The perception of healthcare workers toward primary healthcare communication in South Africa

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ABSTRACT

South Africa's current healthcare conditions show a first world / third world division. The rapid urbanisation of the 1980's and beyond, as well as our population growth rate, has put existing healthcare services under increasing pressure. This increasing demand, exacerbated by limited funding, necessitates a fundamental restructuring of these services. This means that South African healthcare will have to refocus also from being curative to being more preventative. In such a system communication will have to play a major role as the emphasis clearly would also have to fall on education through the provision of information and guidance. Against this broad background, it would seem that Government has failed to adopt a fully integrated approach to primary healthcare communication. As a result, the allocation of communication resources and the design of communication interventions may not be fully effective in supporting substantive improvements in the primary health status of the country's population. The purpose of this study was to investigate this hypothesis through a qualitative analysis of the perceptions held by healthcare workers of the effectiveness and suitability of Governments healthcare campaign.

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INTRODUCTION

According to Dorstal (1990) South Africa's current healthcare conditions show a first world / third world division. Healthcare services catering for the white component of our population appear to conform to standards in developed countries, whilst those available to the rest of the population would seem to resemble more that which would be seen in developing countries.

The rapid urbanisation of the 1980's and beyond, as well as our population growth rate, has put existing healthcare services under increasing pressure. This increasing demand, exacerbated by limited funding, necessitates a fun-

damental restructuring of these services.

The first world / third world dichotomy referred to by Dorstal is clearly shown up by our strong focus on first world academic medicine coupled to an apparent inability to provide meaningful services at grass roots level. This situation can be likened to an inverted pyramid, which amongst other things, is not very stable.

In order to develop a healthcare system that is more suited to the conditions and needs of the people of our country, this pyramid will have to be turned around and the focus will have to be redirected to the grass roots as also emphasised by the World Health Organisation. This implies amongst other things that primary healthcare as a concept needs to be marketed to all parts of the community and then operationalised in terms of it's first order elements such as accessibility, acceptability and equity.

An important lesson to be learnt from medical history is that prevention of disease is usually less expensive and more efficient than curing of the disease. This means that South African healthcare will have to refocus also from being curative to being more preventative. In such a system communication will have to play a major role as the emphasis clearly would also have to fall on education through the provision of information and guidance.

According to Reardon (1989) at least three challenges face health communication experts, these being:

- identifying environmental pressures and idiosyncrasies of target groups that predispose them to risk;
- assessing their level of media and interpersonal dependency with regard to health information and the credibility they assign each source; and
- selecting persuasion strategies suited to the channel and target group.

The challenge remains however not only to inform and educate target publics about healthcare issues, but to convert these gains into changed behavior. At grass rots level this entails turning the concept of primary healthcare into a tangible service for the community through personal ownership, responsibility and action.

Neil Thobejane, Assistant General Secretary of NEHAWU is concerned that this self-responsibility may be a major stumbling block as most people are not aware of preventative healthcare issues until it is too late. Also, in terms of primary healthcare issues such as pregnancy and nutrition, behaviours have become entrenched to such an extent that it will require much more than merely awareness to effect meaningful changes in such communities.

Dissatisfaction with current national health policy is widespread. Criticism of healthcare communication programmes (such as the pre-1991 Aids campaign) is levelled at the Government. Holmshaw (1992) believes that this criticism focuses on Government's lack of credibility as well as it's failure to democratically consult opinion leaders within society at large, also in terms of the essential phases of the communication process.

Government's approach to consultation is seen as an effort to "rubber stamp" decisions rather than an effort to meaningfully co-create solutions. The resentment towards this approach led to the establishment of the Progressive Primary Healthcare Organisation (PPHC) in 1992. Members of this

forum include COSATU, NADTU, the ANC, PAC and SACP, as well as progressive civic organisations such as the South African Health and Social Services Organisation (SAHSSO).

