An exploration of how general practitioners, working in seven Black townships in Cape Town, South Africa, perceive their role in strengthening the district health system

by

Nozuko Arizona Mdlekeza

(Student Number: 3817149)

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Abstract

Despite the recognition of general practitioners' (GPs) role within the health system, and more recently their role in implementing the National Health Insurance (NHI) in South Africa, very little is known about township GPs' role, motivation and experiences and their contribution to strengthening the district health system (DHS). The aim of this study was to better understand private GP's perceived roles in primary healthcare provision within the DHS, investigate their reasons for choosing the medical profession and explore their experiences of being a private GP in Cape Town's black townships.

A qualitative exploratory study was conducted amongst 12 township GPs who provided consent. The exploratory study examined their experiences, to better understand their histories, motivations and socio-cultural work contexts. In-depth interviews were conducted using a semi-structured interview guide consisting of open-ended questions, with interviews conducted face-to-face for approximately an hour per participant. Interviews were recorded with consent and collected data was analysed using thematic coding analysis (TCA).

The participants, who had rural and township upbringing obtained positive role modelling from their local GPs, hospital doctors and peers who were medical students. Parental guidance also influenced their choice of profession. These influencers changed their trajectory towards medicine during their secondary schooling.

The GPs perceived their role in the DHS as providers of quality primary healthcare in low socioeconomic areas burdened by high morbidity and mortality. They emphasized offering quality medication which the public sector cannot offer, thereby preventing mortality in vulnerable communities. Additionally, they viewed themselves as facilitators and advocates, who support patients and connect them to appropriate public or private clinics and hospitals, or to other sectors like police or social services. Ensuring continuity of care for optimal results was also highlighted as a significant feature in their practices as they established good relationships with their clients, referring them accordingly while working in co-ordination with other actors for their wellbeing. The GPs noted that the absence of language barriers (enabled by their fluency in vernacular) enhanced quality service delivery and clinical outcomes in the townships. They also emphasized cultural understanding as key to strengthening doctor-patient relationships and were supportive of traditional healing as it was embedded in the community. Health promotion in the form of health education on disease management and prevention, was cited as central to their work to enable patients to take control of their health, improve it and that of their families plus the broader community. The GPs specifically mentioned chronic

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disease management and family planning, which require continuity of care and health promotion to be effective. Their services included health education to the youth (especially teenage girls) about family planning and encouraging adherence behaviour in patients with chronic communicable and non-communicable diseases (NCDs). They likened their role in the DHS to that of stakeholders fostering public-private partnerships, collaborating with state entities like the police and public health centres. They mentioned that beyond being primary care providers, their services extended to broader patient wellbeing such as assisting victims of interpersonal violence, referring them to police, and providing counselling. They highlighted the convenience of their one stop practices, which offer local daily consultations, procedures and medication at minimal fees and short waiting times. These were seen as examples of their primary healthcare role within the DHS.

Despite these contributions, the GPs reported facing more challenges than rewards in their experiences as township GPs. On their collaboration with public health facilities, they mentioned experiencing constant communication issues with the state doctors and getting poor feedback about the patients they refer. Crime posed a significant risk in their context, crimes such as daytime armed robberies in their practices and break-ins at night were common. A new trend of extortion by gangsters was also mentioned by the GPs. Financial constraints were also reportedly challenging the GPs, attributed to medical aid issues and current high unemployment of their clients who often ask to be seen on credit. However, they derived satisfaction from positive reviews from their patients and were motivated by the good clinical outcomes.

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Declaration

I, Nozuko Arizona Mdlekeza declare that the research study titled: An exploration of how general practitioners, working in seven Black townships in Cape Town, South Africa, perceive their role in strengthening the district health system, is my own work. This work has not been submitted for examination or degree purposes at any other institution of higher learning. All the literature used in this study has been indicated and acknowledged.

Signature:

Date: 1 September 2025

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district health system

general practitioners

medical doctors

national health insurance

primary health care

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health care access

South African townships

primary care doctors

private practice

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Abbreviations:

CHC	Community Health Centre
CON	Certificate of Need
DHS	District Health System
GP	General Practitioner
HPCSA	Health Professions Council of South Africa
MBChB	Bachelor of Medicine and Bachelor of Surgery
MO	Medical Officer
NHI	National Health Insurance
POPIA	Protection of Personal Information Act
SAMA	South African Medical Association
THP	Traditional Health Practitioner
UWC	University of the Western Cape

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Table of Contents

Abstract 2

Declaration 4

Acknowledgements 5

Key words: 6

Abbreviations: 7

Table of Contents 8

1 Chapter 1: Introduction 10

1.1 Study setting 12

1.2 Aim 13

1.3 Objectives 13

2 Chapter 2: Literature review 14

2.1 General Practitioners 14

2.2 National Health Insurance and private GPs 16

2.3 Reasons for choosing a career in medicine 17

3 Chapter 3: Methodology 19

3.1 Research design 19

3.1.1 19

3.1.2 Study population and sample 19

3.2 Data collection 20

3.3 Data analysis 22

3.4 Trustworthiness 23

3.5 Ethical considerations 24

4 Chapter 4: Findings 25

4.1 Introduction 25

4.2 Characteristics of the interviewed general practitioners 25

4.3 Journey to becoming a doctor 26

4.3.1 GP backgrounds and motivations 26

https://uwcscholar.uwc.ac.za/home

4.4 The journey towards medical school 27

4.5 The path through medical school 29

4.6 From medical qualification to current role 31

***4.7* General practitioners' reasons for working in the townships, their views on how they impact the community and how they see their role in the district health system 32**

4.7.1 Reasons for working in townships 32

4.8 How general practitioners view their impact on the communities they serve 34

4.9 How the general practitioners perceive their role in the district health system 35

4.10 Rewards and challenges 37

4.10.1 Rewards 37

4.10.2 Challenges 38

4.11 Collaboration with health sector and other stakeholders 39

4.11.1 Collaboration with public sector facilities 39

4.11.2 Collaboration with traditional health practitioners 42

4.11.3 Collaboration with other government sectors 43

4.12 GPs thoughts about NHI 44

4.13 GPs views on role of professional bodies 48

4.13.1 Health Professions Council of South Africa (HPCSA) 48

4.13.2 South African Medical Association (SAMA) 50

4.14 GPs advice to the state 51

4.14.1 National Health Insurance (NHI) 51

4.14.2 Traditional Health Practitioners 51

4.14.3 Medicolegal forms of assault victims (J88) and Department of Justice 52

4.14.4 Health system strengthening 52

5 Chapter 5: Discussion 55

5.1 Study Limitation 59

6 Chapter 6: Conclusions and recommendations 60

References 62

APPENDCES 65

Appendix 1: Interview Guide 65

APPENDIX 2: Participant Information Sheet 67

APPENDIX 3: Consent Form 72

https://uwcscholar.uwc.ac.za/home

1 Chapter 1: Introduction

I am a black female general practitioner (GP), privately practising in two township areas in the City of Cape Town, South Africa (SA). My interest in this research was sparked by two inter-related observations:

Firstly, one of the key rationales and pillars of the National Health Insurance (NHI) is the pooling and better distribution of health resources. Currently this distribution is highly inequitable (Abrahams, Thani & Khan, 2022). For example, of the 29,000 medical practitioners on the Health Professions Council of South Africa (HPCSA) register on 1 July 2022 (Personal information with Y. Daffue, deputy POPIA/PAIA Information Officer HPCSA, Pretoria,12 July 2022), only 27% work in public sector, the rest were in private sector (Abrahams, Thani & Khan, 2022). The 2018 Health Market Inquiry estimated that in 2015 about 43.7% of GPs, 64% of medical specialists and 26% of nurses worked in the private sector, although these are estimates, as exact numbers are not available (Competition Commission, 2018, pp. 40–41). The GPs are those health practitioners in the private sector who are primary care providers and first contact points in the health system (Le Marechal et al, 2015). They are crucial to the health system as a component of primary health care (PHC), which is a broader more comprehensive approach to healthcare that also addresses social determinants of health (Mash, Gaede& Hugo, 2021).

The South African health system is characterized by a pronounced two-tier structure, with a private sector operating parallel to the public health sector. The private sector caters for 16% of the population who have medical aid and/or can afford to pay out of pocket while the public sector serves approximately 84% of the South African population (Burger & Christian, 2018). The foundation of the South African health system is the district health system (DHS) consisting of individuals providing health care in the district which is a well circumscribed area (NDP 2030, 2011). The DHS is key to universal health coverage as it also addresses the social determinants of health by providing PHC and includes a referral system from the community it serves all the way to the most sophisticated health care available (NDP 2030, 2011).

The changes which will be implemented with the NHI are likely to crucially affect those of us who are currently rendering (private) services to those clients in townships and other low-income areas, who can afford our services (Perrow & Schneider, 2023). The NHI intends to

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redress the inequitable distribution of health services in the country by providing universal health coverage to everyone (Gaqavu& Mash, 2019). While we know anecdotally that there are not many of us, neither the HPCSA nor South African Medical Association (SAMA) have reliable figures (Solanki et al., 2020). It is known that South Africa does not have a single authoritative readily available dataset for medical doctors which gives the numbers, the sector of practice, whether they are part-time or full-time or retired and so on, (Wishnia et al., 2019).

However, we know little about how these doctors, my colleagues, currently understand and experience their role in the health system. We also have very limited knowledge of how they view, and what they know about the NHI. There have been a few articles published about the perceptions of GPs on the NHI (Gaqavu & Mash,2019; Mathew& Mash, 2019), and this study will contribute the views of black solo township GPs in Cape Town as they will be significant in providing quality service to the township population in NHI (Gaqavu & Mash,2019). Currently SA faces a doctor deficit in public health facilities (George&Blaauw,2019), making GPs an important resource for NHI to enable increased access to quality primary care by the public (Gaqavu & Mash,2019).

Secondly, I found during my study that there is very little literature, which elucidates the wider experiences and life histories of black doctors in SA. This latter discovery and the interviews with 12 of my colleagues, which form the core of this study, led to the addition of one objective, which explores my colleagues' rationales for becoming doctors and practising in township areas, in addition to exploring their perceptions of the NHI and working within the district health system. It is known that the global south, especially the sub-Saharan Africa (SSA), faces shortage of healthcare workers including doctors (Boniol, et.al.,2022). This makes it significant to understand factors influencing choice in medicine in less developed countries to encourage our youth to become doctors.

This qualitative study allowed private GPs to narrate their understanding of their roles in primary healthcare provision and strengthening of the health system. The focus was on solo township private GPs and the Cape Town district health system. The study set out to explore the GPs experiences of working in Cape Town's crime ridden black townships, their motivation to work in such areas, and rewards they derive from their work. This study also allowed GPs to share their life histories, their interactions with the public and private health sectors, their collaboration with traditional healers whose significance in black communities cannot be overlooked (Ross, 2008; Bopape, 2013; Zuma et al., 2016), and with other government departments such as justice and police. The GPs also commented on the NHI and its impact on

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their profession, as well as on support provided by HPCSA and SAMA. Finally, this research study allowed them to give suggestions on health system strengthening exercises, from their standpoint as township GPs.

1.1 Study setting

Cape Town is the second largest metropolitan area in SA, situated at the Western Cape (WC) province with land size of 1,8% of the WC. The city has formal and informal dwellings, with 11.7% of households living in the latter in 2022. During the same period the population was predominantly black African (45,7%) and coloured (35%). The dominant race group had 22% of its households living in informal dwellings. It is these black African households that were reportedly the only population group poorly accessing basic services like water, sanitation and waste removal. The total city population then was about 4,7 million with majority of the population being of working age(15-64years) (STATSSA, 2023).

The study was conducted in the Cape Town Metropolitan district, focusing on solo private GPs practising in black townships characterised by formal and informal dwellings, overcrowding, high unemployment, poverty, high disease burden, serious social issues and overstretched health infrastructure (Booysen, 2010; Setswe, 2010). The WC has six other districts with their townships which will not be focused on. South African townships result from an apartheid legacy of Group Areas Act of 1950 where people of colour were allocated marginalised areas of cities (Phillip, 2014). The expansion of these townships is due to rapid urbanisation seen in cities like Cape Town, which is a major cause of township unemployment, poor health, and crime as the cities cannot catch up with the in migration (Fagbohunka, 2018). This results in township population relying overwhelmingly on the public health sector for health care provision as they receive free public primary healthcare through provincial and city clinic services (Western Cape Government, 2019). But there are private GPs working in these areas, who will become particularly important to NHI implementation. These solo GP practices are inside the townships in formal brick houses and are cash and medical insurance based. The doctors also dispense medication in these rooms besides examining, treating and screening patients. Most GPs' rooms consist of a waiting area with a receptionist, consulting room/s, dispensary and toilet facility.

