

Developing indicators for monitoring and evaluating the primary healthcare approach in health sciences education at the University of Cape Town, South Africa, using a Delphi technique

M I Datay,¹ MB ChB, DPhil, FCP (SA), MMed (Int Med); S Singh,² BSpHT, MA, PhD; J Irlam,¹ BSc, BSc (Med) Hons, MSc, MPhil; F Walters,² BSpHT, MSc; M Namane,³ MB ChB, MPhil (Fam Med), MSc, MSc Med Sci, FCFP (SA)

¹ Primary Health Care Directorate, Faculty of Health Sciences, University of Cape Town, South Africa

² Division of Communication Sciences and Disorders, Faculty of Health Sciences, University of Cape Town, South Africa

³ Division of Family Medicine, School of Public Health and Family Medicine, Faculty of Health Sciences, University of Cape Town, South Africa

Corresponding author: M I Datay (ishaaq.datay@uct.ac.za)

Background. The Faculty of Health Sciences (FHS), University of Cape Town (UCT) adopted the primary healthcare (PHC) approach as its lead theme for teaching, research and clinical service in 1994. A PHC working group was set up in 2017 to build consensus on indicators to monitor and evaluate the PHC approach in health sciences education in the FHS, UCT.

Objective. To develop a set of indicators through a Delphi technique for monitoring and evaluating the PHC approach in health sciences curricula in the FHS, UCT.

Methods. A national multidisciplinary Delphi panel was presented with 61 indicators of social accountability from the international Training for Health Equity Network (THEnet) for scoring in round 1. Nineteen PHC indicators, derived from a mnemonic used in the FHS, UCT for teaching core PHC principles, were added in round 2 to the 20 highest ranked THEnet indicators from round 1, on recommendation of the panel. Scoring criteria used were relevance (in both rounds), feasibility/measurability (round 1 only) and application of the PHC indicators to undergraduate and postgraduate teaching and assessment (round 2 only).

Results. Of the 39 indicators presented in the second round, 11 had an overall relevance score >85% based on the responses of 16 of 20 panellists (80% response rate). These 11 indicators have been grouped by learner needs (safety of learners – 88%, teaching is appropriate to learners' needs and context – 86%); healthcare user needs (continuity of care – 94%, holistic understanding of healthcare – 88%, respecting human rights – 88%, providing accessible care to all – 88%, providing care that is acceptable to users and their families – 87%, providing evidence-based care – 87%); and community needs (promoting health through health education – 88%, education programme reflects communities' needs – 86%, teaching embodies social accountability – 86%).

Conclusion. The selected indicators reflect priorities relevant to the FHS, UCT and are measurable and applicable to undergraduate and postgraduate curricula. They provided the basis for a case study of teaching the PHC approach to our undergraduate students.

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The Declaration of Alma-Ata on primary healthcare (PHC), adopted in 1978 at the landmark conference hosted by the World Health Organization (WHO), recognised the need for equity-driven healthcare and aspired towards the goal of 'health for all by the year 2000'.^[1] The PHC approach was reaffirmed at a number of subsequent conferences, including the 2008 WHO PHC conference held in Ouagadougou, Burkina Faso,^[2] and the Astana Declaration of 2018.^[3] In South Africa (SA), PHC was adopted as the cornerstone of the healthcare system, with a firm plan to re-engineer healthcare and to address issues around inequity, inadequate access and a grossly divided healthcare system.^[4]

The concept of social accountability has been widely adopted within international health sciences education over the past decade to direct institutions to produce graduates who can effectively respond to priority health needs, in partnership with the health sector and the communities they serve.^[5] A key set of indicators has been developed by the international

Training for Health Equity Network (THEnet) to assist health sciences faculties to align training with community needs.^[6]

In 1994, the Faculty of Health Sciences (FHS), University of Cape Town (UCT) adopted the PHC approach as its lead theme in teaching, research, health services and community engagement, and in 2003 established the interdisciplinary PHC directorate to champion the PHC approach. It is important that there be an evaluation of health sciences curricula to determine whether they adequately prepare health sciences graduates to function in a health system underpinned by the PHC approach. A PHC working group was established in 2017 to develop indicators for monitoring and evaluating the PHC approach in the FHS, and to undertake a case study of PHC teaching of final-year students.^[7]

The objective of this phase of the study was to develop a set of indicators through a modified Delphi technique^[8-10] for monitoring and evaluation of the PHC approach in health sciences curricula in the FHS, UCT.