The focus of this forum is on the co-creation of healthcare policy. In this process, a holistic approach is taken to healthcare. The real issues which affect the rendering of healthcare, such as inadequacies and inequalities of existing infrastructure and the volatile politicised environment, are taken into account. The PPHC acknowledges the need to restructure health communication and accepts that Government has a role in this. A formalised basis for co-operation between the PPHC and Government has however not been formalised as yet.

A review of successful healthcare campaigns in developing countries such as India and Cuba clearly shows that the success of those campaigns depend on inter alia:

- Government commitment to the primary healthcare concept; and
- Communication interventions based on a full consideration of existing system constraints such as education (including literacy levels), culture and resources.

Against this broad background, it would seem that Government has failed to adopt a fully integrated approach to primary healthcare communication. As a result, the allocation of communication resources and the design of communication interventions may not be fully effective in supporting substantive improvements in the primary health status of the country's population.

The purpose of this study was to investigate this hypothesis through a qualitative analysis of the perceptions held by healthcare workers of the effectiveness and suitability of Governments healthcare campaign.

RESEARCH AND RESULTS

The perceptions of primary health care workers with regard to current Primary Health Care (PHC) campaigns initiated by the government was generally negative.

TOTAL COMMUNICATIONS

Marketing communications, in order to be effective, needs to make use of what is referred to as TOTAL communications. Total communications is an holistic approach where there is an interdependence and interrelatedness between all the components that make up communications. Marketing communications generally takes place within the context of the communication mix. This consists of:

- Personal sales (interpersonal communications);
- Above-the-line advertising (commercial advertising in which space/time is bought in the media);
- Below-the-line advertising (promotional activities); and
- Public relations.

With regard to the governments PHC campaigns, the perception exists that these campaigns do not make use of a total communication strategy. They rely very heavily on above-the-line advertising and public relations. Furthermore it would seem as if there is little concurrency between these two strategies. They may as well be implemented as two independent strategies. They do not reinforce each other and are perceived to be used haphazardly and with little co-ordination. This minimizes the impact of the message. Coulson (1993) is of the opinion that there is a need for an ongoing campaign in terms of health communications, not just one big cam-

paign over a specified period of time. In this regard, it can be suggested that the PHC campaign becomes modified into a persuasive movement (De Wet, 1991:115) that will provide a consistent and continuous PHC message over a non specified period of time. This use of a consistent and continuous message is essential in the building up of adverting stock ("adstock").

Consistency over a long period of time means that one perception of the service (PHC) reinforces another. Knowledge (awareness) is thus obtained through repetition of the same message. Reinforcement of already existing knowledge occurs each time the target market is exposed to another consistent message about the service. Without adstock one would have to start building knowledge of PHC each time the consumer was exposed to a message.

One example that illustrates this lack of a continuous message is that at a PHC clinic – the Alexandra Witsco Clinic – no posters, pamphlets or any other information about PHC per sè and/or PHC campaigns was evident. This despite the fact that the print advertisements were sent out to all the relevant clinics in poster form.

A possible reason for this lack of coordination, is that the advertising contract is pitched for every two years and that each of the components of the communication mix are handled by a different agency. Furthermore, numerous bodies such as the TBVC states, provincial administrators, regional administrators, city and town councils, private organisations, etc., are all involved in PHC. The lack of coordination and cohesion between the various bodies is quite evident (Higgs, 1993). What is needed is some kind of PHC forum that can organise and structure interested parties into a cohesive and effective body. This should include so called alternative structures such as the Progressive Primary Health Care Organisation (Thobejane, 1993).

The campaign was also criticised as relevant bodies were not consulted before the campaign was planned. For example the National Education Health and Allied Workers Union (NEHAWU) were consulted in what they feel was a token manner. An outline of the proposed campaign was submitted to them for their approval, but they had not been consulted in any manner in the planning stages of the campaign (Thobejane, 1993). Similarly, no consultation took place with organisations such as the Hillbrow Primary Health Care Project (Coulson, 1939) or with the ANC (Mgijima, 1993).