The seven townships chosen were Khayelitsha (the city's largest black township), Gugulethu, Langa, Nyanga, Phillipi, Dunoon, and Masiphumelele. About 36km south of Cape Town on the periphery of Fish Hoek suburb is Masiphumelelele, on the Cape Peninsula (Du Preez, 2023)

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whilst Khayelitsha is about 30km southeast of the city centre at its periphery, off the N2 national road (Ncoliwe, 2019). Meanwhile Dunoon is 20km northwest of the city along the national road N7 on the outskirts of Cape Town next to an industrial area (Magidi, 2025). Gugulethu is 20km southeast of the city in the cape flats (Chidavaenzi, 2020) with Nyanga, the second oldest black township as its neighbour along the N2 national road close to Cape Town International airport (South African History Online, 2013). Cape Town's oldest black township, Langa (HSRC,2023) is 12 km southeast of the city along the N2(Irrgang, 2019) and Phillipi, the food garden of the city, lies 20km south of the city with its township next to Mitchells Plain with Nyanga and Gugulethu at its northern border (South African History Online, 2011). Five of the townships in this study are on the cape flats area namely Langa, Gugulethu, Nyanga, Khayelitsha and Phillipi (see Appendix 4). Cape Flats are large low-lying sandy areas southeast of the city which were sites of forced removals during apartheid (Cochrane& Chellan, 2017).

1.2 Aim

To better understand private general practitioners' (GPs) perceived roles in primary health care provision within the district health system and explore their experiences of being private GPs in Cape Town's black townships

1.3 Objectives

- To describe the private GPs understanding of their roles in providing primary healthcare in Cape Town's metropolitan townships.
- To describe and explain the private GPs experiences in their contexts and within the health system.
- To elicit their recommendations on supporting their role in primary care service delivery and NHI implementation.
- To explore the general practitioners' rationales for becoming doctors and practicing in township areas

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2 Chapter 2: Literature review

Despite the recognition of their role within the health system (HS), and more recently in relation to the National Health Insurance (NHI) (Gaqavu & Mash, 2019), there is limited literature available about the contribution private GPs make to the district health system – and specifically those GPs practicing within the urban townships of South Africa. The focus in this study was on South African solo GPs working privately in black townships as there is scarce information about what their role is in the health system. There are also gaps in information on these GPs' work experiences in those low socioeconomic settings. Limited information exists about their contribution to the district health system, or the work and role these GPs play in linking their patients to the public health sector. There is also a dearth of information on their motivation for working in impoverished areas and on their thoughts and attitudes towards NHI. Along the course of the study, it was discovered that not much is known about the participants' reasons for becoming doctors.

2.1 General Practitioners

In South Africa (SA) one must complete a 6-year Bachelor of Medicine and Bachelor of Surgery (MBChB) degree at a local medical university to become a medical doctor and needs further 3 clinical years to practice as a doctor (Brits, Bezuidenhout & van der Merwe, 2020). These qualified doctors can work as medical officers (MO) in public sector with their undergraduate degrees (Perrow & Schneider, 2023) and support nurses in the country's nurse based public health facilities (Mash et al., 2022). However, recently, it was estimated that 73% of the total listed GPs in the country work in the private sector. Some work in the private sector health service organisations such as private hospitals or medical insurances companies (Abrahams, Thani & Khan, 2022). Nonetheless, some of these private GPs do provide services to the public sector as sessional doctors (where they work in public clinics and are paid per hour) to alleviate pressure in the health system whilst still running their practices (Moosa et al., 2016).

The country's medical doctors, including GPs, must register with the Health Professions Council of South Africa (HPCSA) to practice in either the public or private sector. The HPCSA is a statutory body established under the Health Professions Act of 1974, whose vision it is to guide professions and protect the public from medical harm. One of the council's mission statements is to continuously engage its members and other stake holders (HPCSA, 2024). Some GPs are also members of the South African Medical Association (SAMA), which is an

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association whose vision it is to be the leading and preferred membership organisation advocating and supporting medical practitioners in South Africa. Unlike the HPCSA, SAMA membership is not mandatory for GPs (SAMA, 2024). The GPs in this study also revealed their thoughts on these two bodies.

General practitioners, therefore, are primary care medical doctors without specialisation, working in private practice, who provide services such as consultation, diagnosing, treatment, and referral of their patients for investigation. Provision of preventive services such as screening, immunizations, and diagnostics is also offered by these first line doctors. They also coordinate care with other health system components and social services (Baird et al., 2016). The GPs are further divided into licensed GPs who dispense medication whilst others are not licensed to dispense. Private GPs also play a role in referring patients to either private or public sector facilities for higher levels of care based on the patient's financial and medical insurance status (Perrow & Schneider, 2023). Some private GPs prefer to operate as groups whilst some are solo GPs (Mathew& Mash, 2019). One study that was done on private GP group practices found them to be mostly younger white GPs, mostly women and located more in city suburbs and small towns or rural town suburbia (Moosa et al., 2016). These group GPs were found to work for fewer days, saw more patients per day, charged a higher consultation fee and were more optimistic about their future in contrast to solo GPs (Moosa et al., 2016). According to Moosa et al. (2016), black solo GPs who worked in urban townships appeared to be experiencing poor practice conditions, although this was not elaborated further.

Access to exact GP numbers is challenging but recently, the Health Professions Council of South Africa (HPCSA) reported that about 29,000 medical practitioners were registered nationally on 1st July 2022 (Personal information with Y. Daffue, deputy POPIA/PAIA Information Officer HPCSA, Pretoria,12 July 2022). This information is a moving target, as numbers change frequently with some doctors emigrating, specializing and so on. A further breakdown of GP numbers according to recent private sector Medpages database, revealed a total of 15419 SA private GPs registered in their website, with most of these GPs in the metropolitan areas such as Gauteng (5308), Western Cape (3198), KZN (2461) as compared to rural areas like Limpopo (905). In the Cape Town metropolitan area, where this study is based, 2456 private GPs were listed (Medpages 2024). It is evident from these figures that most registered GPs work in the private sector and are concentrated in urban areas, reflecting apartheid's spatial legacies (Hongoro et al., 2016). It is concerning that township urban and rural areas show lower densities of medical practitioners (Competition Commission SA, 2018),

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particularly as the NHI seeks to utilize these unevenly distributed private GPs to improve access to quality healthcare for the entire population (Gaqavu & Mash, 2019).

This study focuses on private GPs in the black townships of City of Cape Town district, where private GPs provide services to underprivileged communities. A few years ago, an estimated 76% of the population in the city remained uninsured, receiving free public primary healthcare through provincial and city clinic services organized into eight Western Cape sub-districts (Western Cape Government, 2019). The remaining 24% of the population, who were insured, along with some uninsured individuals, who were willing to pay out-of-pocket, made use of private primary care providers (Perrow & Schneider, 2023). This percentage is slightly higher than the national estimate of 16% of the population that can afford private healthcare (Abrahams, Thani & Khan, 2022). Private GPs work in parallel to the public health sector within the health system as for-profit bodies (Delobelle, 2013).

2.2 National Health Insurance and private GPs

The South African health system is characterized by a pronounced two-tier structure, with a private sector operating in parallel to the public health sector. The private sector caters for 16% of the population who have medical aid and/or can afford to pay out of pocket while the public sector serves approximately 84% of the South African population (Govender et. al.,2021).

In response to these challenges, the South African government proposed the implementation of a National Health Insurance (NHI) system to address health inequities. The NHI aims to pool resources from the private sector to enhance public health services by contracting private GPs as servicw, 2021).

According to Moosa et al., (2016) who compared group and solo GPs attitudes towards NHI, it was found that black solo GPs in townships were more willing to contracting with the NHI, if their concerns are addressed. These practitioners, experiencing inferior working conditions relative to their suburban counterparts, were found to be more supportive of the NHI initiative (Moosa et al., 2016). Research findings indicate that GPs in SA can competitively contract in the NHI system, and NHI contracting should not be restricted to group practices. Moreover, the GPs interviewed in group practices demonstrated a strong commitment to teamwork and were receptive to utilising nurses more effectively within the NHI framework (Moosa et al., 2016). In the SA studies conducted, all GPs expressed support for NHI but expressed reservations regarding the state's capacity to implement NHI and were sceptical about their reimbursement and resource allocations. They also noted inadequate communication from the

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state to GPs concerning NHI (Gaqavu& Mash, 2019; Mathew& Mash, 2019; Moosa et al., 2016; Perrow, 2022). The GPs also pointed towards estimated high patient volumes in NHI which would reduce quality of care and push up management costs. The GPs in low socioeconomic areas, although more positive about NHI (Gaqavu& Mash, 2019; Mathew& Mash, 2019; Moosa et al., 2016; Perrow, 2022), were concerned that solo GPs would not be accredited (Gaqavu& Mash, 2019; Mathew& Mash, 2019; Moosa et al., 2016). General practitioners were pessimistic about working in a nurse-led primary care service, worried about loss of income (Gaqavu& Mash, 2019; Mathew& Mash, 2019; Moosa et al., 2016), and resultant emigration of younger doctors in NHI (Moosa et al., 2016). However, they recognized the need for training of GPs to re-orientate and upskill them for the imminent NHI (Mathew& Mash, 2019; Moosa et al., 2016).

In preparation for the universal cover, the government developed NHI pilot projects to run over a 14-year period (2012-2026). During this period, it emerged that transformation of policy development and implementation, transformation of systems and processes, establishment of public-private partnerships, making PHC work, and adoption of a systems lens were significant for NHI (Michel et.al.,2020). Strong political will, adequate human and financial resources, good co-ordination and communication and good monitoring were identified as effective for NHI. There was evidence of improved access to doctors where contracting GPs in the pilot sites was implemented and patients perceived this as improved quality of care (Health Systems Trust, 2019).

2.3 Reasons for choosing a career in medicine

As the world faces existing and forecasted shortages of healthcare workers including doctors, there needs to be an exploration into the issues influencing the choice to study medicine in low-income countries (Darzi& Evans, 2016). According to Joseph& Joseph (2016), an investment in health and healthcare workers not only improves lives but is also an economic good and this economic development is much more needed in the African continent which is the poorest continent in the world especially the sub-Saharan African region. Poverty in Africa was worsened by the corona virus disease of 2019 (Covid 19) pandemic as it now has affected 23 of the world's poorest countries, making the continent unlikely to meet sustainable development goal (SDG) 1 which is to end poverty in 97% of the population by 2030 (Aikins & McLachlan, 2022).

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Studies were conducted amongst African medical students (Katjinaani et al.,2024; Woodward et al., 2017; Mabuza & Ntuli, 2018) and Indian medical students (Zayabalaradjane et al., 2018) to elicit their reasons for studying medicine. The first-year student doctors in the African countries of Sierra Leone and Namibia revealed similar motivating factors for studying medicine. These were a desire to help people medically and yield positive results in patients' lives. They cited role modelling from other doctors, family influence especially from parents, peer influence and good job prospects as motivators to being a doctor (Katjinaani et al.,2024; Woodward et al., 2017). Other reasons mentioned for choosing medicine were interest from a young age and having intellectual acumen to study medicine in the Sierra Leone study (Woodward et al., 2017). Furthermore, community health challenges, family health issues experienced by the students, family support and motivation, compassion and desire to serve the health compromised influenced their choice to study medicine in the Namibian university research (Katjinaani et al.,2024). Another South African study of university medical students from 3 different universities was conducted from University of Cape Town (UCT), University of KwaZulu-Natal (UKZN) and Sefako Makgatho Health Sciences University (formerly MEDUNSA). These students, who were first year, and final year medical students were further differentiated into urban-origin students (UOS) and rural-origin students (ROS). They cited their main motivation for studying medicine as coming from parents, and from exposure to health care facilities and healthcare workers. These dominant motivators came mostly from the UOS. It was interesting to discover that parents who were healthcare workers were not so influential in convincing their children to pursue medicine. The influence of role models, friends, high school educators, mentors and tertiary educators in all the student participants did play a motivating role but had a lesser significance in the decision to becoming doctors (Mabuza & Ntuli, 2018).