A companion paper has described the case study that reviewed course documents and interviewed educators and students at selected community-based education sites of the FHS.^[7]

Methods

Ethics approval was obtained from the Human Research Ethics Committee, FHS, UCT (ref. no. 157/2018) prior to commencement of the study.

Participants

Eligible participants for the Delphi panel were educators and practitioners in PHC, known to the research team as having expertise in this field. There were no exclusion criteria. The expert group was expected to be relatively homogeneous. Sample size of Delphi studies can vary from 15 to 20, but some can have >50 participants.^[11] Expecting a response rate of ~50 - 70%, 28 experts were identified in round 1 of the Delphi, and recruited via email by the authors and their colleagues. Informed consent was obtained from each Delphi panellist. Participants invited represented 10 different professions, including basic sciences, family medicine, internal medicine, nursing, occupational therapy, paediatrics, physiotherapy, public health, speech language pathology and surgery. Participants were from different provinces in SA, with the majority ($n=21$; 75%) based at one of the three universities in the Western Cape Province and the rest from other national universities and government research institutions.

Indicators

A search for published indicators was conducted on PubMed, EBSCOhost and Google Scholar, using the terms:

Primary Health Care [Mesh] OR Primary Health Care OR Alma Ata
AND
Quality Indicators, Health Care [Mesh] OR Indicators
AND
Education, Medical [Mesh] OR health sciences education OR medical education OR clinical education

No framework was found that specifically included PHC indicators for health sciences curricula. There was only a set of indicators that applied to a service delivery context.^[12] The Framework for Socially Accountable Health Workforce Education of THENet was the only suitable framework known to the group.^[6] The framework consists of 179 indicators divided into the categories: 'What needs are we addressing?' 'How do we work?' 'What do we do?' 'What difference do we make?' The working group reviewed the entire framework and decided to select indicators only from the category 'What do we do?', which were perceived to be most relevant to the required purpose within the FHS. Sixty-one of 74 indicators in the 'What do we do?' category were short-listed by the group, and some were reworded for clarity and applicability in the FHS, UCT context.

Round 1

The 61 indicators were listed in an Excel 365 (Microsoft Corp., USA) spreadsheet. Each indicator had a 5-point Likert scale (strongly agree = 5; agree of PHC in education and training) and three response options (yes = 3; maybe = 2; no = 1) to signal whether an indicator was measurable or feasible. There was provision for comments and suggestions for additional or alternative indicators by the participants. Members of the Delphi panel were emailed the spreadsheet with

instructions for completion within 2 weeks, and a reminder was sent before the due date.

Eighteen of 28 members (64%) responded (family medicine, $n=6$; internal medicine, $n=1$; nursing, $n=2$; paediatrics, $n=1$; physiotherapy, $n=1$; public health, $n=4$; speech language pathology, $n=2$; and surgery, $n=1$). Each indicator was scored for relevance using the formula:

$$\text{Relevance score (\%)} = \frac{\sum \text{Likert score by each respondent}}{\sum \text{maximum Likert score (5) by each respondent}} \times 100$$

The 20 THENet indicators with the highest relevance scores were included in the revised questionnaire for round 2 (Table 1).

The exclusive use of THENet indicators as a measure of PHC implementation in health sciences education at the FHS, UCT was questioned by an experienced panellist. It was pointed out that the task of the research group was to evaluate the implementation of PHC principles in the curriculum, and that the indicators presented to the panel related exclusively to social accountability, which could not be conflated with PHC. The research team agreed and added 19 indicators in round 2 that were derived from the HEALTH FOR ALL mnemonic (H = health; E = equity/equality; A = accessibility; L = listening to/learning from the community; T = teamwork; H = health promotion; F = funding; O = other sectors; R = rights and responsibilities; A = acceptability and appropriateness; L = levels of care; L = literature (evidence based)), which is regularly used in the FHS to teach the principles of the PHC approach (Table 2).^[7]

Some round 1 panellists questioned the validity of the category 'measurable/feasible', and after agreement that this was not easy to assess, it was removed in round 2. Criteria were added in round 2 for whether the 19 PHC-specific indicators should be 'taught and assessed', 'taught only' or 'neither taught nor assessed' to undergraduates and/or postgraduates (Table 3).

