to confront the nursing staff because they may take it out on the patient • One needs to learn to deal with your own emotions, need negotiation skills, basic life skills • I think it would probably be better to focus more on the broader category of interpersonal and interstaff relations. We do not teach our students basic labour and human rights principles • They must learn to understand the other person's perspective. This often diffused the situation • An example: say there are 50 patients waiting and you find that the clinical nurse practitioner is just sitting there doing nothing and you ask her to see some of the patients; she'll probably tell you to go take a jump. You then won't understand the principle that she will not see them because she's not getting paid for it.

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10. ETHICAL ISSUES

Importance	Covered in Curr	Comments
1 1 1 1	3 3 3 3	• There are four ethical principles... do no harm, confidentiality...gosh I can't remember all of them • I think this is a major gap in students teaching... you can teach students to analyse situations in the patients interests • There is no relationship to human rights, no practical application. It is decontextualised in the course.

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11. MANAGEMENT AND SUPERVISION

Importance	Covered in Curr	Comments
1 1 2 2	3 4 4 4	♦ Appropriate training in management needs to be given in relation to your career choice ♦ Doctors and nurses should increasingly be placed in managerial positions and be taught these skills ♦ We need basic principles within the undergraduate system

12. SETTINGS OF TRAINING

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secondary / tertiary : too much : 1 1 1 1

too little :

community health centres: too much :

too little : 1 1 1

not enough : 1

- Secondary levels are not running at present. The challenge is to separate secondary and tertiary out
- Some students get exposure to community health workers and learn alot from them.

13. ROLE MODELS

- I like to mentor students who are going to contribute but I don't want to waste my time with students who are not interested
- This should be the responsibility of every teacher. Students must see you doing what you teach
- Often it is also the people that inspires them and what kind of role models they are.
- Students are often inspired to choosing a career by a particular role model.

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TABLE OF ANALYSIS - MANAGERS

1. PUBLIC HEALTH POLICY

Importance	Covered in Curr	Comments
1 1	3 4	♦ This is recent policy that has been introduced. The present (newly revised) 4th year curriculum at UCT better prepares students for this; but they haven't yet come through ♦ We are making staff anxious when we say that they need training in every field - it's demoralising them ♦ We have become multi - disciplinary but we still have dedicated services within the system

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2. DISTRICT BASED HEALTH SYSTEM

Importance	Covered in Curr	Comments
1 3	1 4	♦ I think they (the graduates) should know at least the process through which we are going and the concept as to why its going to be a much better service. ♦ It's more addressing the needs of a particular kind of community or setup ♦ Of the 3 or 4 graduates who started here, they do not really understand the district health system

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3. COUNSELLING

Importance	Covered in Curr	Comments
1 1	3 3	♦ First find out what he knows, make sure he understands what HIV is and find out the significance of a positive test, and what he will do if it turns out to be positive, and what preventative measure is he going to use ♦ Find out how is his lifestyle after he finds out he is positive ♦ Also his family situation, his setup in the work situation

4. SOCIAL DYNAMICS AND COMMUNITY STRUCTURES

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No comments

5. PREVENTIVE AND PROMOTIVE HEALTH ISSUES

Importance	Covered in Curr	Comments
1 1	3 3	♦ It's never enough, they just don't know ♦ The most important health issues : we do preventive screening but not sufficiently, we do patient information, we try to address that ♦ There's alot of one on one in the CDL clinics...both doctors and nurses when the nurses are available

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6. INTERSCTORAL DYNAMICS AND COLLABORATION

Importance	Covered in Curr	Comments
1 1	3 4	♦ Role players include : environmental, housing inspectors... because those problems need to be addressed. Also important are NGO's, GP's, gangs, sports bodies can also assist with the youth ♦ Schools are also important, we had the school principles but they faded away after a while

7. REFERRAL PATTERNS

Importance	Covered in Curr	Comments
1 1	4 4	♦ The referral patterns have not really been worked out properly so it is difficult to expect them to know it at this stage ♦ In the metro region it has only been in the past couple of months that some sort of referral network has been sorted out ♦ They will quickly find out more from the senior doctor and senior staff

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8. FUNCTIONS OF THE DISTRICT HEALTH TEAM

Importance	Covered in Curr	Comments
1 1	3 4	♦ There is a district co - ordinating team of all the providers... PAWC, City Counsellors, Metropolitan Council, Regional Council ♦ In response to the question "who should head the district team?": A district manager... it could be a non - medical person ♦ It could be an administrative kind of person because finance / budgeting parameters also need to be looked at.

9. INTERSECTORAL DYNAMICS AND COLLABORATION

Importance	Covered in Curr	Comments
1 1	4 4	♦ I think they may be aware of all the roleplayers, but they certainly do not interact with them

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10. CONFLICT DYNAMICS AND RESOLUTION

Importance	Covered in Curr	Comments
1 1	3 3	♦ It depends on the personality of the doctor, we may have to do groups where they can discuss it ♦ The doctor learns not to react, she becomes a listener in a conflict situation

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		Comments
		• Some of them are able to handle it extremely well but some of them don't and have real problems and take longer to adjust to conflict situation • In response to the question "how are students advised to handle a conflict situation?": There are no formal measures that exist. There is no conflict resolution procedure...in conflict situations between staff members there are no measures in place

11. ETHICS

Importance	Covered in Curr	Comments
1 1	3 3	• I think it's an ongoing thing that they pick up along the way with you • This is a constant ongoing thing ... it gets discussed so resolutions come out when the problem occurs • Problem solving in that manner brings up issues like confidentiality or whatever

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12. MANAGEMENT AND SUPERVISION

Importance	Covered in Curr	Comments
1 1	4 4	• I think it's very important to include (in the undergraduate curriculum)