In the Indian university study among first year medical students the main motivators to studying medicine were parental influence and the perception that doctors are well respected in society. Other mentioned reasons stated by these students for studying medicine were curiosity about the human anatomy and diseases, personal exposure to health services, interest in health research, viewing medicine as noble profession and deciding to do medicine as a challenge (Zayabalaradjane et al., 2018). Parental influence and students' personal exposure to health facilities were the common motivators in India and Africa.

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3 Chapter 3: Methodology

3.1 Research design

An exploratory descriptive qualitative study was used to elicit the experiences and perceptions of private general practitioners in providing care in Cape Town townships (Robson& McCartan, 2016; Sutton,2015). According to Robson (2016), this 'real world' approach is interested in getting rich results and is focussed on participants' perspectives. The GPs' perspectives became central to this research typology, which utilised words and open-ended questions during the interview process to explore the perceptions and experiences of private GPs (Creswell, 2014). This qualitative research collected and analysed rich data in the GPs natural context with the researcher being reflexive and responsive, ready for unexpected findings and results (Sutton & Austin, 2015), using a diary and audiotape, constantly documenting and relistening, and inwardly reflecting throughout the study (Cresswell & Miller, 2000).

3.1.1

3.1.2 Study population and sample

In this qualitative research study, the population of interest was private GPs in Cape Town, from which the study population of GPs who meet the specified criteria was drawn (Willie, 2022). The study population was solo private GPs practicing in the seven black townships of the City of Cape Town district namely Khayelitsha, Gugulethu, Langa, Nyanga, Philippi, Dunoon and Masiphumelele. The adopted inclusion criteria for participants were solo private GPs who work in the mentioned townships and solo private GPs in the City of Cape Town black townships. The study excluded participants who were locum doctors working for GPs, private GPs in other WC districts or coloured township GPs.

It is from this study population that a sample of 12 GPs practising in these townships was selected from the social media group they belong to, also including the snowball recruits. As there is no register for these GPs (Competition Commission, 2018, p. 40), convenience sampling was used to select GPs from the social media group consisting of Cape Town's 18 Black township GPs that the researcher also belongs to. This type of sampling enabled practically quick and easy access to available GPs on the social media group platform (Scholtz, 2021). Whilst being aware that this sampling method would create substantial selection bias, it was the only feasible approach, given the lack of geographic and contact information on GPs,

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time constraints and the scope of the study (Vehovar, Toepoel & Steinmetz, 2016). Purposeful sampling was also used to gain in depth understanding of GPs thoughts, gain rich information from the small sample targeted within the context of scarce information available on township GPs, for a rigorous study (Campbell et al, 2020). There was deliberate over-selection on the assumption that not all GPs will make themselves available to participate in the study. Additionally, snowball sampling was used to identify other GPs who fit the inclusion criteria as fewer than 12 GPs agreed to participate (Kirchherr & Charles, 2018), as a research quality control measure. As the study was conducted in 7 townships the initial intention was to interview 14 participants selecting 2 GPs in each township of both sexes. This was impossible as the larger townships like Khayelitsha had more GPs who were also willing to participate, so the sample size of 12 was sufficient as all the townships were represented.

Access to the GP population (which the researcher is part of), and recruitment of participants was through a GP social media mobile group containing contact details of black township GPs. This GP group was formed by a group of black township GPs who wanted a platform to share experiences faced by black township GPs. The researcher was recruited by another GP from the township she works in, and this group grew in number over the years through word of mouth. All the GPs were solo GPs of both sexes mostly servicing City of Cape Town district areas and one GP in the Cape Winelands district. At the time of interviews, there were 18 GPs in the growing social media group called black doctors forum. The recruitment process identified potential participants, targeted, and recruited them. Information about the study was posted in the social media platform for all the 18 GPs whilst also establishing their interest in the proposed study. As some of these GPs declined the invitation thereby reducing the participants' numbers to below 12, the willing participants recommended other GPs within the criteria and the snowball sampling method was undertaken to recruit additional GPs. All the 12 GPs who positively responded were also contacted individually by telephone to thank and encourage them to participate in the study, which was briefly explained.

3.2 Data collection

In-depth interviews were the data collection method of choice, as conversations were needed with the GPs to elicit detailed accounts of their experiences and perspectives. This collection method also allowed the researcher to clarify the participants' answers and at the same time gave participants freedom to elaborate on questions asked and raise additional points they considered important in the context of the interview (Sutton & Austin, 2015).

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A semi-structured interview guide consisting of open-ended questions for the 12 GPs was utilised, with interviews conducted face-to-face for approximately an hour with each respondent. A list of questions to guide the interview was prepared, with the interview style semi-structured and conversational. The questions were open ended and allowed respondents to provide rich data (Adams, 2015). Those GPs who agreed to participate in the study received the participant information sheets and consent forms through email to peruse and sign. Their times of availability for an interview were asked and noted down.

The questions asked in the interview guide were based on research questions. The opening question was on the GPs background, their decision to become doctors and their experiences of being township GPs. It was important to understand their various backgrounds to ascertain their choice of being township GPs. It was also to put them at ease and be able to provide rich data about their choice and experiences in townships. The next topic to be explored was on their current role in the health system, to get them to explain their understanding of their role within the two-tiered health system. This was to enable them to converse about their interaction with the public and private sectors. After this topic came the discussion about the imminent NHI which was intended to elicit knowledge about NHI plans for GPs and their thoughts on NHI. This topic was unavoidable as NHI intends utilising GPs for increasing access to quality care. Next came the questions about the state and how it can strengthen and support their work in their current context. This was to allow GPs to ventilate about government processes affecting them and give suggestions on how to form effective public-private partnership to improve public health. Questions were also asked about regulatory bodies HPCSA and SAMA and the role they play in township GPs.

The interviews were conducted in the doctors' rooms by the researcher and her assistant with 3 of the GPs, and the remaining 9 GPs were interviewed outside their rooms over weekends in public spaces in suburbs. This change followed safety concerns and unavailability of GPs for interviews during work hours. The interviews were about an hour to 1-hour 50minutes long, face-to-face with the GP, with the researcher taking down notes and audio-recording the interviews on permission. The assistant was also taking down notes, noting non-verbal cues, observing for researcher bias, and later commenting on researcher's data collection, analysis, and interpretation. Interviews were conducted in English. The assistant was later unavailable after the fifth interview due to her study commitments and logistic problems.

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3.3 Data analysis

Detailed notes were made by the researcher from all the interviews and the recordings. Verbatim transcripts were obtained and checked against the recording tapes. The recordings were relistened to by the researcher and the assistant, to enable the researcher to make detailed notes, which were shared and discussed with the supervisor. The supervisor cautioned against researcher bias emphasising reflexivity and advised on how to organise, code and categorize the data. Member checking was done by the researcher by contacting the participants to validate some of the unclear data obtained. Reflexivity was enabled by the assistant after every interview and by the researcher herself prior and during interview process. Themes started emerging from the data collected through an inductive process, deriving meaning from the collected qualitative data, from the recordings and notes. Data analysis started during data collection, as is common in qualitative research, as the researcher mentally questioned the data being collected from GPs, comparing it to data previously provided by other participants and analysing it. A diary was documenting this process.

The preferred framework approach used for data analysis has 5 stages which are (i) familiarisation (repeatedly listening to the recordings and reading transcripts to list key ideas related to the research question), (ii) identifying a thematic framework (identifying all key issues by which data can be examined), (iii) indexing (applying index systematically to all data in textual form), (iv) charting (rearranging data to the appropriate part of the theme) and (v) mapping with interpretation (using charts to provide explanation for the findings) (Pope, Ziebland and Mays, 2000). The framework approach entailed reviewing transcripts, recordings, as well as the notes of both the researcher and the assistant, of the interviews with the GPs and listing key ideas about GPs' role in DHS.

Thematic coding analysis (TCA) was used to manually analyse data and highlight sections of text expressing a specific opinion to produce descriptive codes. Coding starts with identifying parts of the data that represent something of interest related to the research question. The similar coded data was labelled with codes of the same label then grouped together to identify a theme. The themes emerging from the data were further analysed to interpret the data, grouped together, and produce a global theme that explains the findings. The researcher reviewed the produced themes to ensure that they reflect the data. Meanings were derived from the themes and allowed for interpretation of data to draw conclusions from it and provide insights on the research question (Robson & McCartan, 2016).

https://uwcscholar.uwc.ac.za/home

3.4 Trustworthiness

A trustworthy study minimises bias (Robson & McCartan, 2016) and according to Lincoln & Guba (1985) the criteria for establishing trustworthiness in qualitative research is credibility or validity, dependability, confirmability, and transferability in the study. Trustworthiness assists in establishing standards for critiquing qualitative research and determine integrity of the study (Johnson, Adkins& Chauvin, 2020).

The topic of this study was found to be significant to the researcher as she found her role as a GP poorly understood. The intention was to create awareness about the reality of being a suburban GP in townships at the backdrop of the proposed role GPs will play as quality service providers in the imminent NHI. The researcher's objectivity on the study and constant alertness to researcher biases which ensured validity (Cresswell & Miller, 2000), was a challenging exercise. In this study the researcher declared her role of being a current black township GP and maintained reflexivity throughout the study. There was constant need to avoid researcher bias during the interviews as these were not only colleagues but also peers. The assistant was tasked to observe bias during the interviews and to report on them after interviews. It was quite challenging to be reflexive throughout the study on the researcher who is a current GP, but the assistance of the reflective diary, supervisor, assistant and peer debriefing made it possible. It must be noted that the researcher is a clinician with no prior experience in qualitative research and found the tools for establishing trustworthiness highly beneficial.

Whenever there was doubt about collected data, member checking was done by reverting to the participants in the study with the questionable data and interpretations to verify the credibility of the information, also giving them a chance to comment on the data and narrative. In this study GPs were given an opportunity to comment if their responses were incorrectly understood by the researcher. An audit trail was utilised where the research steps were clearly documented by the researcher in a reflective diary, and kept notes (Cresswell & Miller, 2000). The audit trail was to ensure that findings are based on the GPs responses not the researcher's biases to ensure confirmability and support transferability of methods and approaches (Robson& McCartan, 2016).

A detailed description of the setting and participants was given to enable the reader to understand the setting making them feel familiar to the situation described, supporting validity and confirmability. This also allowed readers to decide if the study process or findings are applicable to other contexts (Cresswell & Miller, 2000), a term known as transferability.

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Frequent debriefing was done with the supervisor who criticked and advised throughout the study. Immediately after each interview there was also debriefing with the assistant noting biases and relistening to the tapes and correcting written notes.

3.5 Ethical considerations

Ethics approval was obtained from the University of the Western Cape (UWC) Biomedical Ethics and Research Committee (BMREC) prior to commencement of the study.

An invitation to participate in the study was sent to all the GPs in the social media group and to those outside the group identified through snowballing. The research study was explained to the GPs together with the aim and objectives. It was also emphasised that participation was voluntary and that at any point a respondent experiences discomfort they can withdraw from the study. It was further explained that if a participant experiences any discomfort during or because of the interview, access to professional support will be facilitated by providing the participant with details of appropriate professionals that can help. The participants were informed that confidentiality will be maintained and information of specific location and names of GP or GP practices will be converted to a pseudonym known only to the researcher and the supervisor. The GPs were asked to recommend any other GPs outside the group who fit the inclusion criteria.

A participant information sheet was sent to respondents to assure the respondents of confidentiality. A consent form was sent to respondents to sign before interviews and permission to make audio-recordings of the interviews was sought from the participants. During the data collection and analysis steps, electronic and hard copies of data were generated. The electronic data produced during the audio recordings was saved on a flash drive and securely stored. Hard copies of signed consent forms and transcripts were also securely stored. Electronic versions of the transcripts used during the analysis stage were saved on the researcher's computer that is password protected and known only to the researcher. During the interview, participants' names were not audio-recorded and/or written down. These were converted to a pseudonym known only to the researcher and supervisor and saved on the researcher's computer. The list of identifying codes were kept separate from the interview data, and both will be kept in secure, password protected folders.