Such actions will go a long way to improve credibility of PHC programs in South Africa, which is sorely lacking. Indeed, the perception exists that these programs are nothing more than P.R. attempts by the government to create an image that it is attending to grass roots health needs, whilst in reality health care problems are not being addressed (Mgijima, 1993 and Coulson, 1993). A possible reason for this perception is the lack of supporting infrastructure, including appropriate training of health workers operating at grass roots levels.

AIM OF THE CAMPAIGN

As stated by representatives of the campaigns' advertising agency and its public relations agency (Fisher, 1993 and Coetzee, 1993) up until now, the primary aim of the campaign has been to create awareness of the concept of PHC.

As already indicated Thobejane (1993) of NEHAWU believes that something with more depth is needed than mere awareness if ultimately behavior change of the target market is required.

It would seem as though knowledge enhancement with regard to the concept PHC is the desired end goal of communications. However, knowledge enhancement is not enough to bring about behavior change, which is surely the needed communication effect (Solomon, 1990:87). According to Alcalay and Taplin (1990:123) health campaigns in general, should focus on changing behavior, not simply on the dissemination of knowledge. This is especially relevant as the campaign will be trying to persuade people to take preventative actions when they are healthy. It is far easier to convince an ill person to change their behavior. They further state that to achieve this behavior change, there should not be a heavy reliance on advertising only.

The perception also exists that these campaigns are dealing with the symptoms of a problem and not the problem itself (Coulson, 1993), Schlaff (1991:187) and Woelk (1992:419-423) illuminate this perception by stressing that health behavior is determined by numerous intermediary social and environmental variables. Health care activities should therefore be focused to change these forces. So, in the South African set up, one would need a more holistic approach to PHC. Governmental departments involved with electrification, education, employment, housing, sanitation, agriculture, pollution, etc. will have to be involved in the PHC program as well. At present these interdepartmental structures do not exist, or where they exist (such as the inter-departmental liaison committee) they do not function effectively at all levels.

TARGET MARKET AND MEDIA

Basically, the target market is differentiated between opinion leaders, self-motivators and a large so called grass roots body. This latter market is incorrectly seen as a large homogeneous body. For example, little or no differentiation between urban and rural target markets occur. This is also reflected in the media selection.

In marketing terms it could be said that the campaign is far too product orientated and not sufficiently market orientated. Market orientated campaigns have the interest of the target market at heart. Product orientated campaigns are concerned with the interests of the organisation. (Keep in mind that the perception exists that the government is involved in merely a P.R. exercise). Suggestions for the campaign have their origin in consumers' needs and preferences, in market orientated campaigns. The grass roots level was not involved in the process of planning the campaign. It is because of this product orientation that a general perspective exists, that those who plan and implement the campaign do not have a good understanding of the target market and therefore can't identify with them (Mgijima, 1993; Thobejane, 1993 and Greyling, 1993).

It is felt that if the marketeers knew the target market better, they would have made use of more innovative and appropriate media, such as taxis (especially since this medium had a high success rate in the AIDS campaign), comic books as opposed to western styled advertisements in consumer magazines, graffiti, imbizo's (these are cultural meetings that the entire community attend), traditional healers, rural TV, etc. It was also felt that perhaps most importantly of all, that the emphasis of media selection should have fallen on interpersonal communication. The latter being especially used to overcome the widespread problem of illiteracy.

An interesting development occurred in the magazine ads. The left hand page was aimed at self-motivators and the right hand page of this double page ad was aimed at the grass root

level. In fact, the self-motivators are urged to, " ... cut out the right hand page ... and give it to a person in need of health knowledge..." However, when the Flesch formula (Sevrin and Tankard, 1988:74) was applied to determine reading ease of both ads, the information aimed at the grass roots market required a higher level of education (Standard 9 and 10) to understand the message than that aimed at the self-motivators (Standard 6 and 7). Thus, a higher level of literacy was required form the group that has the higher level of illiteracy.

Mass media is effective in creating awareness of the message and diffusing information, but it should be used in conjunction with interpersonal communication. The latter is very effective in motivating actual behavioural change (Solomon, 1990:100). It was without exception, that those consulted felt that the budget would have been wiser spent if more money had been set aside for interpersonal communication (Greyling, 1993; Thobejane, 1993; Higgs, 1993; Coulson, 1993 and Mgijima, 1993).