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13. SETTINGS OF TRAINING

secondary / tertiary : too much : 1 1

community health centres : too little : 3 3

14. ROLE MODELS

- Yes, I think this is definitely part of our role

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ANNEXURE C

JOSEPH'S STORY

Joseph was a young man who lived in a shack on the outskirts of a large metropolitan city. Ten people lived in the shack which only had two rooms. In rainy weather the shack got very damp and cold and they all had to huddle together for warmth. Two of the men in the shack coughed a lot and kept the others awake at night. Joseph had moved a few months previously as he had heard that there was lots of work in the city. Joseph needed a job so that he could send money to his home in the Transkei. The rains had not been good for the previous three seasons and food was short. His father had gone off to look for work in the mines two years ago. The family had not heard from him since. His mother was struggling to feed the family (Joseph had four younger brothers and sisters). Joseph had tried to find work in a nearby town and in Umtata without any luck. A relative had told him of a cousin who was living in the city who might be able to help him find a job.

Joseph had arrived in the city with very little money. His cousin had agreed to let him live in the shack until Joseph could find his own accommodation. He had told Joseph where he could try and find work but this was difficult to come by. He had managed to find the odd casual job but this did not bring in enough money to feed himself let alone send to his family. He got very thin and was always hungry. About two months after he had arrived he started to cough. At first he ignored it as he was so busy looking for work, but it got worse and worse. He decided to see a traditional healer who lived nearby. The healer gave him some muti but this did not help and the cough got worse.

In the meantime, he heard of a builder who was looking for labourers for a large project which would take a couple of years to complete. He scraped together enough money for the busfare to go and apply for a job with the builder. The builder looked at him and asked if he was well as he did not want any sick workers on site. Joseph suppressed his coughing and said he was fine. The builder told him to report for work the following week on Monday. Joseph was so happy that he had found a job at last. He decided he had better go to the clinic and see the doctor about his cough before he started work.

Joseph went to the local clinic the next day. He waited a long time. They took an X-ray of his chest and asked him to cough and spit into a little bottle. The doctor told him that he probably had TB but that they could only be sure once they had tested the contents of the little bottle. He told Joseph to come back the following week for the results. He said they would start him on pills if he had TB. Joseph hardly heard what the doctor was saying he was so shocked - he knew that people could die from TB. He managed to reply that he would not be able to come as he was to start work the next week and the clinic was only open during the day. The doctor wrote a letter for Joseph to take to his employer explaining the situation. On the way home Joseph remembered what the builder had said about not wanting sick workers on site. What was he going to do? He could not let the builder know that he was sick but the cough was getting worse and perhaps the pills would help.

Joseph started work the next week - it was hard work, digging and carrying heavy loads. Any exertion seemed to bring on a coughing fit and he got tired so easily. Somehow he managed to get through the week. They finished work early on Friday and he hoped to get to the clinic before it closed. However, he had to wait a long time for a taxi and got to the clinic very late. The nurse was angry with him for arriving so late and said he must come back on Monday to see the doctor - she was not allowed to give him the pills. Joseph left feeling very depressed. the other people in the shack were starting to complain about his coughing and he was feeling very sick. He decided that he had better go back to the clinic on the Monday. When he got home, however, there was a letter from his mother saying that his youngest brother was very ill and that she needed money to pay for the transport to the hospital in Umtata. The relative who had brought the letter was going back after the weekend so Joseph gave him most of his wages. His visit to the clinic would have to wait until he had earned enough money to help his mother.

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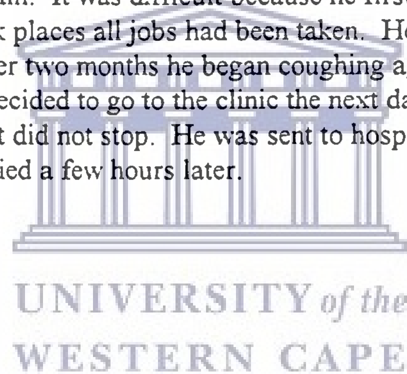
So Joseph battled on at work for another few months, getting thinner and weaker. The cough got worse and he struggled to breath. He sent most of his earnings to his mother and just lived on bread and water. One morning he was so weak he could hardly walk and his cousin insisted that he go to the clinic. Joseph did not have the energy to argue. He had to wait until the afternoon to see the doctor. The doctor was very angry that Joseph had not been started on treatment. He scolded Joseph for not coming back earlier. He also scolded the sister for not going to fetch Joseph at his home. The sister said that they were understaffed and could not cope with the patient load at the clinic let alone home visits. Besides it was dangerous to do home visits in the area that Joseph lived. The doctor told Joseph that he was very ill with TB and that he would have to go to hospital for a while.

After a month in hospital Joseph felt much better. He began to worry about his family and asked if he could leave the hospital. The doctor agreed but said that he would have to take pills for another 5 months. He would have to fetch these at the clinic every day or they could arrange for him to get them at work. Joseph said that he would go to the clinic as he did not want the builder to know that he was sick. The next day after collecting his pills at the clinic he went back to work. There he discovered that the builder had employed someone else in his place. Joseph tried to explain to the builder what had happened and gave him a letter that the hospital had given him for his employer. The builder said he was sorry but he could not help Joseph.

So Joseph started looking for work again. It was difficult because he first had to go to the clinic for his pills and by the time he got to the work places all jobs had been taken. He stopped going to the clinic and eventually found another job. After two months he began coughing again. One night he coughed up blood. He got really worried and decided to go to the clinic the next day. On his way there he coughed up a lot of blood. This time it did not stop. He was sent to hospital where they did what they could for him but it was too late - he died a few hours later.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