In terms of the requirements of the Protection of Personal Information Act (Act 4 of 2013), personal information was collected and processed. This was included in the Information Sheet

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so that participants be informed on type of personal information that will be collected, processed, stored, protected, and eventually destroyed after five years.

4 Chapter 4: Findings

4.1 Introduction

This chapter presents findings of the study starting with the demographic characteristics of GPs and life histories. Their paths before, during and after medical school were traced up to their current GP contexts. They explained their reasons for working in townships and their impact on the communities they service. The study delved deeper into the rewards and challenges experienced by GPs in these spaces and went further to explore GPs collaboration with public and private sectors including traditional health practitioners. The GPs also commented on NHI, and professional bodies HPCSA and SAMA. These doctors later were given platform to advise the state on health system strengthening. The data from the interviews provided a better understanding of private GPs perceived roles in PHC provision within the DHS and their current experiences of working in Cape Town's black townships.

4.2 Characteristics of the interviewed general practitioners

Six of the participants were male and six were female. All participants could speak, read and write English, and Xhosa was the vernacular of majority whilst one was a Sotho and Xhosa speaker. Their ages ranged from 49 to 67 years. Of these, one GP was in the age range of 40-49 years (GP 8), nine GPs in the range of 50-59 years (GP 1, 2, 3, 4, 5, 6, 7, 9, 10) and another two GPs in the 60-69 years age range (GP 11& 12). Nine of the GPs were from Eastern Cape mostly rural areas, and three were raised in townships. Of the latter, one GP was from Mdantsane township in East London (GP 8) with two from Cape Town townships of Langa (GP 3) and Gugulethu (GP 1). (See table 1)

Table 1. Key characteristics of interviewed general practitioners

General Practitioner	Age group in years	Gender	Origin	Number of years as GP in current practice

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1	50-59	Female	Gugulethu township	12 years
2	50-59	Female	Rural Eastern Cape	17 years
3	50-59	Female	Gugulethu township	19 years
4	50-59	Male	Rural Eastern Cape	30 years
5	50-59	Female	Rural Eastern Cape	19 years
6	50-59	Male	Rural Eastern Cape	23 years
7	50-59	Male	Eastern Cape town	10 years
8	40-49	Female	Eastern Cape township	2 years
9	50-59	Male	Rural Eastern Cape	25 years
10	50-59	Male	Rural Eastern Cape	25 years
11	60-69	Male	Rural Eastern Cape	31 years
12	60-69	Female	Rural Eastern Cape	21 ears

4.3 Journey to becoming a doctor

4.3.1 GP backgrounds and motivations

Five of the GP s decided to be doctors at high school level (GP 1, 3, 4, 6, 9) whilst four decided as early as primary school level (GP 5, 8, 10, 12) and three decided at tertiary level (GP 2,7, 11) (see table 2 below).

It was interesting to learn that one GP wanted to be a doctor at a very young age. She said,

" I knew I wanted to be a doctor from the age of 6" (GP 8 interviewed on 24 May 2023).

This was her childhood dream as she said she likes interacting with people and helping people. However, most GPs decided at high school level(n=5) and primary school level(n=4) to become doctors. Only 3 doctors were convinced to be doctors at university.

Role modelling was a significant factor in motivating the GPs to become doctors. There were two GPs (GP 3&8), whose mothers were nurses and role models. GP 8 further explained that her father was a sweet factory laborer, and her parents later divorced.

One GP decided to become a doctor during his laboratory technician job in a hospital, motivated by the hospital's doctors (GP 7). Role modelling also came from their local doctors from their hometowns in six of these GPs (GP 4,5, 6,7,12) whilst parents of four GPs (GP 2, 3, 8, 10), and educators of one GP (GP 1) were also instrumental in motivating some of the GPs. GP 5 explained how she appreciated the services her local doctors gave to her sickly grandmother,

https://uwcscholar.uwc.ac.za/home

'I liked it. That motivated me and fortunately I had the brains for it." (GP 5 interviewed 16 April 2023).

Only one GP (GP 9) had no motivator but chose medicine out of curiosity to learn the seemingly challenging degree whilst GP 11 got motivation from political activists during apartheid years whilst studying BSc. GP 11 studied medicine pre-1994 during the country's apartheid years. This is what he said,

"At the university, political activists decided that those people who are able(academically) must be channelled towards medicine because ultimately doctors will be needed in the struggle (SA s liberation struggle) and even after the struggle. Some of the people left the country in the middle of their medical studies for exile in other countries and completed it there. They are back now as doctors" (GP 11 interviewed 23 July 2023).

4.4 The journey towards medical school

Table 2. General practitioners' journey towards medical school

General Practitioner	Financial assistance for medical school	Motivation to study medicine	Pre-medical school qualifications	Work experience before medical school
1	State funding	High school educators	Nursing degree	Nursing
2	Private funding	Parental	Nursing degree	Nursing
3	State funding	From mother who was a nurse	BSc	None
4	State funding	Local doctors	1st year BSc	None
5	State funding	Local doctors	Radiography	Teacher assistant, later a radiographer
6	State funding	Local doctors	BSc	Unskilled labourer and later a teacher
7	State funding	Local doctors	B Tech	Laboratory technician
8	State funding	From a mother who was a nurse	BSc	None
9	State funding	None	None	None
10	State funding	Parents	BSc	Unskilled labourer
11	State funding	Political activists	1st year BSc	None

https://uwcscholar.uwc.ac.za/home

12	State funding	Local doctors	None	None

The road towards MBChB was long for most of these GPs, with detours into unskilled labour for some, BSc degree, teaching, nursing profession, radiography, laboratory profession before finally landing in medicine. There were only two GPs who went straight to medical school after matric (GP 9,12).

Some of the study participants had previous work experience before studying medicine (GP 1, 2.,5,6, 7, 10), driven by lack of funding for tertiary studies. One GP started working as petrol attendant after high school and later as security guard (GP 10), one was teacher assistant (GP 5), and another was a salesperson in a hardware store (GP 6). GP6 completed matric with flying colors but didn't have university funding and so opted for a hardware assistant job, as his mother was a domestic worker. That was where he was spotted by his previous educator, who came shopping into the store and later assisted him with funding for a science degree in education. He said,

"I didn't have money for university. Then I had to go to Mthatha to look for a job (Mthatha was the capital of Transkei then), after grade 12. I worked in a hardware in 1987 earning R250 per month and didn't even have bus fare to go home so I would collect used tickets at the bus rank and use them to board the bus." (GP 6 interviewed on 4 May 2023).

Another one said,

"Immediately after high school I was a petrol attendant at Shell actually[laughter] and the second year thereafter, I worked as a security guard. And thereafter I came to UWC. I did very well in BSc majoring with Chemistry and Biochemistry. Whilst in UWC final year I decided to apply for medicine. Companies would come to interview us at final year BSc and offer us jobs. So, SAB (South African Breweries) offered me a job to be a brewery[laughter]. Anyway, UWC offered me honours post for Chemistry and when I was about to assume that position, I got admission letter from Medical University of South Africa (MEDUNSA), and I dropped everything[laughter]. It was 1991." (GP 10 interviewed on 23 July 2023).

The three GPs (GP 5,6,10) who started as unskilled laborers after grade 12 later pursued science degrees and subsequently went on to study medicine. In total seven of the GPs started with science degrees (GP 3, 4, 5, 6, 8, 10, 11) at tertiary level and two were nurses (GP 1, 2) before studying medicine. GP 1 worked as a nurse for 12 years before pursuing medical degree. This is what GP 3 said,

https://uwcscholar.uwc.ac.za/home

"Ehh my journey was not a smooth one because during those apartheid years you couldn't get in straight to medicine. So, most of the time you would be taken via BSc (Bachelor of Science), so I went for BSc first." (GP3 interviewed 04 March 2023).

A completed BSc degree was apparently another pre-requisite for entry into medical school pre-1994 as narrated by GP 3.

One of these GPs studied a funded science degree in teaching and became an educator (GP 6), and another had a laboratory technical degree before pursuing medicine (GP 7). This is what GP 7 said about assistance from his working siblings as his parents were already pensioned,

"Yes, my (working) siblings came through for me and finally I got a bursary in my 4th year of study and things started becoming easier then. Lack of sponsorship and funding really affected my (medical) studies but due to determination I was able to soldier through." (GP 7 interviewed 06 May 2023).

There was also a female GP (GP 5) who worked for a year as a teacher assistant after matric, went on to study BSC for a year and dropped out due to lack of funding. It was during her science studies that she was recruited by a private company for funded radiography studies, and upon qualifying for radiography was accepted to study medicine. She only practiced radiography during her first year of medicine as a sessional night duty radiographer to complement her funding for the medical degree. Her subsequent years of medicine were fully funded by the state. Eight of the GPs faced serious financial challenges during their journey towards medical studies and some had to work for some time before medical school (GP 1, 2, 5, 6, 7, 8, 9,10).

4.5 The path through medical school

The path through medical studies was marred with financial challenges for some GPs. One GP (GP 2) who started with nursing career commented that she had multiple loans to pay after completing her medical studies as she had no government funding throughout her medical studies. Another GP (GP 8) faced more financial problems after her parents separated whilst also expecting her first-born child in medical school, to the extent that she got assistance from other postgraduate colleagues. She said,

https://uwcscholar.uwc.ac.za/home

"The issue is I fell pregnant when I was studying medicine. I had a Department of Health (DOH) bursary and National Student Financial Aid Scheme (NFSAS) who wasn't paying 100% and my worst struggles were in my 4th year because my dad who was sending me R400 per month retired and my mom was pensioned as well. So, I didn't get much financial support from my parents" (GP 8 interviewed 24 May 2023).

A few participants experienced academic challenges early on in their medical studies, which were attributed to adjustment issues from rural to city life, sudden independence from parents (GP 12) or curriculum change (GP 4&7). A GP with no previous work experience or academic degree said,

"Everything was also a culture shock, and I came from a strict family, and now I found myself in a city with freedom to move around and learn new things" (GP 12 interviewed on 27 August 2023).

A GP with previous work experience in laboratory technology said,

"Academically the 1st year was tough and because I had a background in the medical space, I thought I'd sail through. But lo and behold, I found it very tough, with those physics and chemistry. After 1st year I knew nothing could be tougher than the 1st year, so I really sailed through." (GP 7 interviewed interviewed 06 May 2023).

These academic issues were quickly overcome by the few who experienced them as they saw these threatening their prospects of becoming doctors. One of the GPs who had no academic challenges but with previous work experience and BSc said this about medical school,

" No, I didn't fail. Remember I was already mature, so I knew very well what I came there for." (GP 6 interviewed 06 May 2023).

One GP who started medicine pre-1994 mentioned institutional racism experience in University of KwaZulu-Natal (UKZN) medical school which led to her joining Medical University of SA (MEDUNSA) which she found fair and accommodating to black students. She said,

"I only passed one course at 1st year. There was a white science lecturer who would deliberately fail us, and this was well known even by his previous students. He discouraged us from being doctors. Racism was systemic at UKZN, so we decided to leave for other universities. Most students applied to study overseas through SA Council of Churches (SACC) to escape institutional racism" (GP 12 interviewed 27 August 2023).

https://uwcscholar.uwc.ac.za/home

4.6 From medical qualification to current role

The moment a medical doctor completes the medical studies in SA, another three clinical years are required to work in a state hospital, first as an intern (two years) and then as a MO (one year, also called community service). Completion of the community service allows a doctor to become an independent practitioner (Reid et al., 2018). Thereafter the doctor can choose to work anywhere or specialise (Brits, Bezuidenhout & van der Merwe, 2020).

After obtaining the medical degree, five of the GPs were interns at Eastern Cape hospitals, and five in Cape Town hospitals. One did an internship in Pretoria and another in Natalspruit hospitals. Seven of the GPs were MOs at Eastern Cape hospitals whilst two were MOs in Cape Town and two were MOs in both Eastern Cape and Cape Town. One GP was MO at both Limpopo and Mpumalanga provinces. These GPs finally settled in Cape Town and currently practice in black townships in the city.

On being asked about her post-MBChB clinical years at state hospitals GP 5 said, she worked at,

"PE (Port Elizabeth) provincial and Livingstone hospital (Eastern Cape). But that's a complex. That's where I did my internship and comm serve (community service) (as MO). Afterwards I came to Cape Town, GF Jooste (hospital) (as MO)" (GP 5 interviewed 16 April 2023).