Round 2

The round 2 questionnaire asked panellists to rate the relevance of all 39 indicators using the same 5-point Likert scale as in round 1. Sixteen of the 20 members (80%) responded. Responses from round 2 were again scored and ranked by relevance. A total of 21 THENet and PHC indicators scored >80% in the second round, but it was decided to raise the cut-off for inclusion in the final set to 85% to limit the indicators to a number deemed feasible for the subsequent phases of the research. A third round was part of the original protocol; however, it was decided that no further rounds needed to be conducted, as there were sufficient responses for consensus, and insufficient time without delaying the case study phase.

Results

Four of THENet indicators had a relevance score of >85%. These indicators measure priority given to student safety in communities (88%), reflection of priority health and social needs of communities in the education programme (86%), embodiment of social accountability in teaching philosophy and practice (86%) and whether the teaching philosophy and practice is appropriate to learners' needs and context (86%) (Table 4).

There were 5 PHC indicators for undergraduates and 4 for postgraduates that had relevance scores of >85%. Common indicators across undergraduate and postgraduate study were continuity of care and respecting human rights of healthcare users (Table 5). The majority of the panel thought that the PHC indicators should be both taught and assessed in undergraduate and

postgraduate curricula. The 5 undergraduate PHC indicators were used with the abovementioned 4 THENet indicators in the case study phase of the research, which has been previously published.^[7]

Discussion

A conventional Delphi technique was used to harness the expertise of practitioners from a diversity of health professions in prioritising indicators for monitoring and evaluating the implementation of the PHC approach in FHS, UCT curricula. Their feedback from round 1 led to the addition of PHC-specific indicators to THENet indicators in round 2. After two rounds, 4 THENet indicators and 7 PHC-specific indicators emerged as the most relevant.

We have grouped these indicators into the following categories: learner needs, healthcare users' needs and community needs (Table 6). When grouping the indicators in this manner, it emerged that indicators prioritising learner needs related strongly to the social accountability framework, healthcare user indicators related strongly to the PHC approach and indicators prioritising community needs reflected both PHC and social accountability.

Learner needs

The emergence of 'safety of learners in the community is a priority' as the highest ranked THENet indicator reflects prevalent concerns about personal safety in SA, which obliges health sciences curricula to engage meaningfully with communities around community entry, community values and partnerships for student work.^[13] Determinants of community safety are multifactorial and thus also require intersectoral collaboration to address.^[14] The safety of learners needs to be ensured not only in communities, but also within the broader understanding of the curriculum. Mental health has emerged as a major challenge at university institutions, with self-harm, bullying and hierarchical institutional cultures contributing greatly towards student distress.^[15] These points tie in with the indicator 'The teaching philosophy and practice needs to be appropriate to learners' needs and context'. The curriculum needs to prepare students to engage not only with diverse societies, but also with the many life challenges they are likely to encounter. In addition to the professional work that students are expected to master during their careers, other multifaceted challenges (such as stress and limited resources) impact their lives. There is also a hidden curriculum that needs to be addressed when working for social accountability.^[16] It is therefore pertinent that the teaching philosophy encompasses a caring space where coping skills and resilience are prioritised.^[15]

Healthcare user needs

Indicators of the needs of healthcare users were derived exclusively from the PHC principles and included continuity of care; providing evidence-based, acceptable, holistic and accessible care; and respecting human rights.

SA has a fragmented health system, which negatively impacts on continuity of care, patient experiences and health outcomes.^[17,18] Health sciences curricula should therefore prepare graduates to address challenges within the health care system and to improve continuity of care.

Provision of holistic care is a key principle,^[19] which differentiates the PHC approach from the biomedical approach that characterises much of clinical practice.^[20] Holistic care recognises psychological and social impacts on health and patient management. When a curriculum prioritises holistic care, students can rather adopt a person-centred approach to address the psychosocial determinants of health.^[21]

Human rights violations continue to perpetuate negative health outcomes, resulting in limited access to care due to physical, linguistic, disability and financial challenges, and ultimately poorer quality of care.^[22] Educating health sciences students about human rights will conscientise them to recognise, and potentially redress, such violations.

A curriculum that prepares graduates for work in a multicultural society should equip them to provide care that is socially and culturally acceptable to healthcare users and their families. Students should therefore be made aware of, and respect, different healthcare needs, health-seeking behaviours and treatment choices. In preparing students for lifelong learning about safe and quality practice, it is essential that curricula develop their skills to critically appraise the research literature, and to provide evidence-based care that carefully considers their patients' preferences.