Interpersonal communication would enable the communication to be context specific and tailor made for each specific community. It takes into account and acknowledges the differences in need, perceptions, traditions, expectations, desires, etc. of the various communities respectively. For example, Alexandra, Mamelodi and Khayelitscha townships are vastly different from each other. Interpersonal communications will enable the message to become integrated with local concepts, which will bridge the gap between modern health messages and indigenous health concepts (Stone, 1992:4110.

This interpersonal rapport can be achieved through community involvement on the grass roots level.

COMMUNITY INVOLVEMENT

As with interpersonal communication, all those consulted said that a greater attempt should be made to truly involve communities in PHC. Surprisingly enough, little focus has been placed on this aspect in existing PHC programs. Community involvement means more than getting the target market to fill in a coupon for a free booklet on Self-Help in Health. Community involvement implies participation from the community in planning the campaign, through to implementing the campaign and also in maintaining the program.

Without identifying and solving health problems through the eyes of a specific community, the campaign is perceived to be ethnocentric and paternalistic (Stone, 1992:409). At present downward communication occurs where campaigns are unilaterally designed by the authorities for the community. Community involvement in contrast, would place PHC issues on the agenda of that community (Mgijima, 1993). This is making use of what is referred to as a "breakthrough campaign" (Alcalay and Taplin, 1990:114). The issue becomes popularized. The community will end up seeing the benefits of changed health behavior, not only the authorities. Actions become realistic and feasible for the community (Hubley, 1988:135).

The benefits of meaningful community involvement include (Schlaff, 1991:187):

- The true needs of the community as perceived by the community are addressed;
- The legitimacy of the program is increased as there is greater acceptance by the community;
- Community participation is a means of empowerment. People

have greater control over their own environment. As Stone (1992:409) states this will enable communities to identify their own health needs and at the same time assume responsibility for their own health development. The community can develop and implement their own health care campaigns. Empowerment encourages devolution of power form the government to the communities which in turn will minimize the communities dependency on outside resources;

- The greater acceptance will provide greater momentum for change;
- The use of community based health care workers will result in a partnership being developed with the broader community. Trust is fundamental to any attempt of persuasion. South African PHC programs need to place far greater attention on the use of lay health workers for each community. Throughout the third world, home based health programs have improved both the participation and the acceptance of the campaigns; and
- It provides a means for feedback. Campaigns can be adjusted to meet the changing needs of the target market and environment as they occur.

CONCLUDING REMARKS

An integrated approach to healthcare communicaiton requires a systemic view on how system constraints, the population and the intervention interacts.

The results of the research as discussed clearly supports Atkin and Freimuth (1989) in their belief that attention should be given to at least the following aspects:

- a pre-assessment of audience needs and characteristics;
- the social material and logistical support required to affect and reinforce behavioural change;
- the quality of the message propagated; and
- the causal relationships between the various components of the intervention.

Over and above the findings in terms of communication, it is also worth mentioning that a number of broader issues are also important to take cognisance of.

The lack of co-creation through involvement of all stakeholders results in policies formulated by the Department of National Health and Population Development being reinterpreted at Provincial level. This reinterpretation leads to implementations at grass roots level that are largely divorced from the national primary Healthcare campaign. Evidence of this is found in the numerous independent healthcare projects undertaken by local authorities, community organisations and universities. Clearly, this lack of strategic alignment amongst the various parties involved in primary healthcare adds a further complicating dimension to any healthcare communication intervention.

A prerequisite for effective primary healthcare is the existence of adequate supporting infrastructure. However effective the communication interventions may be, they cannot succeed where:

- nursing sisters are not trained in primary healthcare; and
- insufficient primary healthcare clinics exist or are not accessible.

The simple truth seems to be that the communications programme for pri-

mary healthcare was launched prematurely. Unfortunately, this creates the impression with the community that false promises are made by Government, which brings the entire primary healthcare program into potential disrepute.

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