Financial constraints were again mentioned as reason for GPs (5,7&11) to work elsewhere prior to opening their own practices.

GP 5 had started as an MO in Eastern Cape and later continued in Cape Town and has been a GP in Cape Town townships for 19 years. GP 11 went to specialise after completing his community service in hospital and soon dropped out of the programme due to financial pressures and went into a group GP township practice and later went solo 31 years ago. GP 8 also remained in public sector as senior MO (SMO) in Cape Town day hospital and later joined the corporate sector as administrator for medical aids and finally opened her GP practice two years ago. The rest of the GPs also spent some time in public sector as SMOs, before opening their own practices or spent some years as locums for other GPs (GP 8). One worked for a clothing industry medical centre, whilst building her own practice (GP 3). These delays in opening their own practices were mostly due to the need to save funds to open a practice. Three

https://uwcscholar.uwc.ac.za/home

interviewees started their own GP practices in other cities, before opening practices in Cape Town townships (GP 4, 6, 12).

GPs (2, 3, 11) wanted to specialise in obstetrics and gynaecology, paediatrics and internal medicine respectively. GP 2 got married and had children whilst waiting for a registrar post from the military and she said,

"They (the military) took so long and then I said let me start and do the GP work. Then after some time after few years then I will go and study, but in the middle, I get married, children and then I couldn't leave my children I love children so much I couldn't leave my children" (GP 2 interviewed 17 February 2023).

She (GP2) then started a GP practice.
GP 3 separated from her husband and left him to raise her two children alone, and start a township GP practice working after hours, whilst also working at the clothing industry.
GP 11 started GP work but wanted to specialise. He said,

"During that time, I had also applied to specialise at UCT, so I was accepted and had to work 6 months at Livingstone Hospital in Gqeberha as a registrar in medicine but extended my stay to 2 years, but I dropped out due to financial responsibilities. So, I came back to run a GP practice in partnership with other GPs but in 1992 I went solo" (GP 11 interviewed on 23 July 2023).

4.7 General practitioners' reasons for working in the townships, their views on how they impact the community and how they see their role in the district health system

4.7.1 Reasons for working in townships

The interviewed GPs presented various reasons as to why they chose to work in townships. Most of these were service related. One GP said she opened her practice in the township "*as a service to her people, the black people."* (GP 1, interview on 11 Feb 2023). She explained that *"her people"* meant the community she was raised in, as she grew up in one of Cape Town's black townships. This view was shared by GP 3 who grew up in Cape Town's townships who expressed that she chose to work in the community that raised her to provide much needed services there. They all saw themselves as quality service providers in disadvantaged areas and this service was provided at an "*affordable fee"* according to GP 9.

https://uwcscholar.uwc.ac.za/home

GP 2 who had previously been a township nurse, chose the township after identifying a demand for GP services, whilst viewing herself as a resource in the community. She left nursing because she felt restricted and limited in her role as a nurse when seeing patients and was always dependent on the doctor. She said,

"Our people die not because they are supposed to die but because of scarcity of resources. I, myself was going to be the resource in the township. I understood township life very well." (GP2, interview on 17 Feb 2023).

There was one GP, (GP6) who also identified a demand for his services in the township and saw no need to open a practice in the city's suburbs where there would be fewer potential clients. He found no barrier in a black township as his clients share his norms, values and language. This is what he said,

"So, the reason for me to open my surgery in the location is because it is my people, it is my client. I would never get clientele in the white suburbs. If I were to open in the white suburbs, no person would ever think I would cure them unless in times of emergency where they would have no option..." (GP 6, interview on 4 May 2023).

Another GP, (GP 9) said he opened a practice to save patients from the long hospital queues by offering people alternative services at an affordable rate on their doorstep. He had previous experience of being a medical officer in the local day hospital and could see the long waiting times the locals experienced and took the opportunity to open a practice as an alternative for the locals.

Financial gain was mentioned as an incentive to opening a township practice by two GPs, (GP 8&12) who work in the populous Khayelitsha. GP 8 said that while she

"Wanted to make an impact in the community by providing good health outcomes in a black marginalized area.", she also said that "if you're looking at the population size thinking now businesswise you will definitely get more clientele in the location, yah" (GP 8 interviewed on 24 May 2023).

Although a few GPs mentioned financial incentive as reason for setting up a township practice (GP 8&12), this was not expressed by the rest of the interviewed GPs. GP 8 thought that an overpopulated township would make business sense, but one mature GP offered a contrasting view on this narrative that GPs are rich and said,

https://uwcscholar.uwc.ac.za/home

"You can't make millions of rands in the township. In fact, medicine as a whole is a service not a business. They(patients) expect every service and see you as a 1 stop shop. In the township patients expect you to mother them, treat, counsel, dispense and so on. But for you to achieve that financial reward you have to work 2 or 3 times harder than the urban doctor, because here people don't have money, so you find most of the time you are just donating most of the services (GP 12 interviewed on 27 Aug 2023).

4.8 How general practitioners view their impact on the communities they serve

All the GPs felt their impact to these communities was huge as they received good reviews from the patients. They all said they see themselves as an asset to the communities they serve because of the quality service they offer which earns them good reviews. Ultimately this would result in outward ripple effect to create a healthier community albeit in a small scale.
A male GP made this comment,

"That is what sustains me there (in the township), being genuine and people love that." (GP 6, interviewed on 04 May 2023).

He also prided himself for offering patients quality medication equitably regardless of their financial status. GP 3 thought she makes a difference in the community by providing patients with acute medication which the state cannot afford, whilst GP 4 saw himself as a role model for other people in the community thus creating a positive impact on community health. He also saw presence of a GP in the township causing a positive shift towards the medical world as for example community members now no longer see tuberculosis (TB) as a spell of witchcraft like in the olden days, but as a curable medical disease.
GP 8 was confident of her services and said,

"I know I do have an impact in terms of their health due to their clinical outcomes. I've seen some of the patients' good outcomes that have been educated on importance of compliance." (GP 8 interviewed on 24 May 2023).

Another GP, (GP 10) felt he was making positive change in the community due to his quality service. He said,

"From where I'm sitting, I can see I am making a difference (in the community). Although I'm based in (Nyanga), I think my services are being sold outside my township. I've got

https://uwcscholar.uwc.ac.za/home

people coming from the Eastern Cape. People are seeing the difference and calling others from Eastern Cape." (GP 10 interviewed 23 July 2023).

GP 12, who also involved herself in youth mentoring and community donation, saw that as social upliftment of the community which has a positive impact on his serviced community. She also mentioned employing the locals in her practice, thus reducing township unemployment.

4.9 How the general practitioners perceive their role in the district health system

All the GPs mentioned their role of linking their patients to public and private health facilities as health system strengthening, thereby reducing morbidity and mortality in the City of Cape Town district. These GPs understood that their work as primary health care providers at community and health system interface places them at key point of patient linkage to the DHS. Thus, they mentioned their contribution to relieving the overburdened health system and connecting patients to the DHS facilitating public-private partnership between GPs and the DHS. To these GPs they are strengthening the health system by this action.

Some GPs also saw their role not only as curative and preventive in the medical sense, but also as community activists, health promoters, educators, social workers, advocates and addressing social determinants of health. Their role was understood to being multifaceted and likened to stakeholder role in the DHS.

GP 2 said her role in the system is

"To reduce mortality in the township and to…to make them(patients) understand the gravity of their illness" (GP 2 interviewed 17 February 2023).

This reduced mortality according to her, would come about from her quality service and her education to patients about their diseases.

GP1s role was expressed as being a consultant to people of different age groups in her area. She saw her role as curative towards babies up to the elderly in the township. Another GP, (GP 3) spoke about her role as applying continuity of care to her patients as she follows them up throughout their life cycle, so they are not lost in the system. She also prides herself in providing quality service to the locals in the district.

It was GP 5 who said,

" We are assisting the DHS by reducing patient numbers in public(sector)." (GP 5 interviewed 16 April 2023).

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GP 5 also believed her other role as advocating for seriously ill patients to be admitted at tertiary hospital through bypassing the referral system, whilst GP 2 said this about her advocacy role,

"Sometimes I took patients straight there(to hospital) especially those who are critically ill because I know if I write a letter nobody cares but if I come in with the patient and then go straight to the doctor and say can you please attend to this patient and if you don't, I will lose this patient and I am not ready to lose this patient." (GP 2 interviewed 17 February 2023).

GP 7 saw himself as service provider bringing PHC, saving people from travel costs by bringing convenience at their doorstep. He also mentioned GPs' gatekeeping and sorting role. He said,

"Although we may not be glorified as other colleagues in the public or private space, we really reduce the load burden of patients both in the private and public hospitals. We are the gatekeepers; we channel who goes to hospitals and who does not. Otherwise, the public sector would be overburdened if we were not there especially in our disadvantaged areas." (GP 7 interviewed 06 May 2023).

GP 8 said her primary focus is preventive care and believes prevention is better than cure and promotes health to her community. Her role was seen as providing a lot of wellness and education, screening, and quality care. She said,

"My primary focus there is on preventative care, so I do that through awareness, education as I believe in prevention is better than cure. It's so unfortunate that the healthcare system is so overcrowded. My practice is close to Khayelitsha district hospital which is overcrowded. So, most patients who could have gone there (KDH) come to my practice and I know I do have an impact in terms of their health due to their clinical outcomes. I've seen some of the patients' good outcomes that have been educated on importance of compliance. I have emphasised the importance of adherence and compliance with my chronic patients. I do a lot of wellness and education so that patients understand that screening is preventive. I am an asset to them and I'm not just saying this but because I do get feedback." (GP 8 interviewed on 24 May 2023).

GP 10 also added the role of being a health promoter to the community as he promotes good health by offering additional screening services.

GP 12 said,

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"You are first line doctor for everything, so you are everything. And I am grateful for my MEDUNSA training in a disadvantaged community because it prepared me for exactly where I am right now. With us having trained in MEDUNSA I encompass all aspects of the patients and their socio-economic issues as well." (GP 12 interviewed 27 August 2023).

She further explained about the educational talks she conducts to youth about contraception whilst also mentoring them and donating to the local clubs. She said,

"I also employ the locals in my practice and do community upliftment projects by mentoring the youth and donate to the community project." (GP 12 intervi+ewed 27 August 2023).

4.10 Rewards and challenges

4.10.1 Rewards

Rewards reportedly come in the form of patient satisfaction, when patients' conditions improve and this was mentioned by GPs (GP 2,3,4,5,7,8,11). One GP said,

"So, if for a day you feel you have helped at least one soul, it doesn't matter what it is, the intervention, it makes the stay worth the while." (GP 4 interviewed 18 March 2023).

The GPs also mentioned warmth, acceptance, trust, and protection by community as rewarding (GP 7,8,10,11).

This is what the newest and youngest GP said about rewards,

"Ehh for me it's the love and support from the community members. Even though I opened 2years ago I see the support I get from the community as I now see around 60 people a day. I'm getting support because of the good clinical outcomes" (GP 8 interviewed 24 May 2023).

The eldest and longest serving GP 11 spoke of being embraced by the community who even protect him from outside criminals. Similarly, GP 10 mentioned his community as being protective to him. He said,

"That element of being accepted by the community, I feel looked after by the community although there are elements of crime." (GP 10 interviewed 23 July 2023).

Being thanked by grateful patients is another reward appreciated by the GPs, GP 11 said,

"At the same time, it's quite rewarding when you see somebody you have helped because they become thankful" (GP 11 interviewed on 23 July 2023).

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4.10.2 Challenges

Crime seemed to be the greatest challenge, creating unsafe work environment. Doctors reported that they are constantly robbed at knife or gunpoint and their practices burgled at night to steal their equipment (like computers) and medication like face creams. These robberies were experienced by all 12 GPs and mirror the personal experiences of the researcher.

"Crime is up to the neck and every day we are afraid, worried. We never know what will happen to you" (GP 6 interviewed 04 May 2023).

"We really go there knowing that you might not go home neh? But you think about the people that you service neh?" (GP 7 interviewed 06 May 2023).

One mature female GP (GP12) expressed safety issues in her work context as she sometimes works till late. She experienced armed robbery at gunpoint many times and found SAPS to be unsupportive and not responsive. She has now upgraded her security features, and this has deterred criminals.