Community needs

The high ranking of the indicator on curriculum content needing to reflect the priority health and social needs of the communities served by the institution, signals the importance of contextually relevant curricula. Historically, prioritisation of content in health sciences curricula has been based on developments in the Global North.^[23,24] Built on colonial and postcolonial infrastructures, health services in developing countries were not necessarily geared to deal with the priority needs of the communities being served.^[23] Ways in which this can be addressed include using epidemiological data on the burden of disease and disability, and by engaging with local communities about their priority health and social needs.

Another community needs indicator states that the teaching philosophy and practice needs to embody core values of social accountability, such as respect for the dignity and rights of learners and patients, and social justice. The challenges of ensuring the rights and dignity of learners and patients have been well described in the literature.^[25] The power imbalance is even more challenging when it involves deeper issues such as racism, or perceptions thereof,^[26] gender-based violence^[27] and bullying.^[28] Addressing these issues in the curriculum requires widespread awareness and multipronged approaches to enhance the rights of learners and patients, such as safe spaces for reporting, a culture of zero tolerance and policy review that enables the abovementioned issues to happen.^[29]

'Promoting health by means of health education' emerged as a priority indicator. Health promotion speaks to a model of improving health and wellness, compared with curricula of traditional models focused on illness.^[30] Empowering health sciences students on how to deliver effective health education can help individuals and communities to understand factors that promote good health, maintain a healthy lifestyle and encourage appropriate health-seeking behaviours. Health education forms a cornerstone of health promotion, ideally enabling collaboration between healthcare practitioners, students and the community to identify health needs and to promote the health of the community.^[31] Indicators of public advocacy and policy reform, which are also essential components of health promotion, should also be included.

Study strength and limitations

The strength of this study is that it represents a novel approach of integrating PHC and social accountability indicators. The limitations are that we were unable to do a third round because of time constraints, although consensus

Table 1. THEnet indicators presented in round 2 (n=20)

Indicator	Relevance score, %
1 The curriculum design and delivery provide sufficient learning about priority health needs of the communities served	94
2 The community placements provide good learner exposure to priority health needs	92
3 The curriculum design and delivery provide sufficient learning about cultural issues impacting the community	91
4 Assessment is designed to assess required knowledge, skills and competencies to meet priority community health and social needs	91
5 The curriculum design and delivery provide sufficient learning about social and environmental determinants of health	90
6 The teaching philosophy and practice embodies core values of social accountability (e.g. respect for dignity and rights of learners and patients, social justice)	90
7 Local community partners are involved in the selection and evaluation of community placements	90
8 The curriculum design and delivery provide sufficient interprofessional learning and teamwork	88
9 The curriculum design and delivery provide sufficient learning about disease prevention	87
10 The curriculum design and delivery provide sufficient collaboration with sectors other than health	87
11 The safety of learners in the community is a priority for the faculty	87
12 Learner satisfaction with curricula and teaching methodology is reviewed frequently	86
13 The education programme, including curriculum content, reflects priority health and social needs of the communities served by the institution	85
14 There is contextually appropriate preparation (e.g. role-play) for community placement and engagement	84
15 The teaching philosophy and practice is appropriate to learners' needs and context (e.g. support for dealing with language and cultural diversity in unfamiliar settings)	83
16 Placement opportunities are measured in terms of the proportion of learner time spent in community and primary care settings v. time spent in secondary and tertiary settings	83
17 There are continuous and sequential community and clinical experiences throughout the curriculum	83
18 A specified proportion of curriculum weeks is allocated to learning about priority community health and social needs	82
19 Clear guidelines are provided to learners about their placement locations	81
20 The criteria for selecting community placement sites are clearly defined	81

THEnet = Training for Health Equity Network.

Table 2. PHC-specific indicators presented in round 2 (n=19)