Some GPs (3,5,10,11) complained about patients who come and ask to be seen on credit as they have no money. One GP said she is operating a risky business financially,

"It is risky. Unless [pause], because some of them don't have money." (GP 5 interviewed 16 April 2023).

GP 3 commented on the culture of non-payment by these patients,

"At the beginning I let them come on credit especially the old ladies, I thought they were honest and would come and pay me after their pension grant day. Yho haai /oh no/, they are actually so dishonest…" (GP 3 interviewed 03 March 2023).

Many GPs also complained of short payment, late payment or non-payment by medical aids creating financial constraints for them These GPs were GPs 2,3,6,8,10,11& 12.

GP12 said,

"Unfortunately, doctors never have a say on medical aids, they are being dictated on by the medical aids. Even the (charge) rate was determined by the BHF (Board of Healthcare Funders)" (GP 12 interviewed 27 August 2023).

Medical aids were further accused of spying on doctors by GP 6,7 & 10 as one of them said,

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"There's a new thing trending now, spying on black doctors by medical aids. They would send someone as a patient with a hidden camera and say go to doctor so and so and hide the camera in your weave or spectacles. They want to see if you have examined the patient or the sick certificate you have issued is it legit. Thereafter you are summoned to their (medical aid) offices and threatened with erasure from the HPCSA roll or pay an exorbitant amount. Of course, the poor GP is cornered and pays!" (GP 6 interviewed 4 May 2023).

4.11 Collaboration with health sector and other stakeholders

4.11.1 Collaboration with public sector facilities

It was found that all the GPs refer patients to private and public health facilities, and to both hospitals and clinics. In GPs' private practice it is common to see both medical aid and cash clients (Perrow & Schneider, 2023) and these GPs confirmed that they refer medical aid patients to private hospitals and cash patients to public clinics and hospitals. All GPs reported they had good collaborations with the private health sector, but less so with the public sector. Many GPs described that the public health sector was fraught with systemic and staff issues challenging collaboration with public health facilities such as

- lack of discharge letters from the public hospitals (GPs 2,8,9,10,11&12)
- under-resourced nurse-based clinics, community health centres and district hospitals (GPs 5,8,12) providing poor quality of care in public health facilities (GP5&6) leaving the referred patients dissatisfied and bouncing back to the GPs
- poor or no communication with public sector doctors, bad staff attitude over the phone and lack of collaboration with the public sector was experienced by GPs (4,5,10 & 11)
- the red tape in public hospitals which GPs viewed as prolonging patients' waiting time and delaying patients was reported by (GP 4,5&10)
- drainage referral system was cited as compromising urgent referral cases (GP 4,5).by creating a detour via day hospitals
- the new Vula app was seen as an unmanned, neglected convenient App with missing departments (GP 1,4,5,6,11)

Within the staff issues, public sector doctors and specialists were seen to be the impediment to collaboration. GP 12 had this to say referring to lack of discharge notes from hospitals,

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"I do get feedback from the private sector, but from the public nothing at all. You only hear from the patient what was done, whereas I need to see a discharge summary of what was done". (GP 12 interviewed 27 August 2023).

There was even a mention of racism experienced from public sector specialists towards black patients and black GPs (GP6).

"The patients call me telling me they are being tossed around, I'm telling you if that was a white patient, they wouldn't be doing that. "(GP 6 interviewed 4 May 2023).

The GPs were pessimistic about current private-public collaboration in the health sector. GP4 reported that he resorted to writing letters to refer, as he found that telephonic referrals are not an option as the calls were ignored at the hospitals, an experience confirmed by others. One GP said,

"Eh generally its quite a rocky kind of relationship, it's very different from the private hospitals" (GP9 interviewed on 16 July 2023).

He further made an analogy to a fight, he said,

"GP always must put up a fight to get patient admitted (in hospital)" (GP 9 interviewed 16 July 2023).

They also reported an element of disrespect and undermining from their hospital colleagues which annoyed the GPs. A call by ten GPs (1,2,3,4,5,6,9,10,11,12) was made for hospital doctors to stop undermining and bullying GPs who send referrals. Two GPs complained:

"They (hospital doctors) think that we are cheap small doctors, you, see? They ask us a lot of funny questions that are uncalled for as if you are in the university exam room" (GP 6 interviewed 4 May 2023).

"We are so disrespected by the MOs (medical officers) in the public service compared to the respect I would get from the private sector. Now I've gotten to the state that I now refer without phoning." (GP 3 interviewed 03 March 2023).

This was after several telephonic encounters by GP3 with hospital doctors during referrals. She went further to say,

"I had a patient with acute appendicitis, very sick. And then the doctor tells you did you check the urine? Are you sure it's not a urinary tract infection? [laughing.] Are you sure it's

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not a PID (pelvic inflammatory disease), did you do a pv (vaginal examination)?" (GP 3 interviewed 03 March 2023).

Most GPs felt unacknowledged at the secondary and tertiary hospitals as it becomes a daunting task to refer telephonically to receiving doctors who constantly grill them about the patient they are referring. And on telephonic communication from hospital doctors they said,

"They only call when you wrongly refer a patient" (GP 4 interviewed on 18 March 2023).

"Some will be rude enough to call me and say, why did you refer here?" (GP 5 interviewed on 26 April 2023)

"They(staff) are forming a barrier between the GPs and the hospitals."(GP 11 interviewed on 23 July 2023).

Public health facilities' staff were cited as having a negative attitude towards GPs' patients, intimidating referred patients, mocking them about wasting money on GPs (GP1,2,6). GP 1 said,

"There is a tendency of not wanting to consult patients coming from GPs. They(hospitals) would say you were having money you went to the GP now you're coming to us. That attitude!" (GP 1 interviewed11 February 2023).

"We have a problem in our clinics because the care isn't that much, honestly. There is no enthusiasm there, maybe because of high patient load in the clinics." (GP 6 interviewed 4 May 2023).

GPs also identified systemic issues affecting their work, such as the drainage referral system, which they say it states that each secondary hospital admit only patients from its defined catchment area of community health centres (CHC)s. The CHCs in Cape Town are the primary level facilities (previously called day hospitals as they mostly open during the day), which are the health system's entry point for patients seeking emergency or primary care in the public health sector. These CHCs are incapacitated to handle the large population of public patients and have limited staff and technical equipment (Richards &Jacquet, 2012). One GP felt the referral system was delaying urgent referrals to secondary hospitals, by requiring all patients to start at local CHCs instead of sending directly to specialists in hospitals. She said,

"It's not common to override the drainage system, I've just done one after a long time of not doing it. It's an old man with Ca of bladder, I overrode to GSH (Groote Schuur Hospital)

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because urology dept is there. So, I feel like we are delaying them(patients)." (GP 5 interviewed 16 April 2023).

One GP mentioned the red tape in public hospitals, which for instance prevent direct access to radiology and other services for their referred patients. Patients are then sent to the MO first who will determine whether to send the patient to the radiologist. These issues according to GPs created a situation where patients become tossed around between GPs and the CHCs creating poor health outcomes.

The new public sector referral Vula app was praised, as it conveniently links public sector specialists to GPs directly (GP1,5,6). However, the app was reportedly sometimes unmonitored and does not have all specialist departments and still necessitates an accompanying manual referral letter on paper (GP 4,6,11). This is what GP 11 said about the novel App,

"There is lack of feedback, and they would give a patient a date and when the patient goes to that appointment, they find that no one looks at that Vula app and no one is expecting the patient." (GP 11interviewed 23 July 2023).

"No, for orthopaedics in Tygerberg Hospital (TGB) you refer via their website you don't use Vula. Those guys don't answer them (Vula App)" (GP 6 interviewed 4 May 2023).

4.11.2 Collaboration with traditional health practitioners

The GPs had diverse views on traditional medicine. About half of the GPs (1,2,3,5,6,7,9) had no collaboration with traditional health practitioners (THP), as they do not understand them or how they work. GP 2 commented that patients see GPs as a last option when traditional healers fail them, and GP 3 also did not refer to THPs but did mention that THPs refer to her. GP4&9 believed that Western medicine does not really fit traditional medicine.

GP 8 was more accommodating on THPs, as she allows her patients to seek traditional help after completing her treatment. She, like GP 12, has traditional healers as patients and would collaborate with them if the opportunity arises. This is what GP 12 said,

"You know I realised a long time ago that we are Africans, and we have our own beliefs, Western medicine is part of medicine. We grew up using herbs. Like when I was young, I never attended a doctor for flu, I would pick up umhlonyane (an herb) and steam with it. So, I have realised that we cannot separate the 2(forms of medicine) or bypass the traditional one, and our people believe in our traditional healers. So, I had to develop a rapport with them

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(traditional healers) and sit them down and advise them to refer patients to doctors on time. There are some patients I see who refuse to take Western medicine and prefer traditional medicine and those I explain to them how to combine the two forms of medicine. In doing that I also advise their traditional healer as well, because by doing that I'm considering the most important person here who is the patient." (GP 12 interviewed on 27 August 2023).

GP10 was also supportive of THPs and sends them his terminally ill patients for palliation. GP 11 refers to traditional healer and they refer to him. He also has traditional healers as patients and commented that most patients attend THPs anyway.

GP 9 had no objection to THPs and said,

"Whether we like it or not, they (THPs) are part of the health system and a big part in that. If we work together and get an understanding of the disease-causing factors etc then we will come up with something better" (GP 9 interviewed on 16 July 2023).

He further said the competition between THPs, and western medicine is increasing mortality and unfavourably impacts patients' lives.

4.11.3 Collaboration with other government sectors

Beyond working with the public health sector, GPs also spoke about their collaboration with other government departments such as South African Police Service (SAPS) in interpersonal violence cases such as assaults and or rape of their patients. All GPs admitted to assisting SAPS by filling medico-legal forms.

GP1 explained how she refers physically abused, gender-based violence (GBV) or threatened patients to the South African Police Service (SAPS) and fills in medico-legal forms for the assaulted patients. Similarly, GP2 who also assists SAPS in filling the medico-legal forms for assaulted patients, had this to say,

"Before I see the patient, I say go and open the (criminal) case, I send to SAPS and then come back so we can sit down." (GP 2 interviewed 17 February 2023)

GP3 stopped completing SAPS medico-legal forms because of the slow justice system, which affects her income, due to frequent work absenteeism when subpoenaed to court. On further enquiry it emerged that she sends her patients to hospital for the paperwork as she said,

"I see assaulted patients treat them and tell them that if you need a J88(medicolegal form) go to the clinic first, open a case and then I will treat you for your injuries. I experienced myself

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that with these J88 I get a summons, go to court in the morning and sit there the whole blessed day waiting for your case which means I have missed on my work. So, it means you must get a locum to work for me at a fee or I close my surgery. No man this thing affects my income, so I came to an agreement that I will treat them only and patients agreed because it seems other GPs do the same thing and don't fill J88 as they feel it's too tedious." (GP 3 interviewed 03 March 2023).

GP7 is one of those GPs mentioned by GP3 who refer to hospital for the J88 paperwork. He said,

"Yes, I do have those patients who come assaulted physically and later come back with a J88 form that I must fill, and they take to SAPS which eventually land up in the justice department. Otherwise, if I'm aware that it's something that might go the legal route, I advise them to go to the day hospital because I might not be able to fulfil my obligations to go to court because I am running a private practice. To close my practice in order to go to court might not serve my interest well. As a result, I charge a very exorbitant fee for that form to be filled." (GP 7 interviewed on 06 May 2023).

The only other department that the doctors work with is Home Affairs (DHA), where GPs screen Zimbabwean immigrants for notifiable diseases. GPs 3&4 were the only GPs screening patients for DHA with the latter GP doing also radiology screening for TB.

4.12 GPs thoughts about NHI

All GPs were aware of what NHI was but had scanty recent direct updates on NHI through media announcement about the approval of the NHI Act and from a recent continuous professional development (CPD) event on NHI**.** This CPD event was not compulsory and was hosted by the local Independent Practitioner Association (IPA) named Qualicare which was poorly attended by these GPs as some of them did not belong to this IPA. It is normally an annual event covering a broad array of common medical topics including the NHI topic which was preparing GPs for the imminent NHI.

There was a lot of discomfort picked up from their body language on initially asking about NHI. One GP even said,

"Umm NHI I hate it, okay. At the beginning I was following it nicely because I knew that they wanted to have one something like medical aid for everybody. And then everybody was supposed to use GPs, I'm not quite sure they were supposed to close what space because we

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are already in our space as GPs. They wanted to use us as their frontline and then in hospitals". (GP 2 interviewed on 17 February 2023).

The same GP later learned about how GPs had to work under family physicians and about the poor remuneration which led to her distaste for NHI.

All the GPs were concerned about NHI, with some GPs seeing the NHI as bringing financial burden and poor remuneration to GPs (GP1,2,3,5,6,7,10,12). Some saw no opportunities for themselves in the NHI and were disillusioned about the actual implementation. One GP said he no longer reads about NHI as it has been talked about for too long but not implemented. They also felt left behind by the state in NHI planning as one GP said,

"They must approach us these NHI people, we are the people who know, and they know nothing."(GP 6 interviewed on 04 May 2023).

The GPs could foresee loss of their autonomy from the state, being bullied by family medicine specialists, closure of their solo practices by the state if they don't fulfil certain criteria, being overworked and underpaid, and being exposed to more crime due to the anticipated massive influx of patients in NHI. GP11 spoke about Certificate of Need (CON), a certificate for GPs needed for NHI, which restricts the number of GPs to practice in certain areas as a decongestion measure. In this CON some GPs will be forced to move their practice to other areas (Bateman, 2014), especially to underserviced areas like rural areas. About CON and bullying GP 11 said,

"So, at the end of the day all they (the state and NHI) want to do is tell people where they must go and what to do" (GP 11 interviewed 23 July 2023).

And about family medicine specialists they said,

"What family medicine has done they've made general medicine as a skivvy of family medicine. And a lot of GPs are not even organised for general practice. And family medicine is different from general practice, remember family physicians work at a district level in the hospital base. We are in the community, and community based." (GP 4 interviewed 18 March 2023).

"And now they are coming with a senior family medicine doctor because those are specialist. Then, when NHI is coming, they want to take the family medicine as a big umbrella and then we fall in that and then we are told by those specialists what to do. It's like we are going to have seniors now" (GP 2 interviewed on 17 February 2023).

On the issue about remuneration and being bullied they said,

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"Problem with myself, is I don't want anybody who is going to come and tell me do this at this amount. Because they want to downsize from the medical aid, the medical aid they downsize themselves and then the NHI is going to be worse. Because everybody now, for instance if you are being paid R400 by a patient they want everybody to pay R200, for me it's still taking me downwards" (GP 2 interviewed on 17 February 2023).

"Then you find that the money they are suggesting is so ridiculous it's like spitting in your face. So, if they are coming back with those suggestions again, I don't think I'm interested because there's a time when you get too old and thinking why I should work so hard for so little. I love my community but why should I work for nothing?" (GP 3 interviewed on 03 March 2023).

GP 5 said,

"And they say people should apply to NHI to be the service provider. And I'm not sure if it's going to work. We will have issues in the townships like space, like safety and I don't know how it's going to work because I heard the price they offer is lower. If they supply us with medication then its fine but if they don't and pay us less, then it's gonna be a problem ". (GP 5 interviewed 16 April 2023)

The amount of work and patients NHI is bringing led to GP saying,

"So, let me reinstate this, obviously you don't want to be overcrowded and overburdened because now you will lose sight of being able to manage your patients. So patient care won't be there, proper management won't be there, quality won't be there, [thinking] mhh . So, ja.. they probably will need to deploy more doctors from Cuba or wherever and we share the patients. Because it won't be feasible, remember we have our own private patients which is a certain percentage of the population I was talking about." (GP 8 interviewed 24 May 2023).

Time management and safety was mentioned as an issue they were sure to face with high number of patients in NHI, as these numerous patients would be accompanied by increase in robberies and burglaries in townships. Those statements about crime came from a male GP (GP 9). This is what he said,

"Crime will also go up. And if we put more equipment here it will attract more thieves and more break ins" (GP 9 interviewed on 16 July 2023).

GP 12 also said,

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" So, the NHI will be very challenging for the GPs. Time management as a GP is a problem right now and with NHI it will be worse.". (GP 12 interviewed on 27 August 2023).

One GP (GP4) felt that GPs are unprepared for NHI and do not have the required infrastructure to handle NHI. He said,

"Look, the structure of general practice. Look we, one is working solo with the staff that we have, yes you have some management experience and other things you have clinically, but if you are going to have a list of 10000 people, you don't have the infrastructure to manage 10000 people. You can't do planned care within that. So, it would be difficult." (GP 4 interviewed 18 March 2023).

He further said,

"GPs even within this multiple of 14years they've not been prepared to take that responsibility. But at the same time, I think GPs in their current form are not ready, wouldn't be ready to give services in that environment, in a contracted environment. That's my personal view." (GP 4 interviewed 18 March 2023).

GP 7 believed NHI will poorly remunerate GPs in same manner as medical aids are currently doing and he did not see any opportunities being brought by NHI for GPs. He added that NHI will bully GPs and GPs will be subservient. This is what he said,

"There's going to be major challenges. As I said, for us it will be giving back to society we won't be getting much out of NHI. And of course, we are so used to that. We GPs we won't even question that as you know we work under difficult circumstances already, although people may not realise it. Even then I know there's some talk, when we as doctors meet, we know we are the downtrodden. We just give and we are expected to accept. No matter what. For instance, we were talking about medical aids, medical aids prescribe to us how we should charge our patients. We are the only professionals that are prescribed to, and we doctors accept that. A lawyer is not prescribed what they should charge, if they are being prescribed to, they will challenge that. We accept it lying down so even in this case doctors wont challenge it." (GP 7 interviewed on 06 May 2023).

He also believed NHI will not assist GPs and said,

" I think it's (NHI) primary objective is to alleviate the burden on the public health system. So, for us it will be primarily to assist the public health system." (GP 7 interviewed on 06 May 2023).

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There was a feeling by GP8 that an alliance between GPs and the state such as NHI would assist in overcoming the current healthcare crisis. GP6&8 were amenable to working with NHI if the state subsidises them with medication but GP8 was wary of doctor fatigue that would accompany NHI. GP11 was unsure if NHI will support GPs, as government is not taking GP recommendations seriously. He said,

"My view, GPs at the primary level were supposed to be cornerstones of the NHI, but whether it supports GPs I don't know We made recommendations and comments as GPs to these bodies (IPAs) to take to national but whether they take our views seriously that's another matter." (GP 11 interviewed 23 July 23).

It was quite interesting that GP 10 said,

"In terms of value, I think with high numbers you will see different conditions and build your confidence. With the confidence comes your judgement of how communities value you as a GP, but in terms of financial gain I don't think so. I don't think we are going to be rich, but we will be able to survive." (GP 10 interviewed 23 July 2023).

4.13 GPs views on role of professional bodies

4.13.1 Health Professions Council of South Africa (HPCSA)

All the GPs saw HPCSA as unsupportive to their needs as the council was branded as criminalising GPs, antagonistic towards doctors and biased towards the complainants.
With regards to support GP 8 said,

"I think HPCSA needs to come and understand our challenges. It's such a pity that our own regulating body is not supportive" (GP 8 interviewed 24 May 2023).

On further probing she said,

"I know that HPCSA is not really fighting for doctors because sometimes people will say things that are not real (about GPs) and HPCSA will not fight for doctors even though they have no validated information that this has happened. I'm talking in general, but I know a lot of GPs don't feel they are getting the support from their own regulatory body" (GP 8 interviewed 24 May 2023).

Another GP responded to a question about HPCSA and SAMA and said,

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"[A deep sigh] Wow these organisations, they are all looking after themselves, but you know. I would want for them to provide assistance in advising maybe on what to do and giving you the latest in legislation and help you comply (compliance with labour laws)" (GP 5 interviewed 16 April 2023).

"HPCSA, now if somebody has reported you, they take whatever that person is saying as true. At least you want someone on your side to support you, you don't want a policeman, a policing body, we want a supportive body" (GP 5 interviewed on 16 April 2023).

And that was not all as she further said,

I am paying them (HPCSA) to prosecute me[laughing]. They are persecuting us. I mean they send people to your practice unannounced to check. I once had a professor, the late professor because a company in Killarney whose employees were using me as their GP. The prof came with an investigator looking for information on patients who had my medical certificates, and they checked the folders. HPCSA could have called me beforehand about the complaint against me but no they sent people to investigate. But you know, you want a supportive body. Especially when you are the one who is paying. And you know how much we are paying? Three thousand something!" (GP 5 interviewed on 16 April 2023).

Some GPs felt unappreciated by HPCSA despite all the hard work they do in communities. The council was instead seen as targeting good doctors whilst fake ones get away.
GP 3 said,

"They shouldn't be policing us and making us feel we are doing things that are wrong. There are doctors that are fake but for the good doctors why are they not helping us by sending somebody to help you with 1,2,3. I don't know" (GP3 interviewed on 03 March 2023).

They felt they received no guidance from the council as is their mandate but were instead seen as vicious towards doctors. One doctor said,

"The role of HPCSA is to guide us as doctors and protect the public. Let's start now even before NHI, what role have they played? From my experience HPCSA, I see as a body that victimises doctors, they are not guiding us." (GP12 interviewed on 27 August 2023).

The GPs felt under constant surveillance from the HPCSA and saw the council acting as a policing body instead of being supportive to GPs. GP7 said,

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"Doctors in their nature do not really harm people. Of course, there should be a controlling body somewhere, but the way HPCSA does this it makes us feel that we should be watched, put under a microscope all the time 24/7." (GP7 interviewed on 06 May 2023).

GP 2 said she sees HPCSA as only a compulsory registration body and another GP complained that doctors pay the association large amounts annually only to be bullied by HPCSA.
This what the GP said,

"Let's say you have seen a patient then you make a mistake like any other person. You think that body can assist you or protect you. That body is exposing you to the community, but who is paying that body? I am paying that body, I am paying a body that is fighting me, a body that will take my licence when I have done something. That body is not assisting me in anything, but yes, it's giving me the registration card but yearly I am paying plus minus three thousand and something rands and not assisting me but bullies me" (GP 2 interviewed on 17 February 2023).

Another complaint was that HPCSA takes GPs for disciplinary hearing easily when patients complain to them. There was a suggestion of a need for a body to determine the standard of care for GPs which should be supported by SAMA and used by HPCSA when judging GPs. GPs felt that HPCSA only disciplines its members and collects annual fees from doctors without ever issuing a financial report. The HPCSA was also known to audit doctors on continuous professional development (CPD) points.

One GP suggested that HPCSA should provide free CPD meetings for GPs as the council is the one auditing them. GP 11wants the HPCSA to redefine their role, and he said,

"They (HPCSA) say they are protecting the community against doctors; I suppose unethical behaviour by doctors. Besides that, I don't think there is anything the HPCSA does." (GP 11 interviewed on 23 July 23).

All GPs were displeased with HPCSA for multiple reasons, there was not a single GP praising the council. In fact, GP 11 suggested about HPCSA that *"I think they need to redefine their role."*

4.13.2 South African Medical Association (SAMA)

Most GPs were not affiliated to SAMA as they felt it was a dormant association, self-serving, costly, and most were not sure what its role is.

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"I don't even know what it is they are doing. I'm not sure." (GP2 interviewed on 17 February 2023).

"They are not genuine; they are not really interested in dealing with doctors' problems. They need to sit down and do introspection. Its everyone for themselves!" (GP 3 interviewed 03 March 2023).

4.14 GPs advice to the state

As the GPs were mostly concerned with NHI and crime in their area of work, advice was focused on those areas. They also made suggestions on THPs, medico-legal processes in assault cases, and the rest of advice was on health system improvement, which the GPs have no direct control over. There was an appeal to the district for paid sessional GP work in district hospitals to alleviate patient burden in public hospitals and upskill them in preparation for NHI.

4.14.1 National Health Insurance (NHI)

The GPs felt overlooked by the state in NHI planning and advised more involvement of GPs to strengthen health systems as they have been chosen as service providers for the insurance. One GP said,

"I'm not sure if they know we are here[laughter], we are the stepchildren of the health system[laughter]. In fact, a stepchild gets to be acknowledged as a part of the family, but we are like an unacknowledged child". (GP 9 interviewed on 16 July 2023).

"They must approach us these NHI people, we are the people who know, and they know nothing."(GP 6 interviewed on 04 May 2023).