Indicator of PHC principles	Explanation/definition
1 Having a holistic understanding of healthcare users and their context	Health is a state of total wellbeing, not just the absence of disease
2 Providing person-centred care, with client/patient participation	Healthcare should be person- and community-centred and should reach people where they live and work
3 Working as a multidisciplinary team	Every member of the health team should be valued and appropriately involved in care
4 Promoting community participation in healthcare	People, families and communities should be engaged as active partners in caring for their health
5 Continuity of care at all levels of healthcare delivery	Primary care should be the first level of contact between people and the health system, with appropriate and timely referrals between levels of care
6 Promoting equity and social justice in healthcare delivery	Priority should be given to the health needs of vulnerable people who have been marginalised by society
7 Respecting human rights in healthcare	People's rights to quality healthcare must be respected at all times
8 Promoting broad intersectoral collaboration in addressing the social determinants of health	Different sectors of society must work together for healthy living conditions for all
9 Providing care that is:	
A Affordable to users	Healthcare should be affordable for all
B Accessible to all users	Everyone, everywhere should have good access to quality healthcare
C Appropriate to users' needs	Healthcare should be appropriate to people's health needs
D Acceptable to users and their families	Healthcare should be socially and culturally acceptable to people's health needs
E Sustainably funded	Healthcare should be sustainably funded and cost-effective
F Environmentally sustainable	Healthcare should minimise any negative impacts on the natural environment
10 Providing evidence-based care	Healthcare must be based on the most up-to-date evidence of what is effective and safe, integrating clinical expertise and patient preferences
11 Promoting health by means of:	
A Health education	Health education should always be offered to individuals, families, communities and healthcare workers
B Behaviour change	Methods to change behaviour for better individual and community health must be effective and acceptable
C Public advocacy	There must be work at different levels to remove barriers to optimal health
D Policy reform	Working towards HEALTH FOR ALL policies is needed to optimally address the multiple determinants of health

PHC = primary healthcare.

Table 3. Indicators and rating criteria per round

Indicators	Round 1	Round 2
THEnet indicators, <i>n</i>	61	20
PHC indicators (HEALTH FOR ALL), <i>n</i>	-	19
Rating criteria		
Relevance score	✓	✓
Measurable/feasible response	✓	-
Undergraduate teaching and assessment	-	✓
Postgraduate teaching and assessment	-	✓

THEnet = Training for Health Equity Network; PHC = primary healthcare.

Table 4. THEnet indicators with relevance scores of >85% in round 2

THEnet indicator	Relevance score, %
The safety of learners in the community is a priority for the faculty	88
The education programme, including curriculum content, reflects priority health and social needs of the communities served by the institution	86
The teaching philosophy and practice embodies core values of social accountability (e.g. respect for dignity and rights of learners and patients, social justice)	86
The teaching philosophy and practice is appropriate to learners' needs and context (e.g. support for dealing with language and cultural diversity in unfamiliar settings)	86

THEnet = Training for Health Equity Network.

Table 5. PHC indicators relevance scores for undergraduate and postgraduate curricula

Indicator	UG, %	PG, %
Continuity of care is provided at all levels of healthcare	94	87
Holistic understanding of healthcare users is emphasised	88	80
Respecting human rights of healthcare users	88	87
Providing care that is accessible to all users	88	80
Promoting health by means of health education is emphasised	88	80
Providing care that is acceptable to users and their families	81	87
Providing evidence-based care	81	87

PHC = primary healthcare; UG = undergraduate; PG = postgraduate.

after two rounds was deemed sufficient. There was a preponderance of family physicians in the panel, which was not unexpected given the centrality of social accountability and PHC principles in the discipline of family medicine.

Conclusion

The Delphi technique enabled a consensus to be reached by a panel of moderately diverse healthcare professionals on the prioritisation of 11 indicators of the PHC approach in health sciences curricula in the FHS, UCT. Four were derived from THEnet framework and 7 from the HEALTH FOR ALL mnemonic that is used in the FHS for teaching the principles of the PHC approach. Nine of these indicators that were selected as priorities for teaching and assessment in undergraduate curricula were

Table 6. Categorisation of indicators according to learner, healthcare user and community needs

Learner needs	The safety of learners in the community is a priority for the faculty
	The teaching philosophy and practice is appropriate to learners' needs and context (e.g. support for dealing with language and cultural diversity in unfamiliar settings)
Healthcare user needs	Continuity of care is provided at all levels of healthcare
	Holistic understanding of healthcare users is emphasised
	Respecting human rights of healthcare users
	Providing care that is accessible to all users
	Providing care that is acceptable to users and their families
	Providing evidence-based care
Community needs	The teaching philosophy and practice embodies core values of social accountability (e.g. respect for dignity and rights of learners and patients, social justice)
	The education programme, including curriculum content, reflects priority health and social needs of the communities served by the institution
	Promoting health by means of health education is emphasised

used in a case study of teaching PHC at community-based education sites of UCT's FHS.^[7]

The PHC approach is more important than ever in a nation and world of growing inequities, and faculties of health sciences have a crucial role to play in educating the next generation of health professionals to exercise their agency in implementing PHC. Indicators such as social accountability and PHC in health sciences education appear to fill an important gap in the literature.

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