GP 9 also needed clarity on NHI as he said,

"If this NHI is explained clearly maybe I would be able to comment" (GP 9 interviewed on 16 July 2023).

4.14.2 Traditional Health Practitioners

It was a suggestion that GPs work together with THPs in supporting patients as a health system strengthening exercise. According to these GPs this collaboration would save many lives. This is what they said,

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"Yes, I would. I think whether we like it or not they are a part of the health system and a big part at that. And if we work together and get an understanding of the disease-causing factors, complications and stuff you see then we'll come up with something better. Because I've seen sad stories of patients being lost from the western care to traditional healers and those patients were on the path of getting help but they think that no this disease need a traditional healer and they end up dying" (GP 9 interviewed on 16 July 2023).

4.14.3 Medicolegal forms of assault victims (J88) and Department of Justice

The GPs felt it unnecessary that they should leave their practices and attend court hearings of their assaulted patients. They felt it was unnecessary for the state and Department of Justice (DOJ) to summon them to court about clearly documented J88 forms. They saw it as bringing opportunity cost to their practices and wasting state resources. The GPs were all willing to assist assault victims medically and fill the J88, but their advice is that the state should not call them to court to testify on clearly written notes. They said,

"That is the importance of documentation, because the moment I saw the J88 I had filled, I remembered. But any other doctor could have testified because it was clearly documented, but to be flown from Cape Town (to Grahamstown) to testify? What if I had passed away? Wouldn't they use the medical officer currently present there?" GP 7 interviewed on 06 May 2023).

"No, I have never been called to court for that. Because I think if you put everything clear there on the J88,I don't think it will be reasonable to subpoena you because what will be the purpose when its clearly documented there on the J88? "(GP 9 interviewed on 16 July 2023).

4.14.4 Health system strengthening

There was advice for regular morbidity and mortality meetings by public health sector personnel with GPs (GP3&5) to improve communication between GPs and public health sector. The culture of bad communication, bad staff attitude and lack of collaboration within the public sector was seen as impeding health system strengthening by GPs (4,5,10&11) and GP 4 suggested an ombudsman for health facilities where the public can complain to combat ill treatment of patients in hospitals.

There was also a suggestion that public health sector collaborate with external stakeholders like GPs and NGOs to strengthen health systems. The GPs 2,3,5,7 believed private GPs could benefit from remunerated sessional hospital duties and viewed that as an upskilling opportunity for GPs whilst also reducing patient burden in hospitals.

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There were 2GPs *(*7&12) who mentioned providing funding in the townships to assist in community upliftment. The 3GPs (5,7&12) were also cognisant of the social injustices in the communities they work in, and the GPs were reducing township unemployment by using local staff. This is what GP 12 said,

"I also employ the locals in my practice and do community upliftment projects by mentoring the youth and donate to the community project." (GP 12 interviewed on 27 August 2023).

"They (the state) also need to make sure the needs of the community are met, our communities are dirty, poor, with child orphans, you know? Child headed families. They need to sort out social issues, there should be clubs, they need to bring in NGOs they can partner with them", (GP 5 interviewed on 16 April 2023).

This chapter began by exploring the GPs characteristics, their paths to medical school and work thereafter. It was important to include the GPs background to ascertain their interest in being doctors working in private sector in black townships. They were all mature GPs with a strong Xhosa background and this language advantage placed them at their areas of practice. The participants came from families with financial constraints as all of them needed financial assistance to complete their medical studies, no GP was self-funded throughout their medical studies. Private companies and government were their benefactors, with the latter assisting most of these doctors. Despite all the circumstances they faced, which included prior work experience and academic achievements, their determination to pursue and complete medicine never wavered. The number of years in current private practices ranged from two years to 31 years in township private practice. All the GPs were confident of the quality service they provide which in turn brought good outcomes earning them trust from the locals. Crime was the greatest concern amongst all the GPs, as they mentioned violent crime and robberies in their areas which necessitated contingency plans to counteract crime as police were seen as useless. They also mentioned lack of collaboration between them and state doctors and nurses in their public-private engagements, even citing being undermined by state doctors. The GPs current co-ordination with the public health sector was seen as very poor and lacking in communication. Nonetheless GPs were all passionate about providing good service to their patients and were encouraged by the good outcomes as narrated by their clients. The GPs understood their role to be facilitators of public-private partnership in the health system when they refer patients to the public sector, or work with the public sector in the townships.

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All the GPs were aware of THPs as the latter had a strong base in black townships and even had THPs as patients, but a few GPs were hesitant in collaborating with them. The latter group cited information deficit about THPs and how the collaboration would be assumed. All GPs attended to assault cases, but some were deterred by the subsequent slow, time-consuming justice system which necessitates that they go to court to corroborate the written J88 form. They were not in favour of opportunity costs created when they leave their rooms to attend court cases. These GPs were doubtful about any support from NHI but viewed it as the state's plan in strengthening public health system. They also lacked updates on NHI and their role in it. The SAMA was not popular amongst the GPs, and they were unsure of its role in their profession whilst HPCSA was seen as unsupportive to doctors. The state was advised to work on improving collaboration between GPs and public health sector in the quest for health system strengthening.

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5 Chapter 5: Discussion

Data collection began with a focus on who the participants were, their backgrounds, and followed their history throughout their studies and after medical school. It was revealed that most were in the 50-59 years age group, mostly from Eastern Cape with a few from the surveyed townships, and all were fluent in Xhosa and English. All genders were equally represented. Half of the GPs had previous work experience in other fields before studying medicine, driven by lack of funding for tertiary studies. Entry at that period into medical school was also based on a completed BSc degree and most GPs had BSc degree. These doctors completed the medical degree at record time assisted by government funding. Post MBChB training for majority was in Eastern Cape public hospitals and subsequently the doctors came to Cape Town hospitals to work as senior MOs and later settled for practices in the townships. The post MBCHB clinical years spent by these GPs in public hospitals as pre-requisite to independent practice correspond to statements made by Brits, Bezuidenhout & van der Merwe, (2020) and Perrow & Schneider, (2023).

The motivating factors in these GPs mirrored those mentioned in studies conducted in Namibia, Sierra Leone, SA and Indian (Katjinaani et al.,2024; Woodward et al., 2017; Mabuza & Ntuli, 2018; Zayabalaradjane et al., 2018), such as local doctors and parents being influential in the decision. Motivation to study medicine for these GPs mostly came from local doctors, parents, and less from educators and peers. Role modelling from local doctors was quite significant in influencing most GPs, followed by parental motivation. Surprisingly, in a SA study by Mabuza & Ntuli (2018), parents who were medical personnel were not so influential in convincing their children to pursue medicine, unlike with some of the GPs whose role models were mothers in nursing profession. Also, the influence of role models, educators, mentors in all the SA student participants did play a motivating role but had a lesser significance in the decision to becoming doctors (Mabuza & Ntuli, 2018). This was quite contrary to what the GPs said. As in the Sierra Leone study (Woodward et al., 2017), interest from a young age and having intellectual acumen was mentioned by some of the GPs as influencing their choice to become doctors. One GP mentioned studying medicine as it seemed challenging, much like the students in the Indian study by Zayabalaradjane et al. (2018). Exposure to medical facilities and its doctors whilst growing up was another motivator mentioned by the GPs. Overall, exposure to health facilities and role modelling from doctors was the common motivator in all the studies done (Katjinaani et al.,2024; Woodward et al., 2017; Mabuza & Ntuli, 2018; Zayabalaradjane et al., 2018), including the township GPs.

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Most reasons given by GPs for working in the black township areas were service related, such as serving the marginalised who are overwhelmed with high disease burden, and some cited the advantage of operating without language barriers. The cultural connection was also mentioned as an advantage in their work contexts. The love for township community and desire to impact positively on the sick was another incentive mentioned. Their work context was seen as having a huge client base making it financially attractive, and demand for GPs in townships was also mentioned as a pulling factor. Another GP mentioned ploughing back to the township that raised her.

These GPs saw their role as providing accessible quality service at a primary level for marginalised black people to prevent mortality. They mentioned dispensing quality medication not available in local clinics and day hospitals, as they all had dispensing licences in these communities, providing convenience to the locals. The participants were service providers to both medical aid and cash patients as explained by Perrow & Schneider, (2023). They also saw themselves as gatekeepers who link patients to hospitals, as all the GPs referred to public and private hospitals. Another role mentioned was advocacy for the sick in hospitals, when patients need emergency admission in public hospitals. Their other role was seen as holistically managing patients by including health promotion in their services. They likened their role in the DHS to that of stakeholder facilitating public-private partnership. According to Perrow & Schneider, (2023) and Baird et al., (2016), GPs coordinate care with other health system components (public or private) and the latter further mentions co-ordination with social services.

Feedback of good clinical outcomes as narrated by their patients was rewarding to the GPs. Having grateful, protective and loyal community members was another reward mentioned. Financial reward was another incentive mentioned by some GPs.

They also experienced challenges in their context and work. Crime was seen to be most challenging as daytime armed robberies in their rooms and break ins at night dominate in the townships. Lack of SAPS support was also mentioned as compounding the crimes. GPs were also challenged by patients asking to be seen on credit due to high unemployment in townships. Cash flow problems were also experienced due to payment issues of medical aids and their unfair audits. It is not clear what challenges Moosa et.al., (2016) referred to when they stated that black solo GPs, who worked in urban townships, appeared to be experiencing poor practice conditions.

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The public-private collaboration between GPs and the state hospitals seemed threatened by several factors including poor communication between the two entities. GPs felt undermined and bullied by hospital doctors who provide no feedback about referred patients. Bad staff attitude towards GPs' patients was mentioned by GPs as experienced from CHCs. Telephone calls were seen as a problematic non-effective mode of communication in tertiary hospitals whilst the Vula app was accessible but lacking some departments. Quality of care in local health facilities was seen as poor, resulting in patients coming back to GPs. This was quite the contrary to private hospitals that they claim had effective services.

The GPs also saw the township based THPs as members of the health system and were willing to collaborate with them as a health system strengthening exercise. The GPs' argument was that THPs dominate in black townships and most community members attend them making it impossible to be overlooked. They felt it inevitable to collaborate with them whether they believe in them or not. A study by Moeta et.al., (2023) stated that equipping THPs with basic first aid skills would prevent complications and reduce mortality. These were the sentiments of most GPs as they were willing to impart some clinical skills to the THPs to prevent further morbidity and avoid fatalities. This was an unexpected finding that medical doctors were amenable to working with THPs.

The existing intersectoral collaboration with police and justice departments in dealing with interpersonal violence patients was welcomed by GPs save for some few adjustments by the justice department pertaining to court attendance. The GPs were unwilling to attend court proceedings of the assault cases and leave their busy practices. However, they welcomed intervening medically to the assault victims and filling the accompanying J88 forms, as crime was inescapable in their work context.

The NHI was a touchy subject to most GPs. There were no reported recent direct NHI updates to GPs according to many and NHI was viewed as coming to constrain their finances further, together with overworking GPs thereby subjecting them to more crime. GPs felt unprepared for NHI educationally and financially as infrastructure is necessary for NHI. There was a fear of being bullied by NHI and its family physicians. There was forecast on doctor fatigue following implementation of NHI and they doubted its sustainability in the current Eskom crisis and widespread SA corruption. They also noted inadequate communication from the state to GPs concerning NHI. These comments were in line with studies conducted on other GPs (Gaqavu& Mash, 2019; Mathew& Mash, 2019; Moosa et al., 2016; Perrow, 2022). The NHI was viewed by the participants as a good concept which could integrate GPs into the system to

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assist in prevention and managing diseases if well managed. Interviewees wanted the state to capacitate them for NHI and provide medication. They understood the benefits of NHI to the marginalised and embraced their primary healthcare provision role in NHI, and these were the sentiments of other black GPs in the Eastern Cape (Gaqavu and Mash, 2019). Moosa et al., (2016) had mentioned in their study that solo township GPs welcomed NHI. These interviewed township GPs viewed NHI as coming to assist the overstretched public health system, and several studies alluded to that fact (Gaqavu & Mash, 2019; Mathew& Mash, 2019; Moosa et al., 2016; Perrow, 2022).

When asked about their contribution to the communities, GPs viewed themselves as improving community health by providing quality care, advocating for the sick in hospitals and applying good role modelling to their communities. The latter was significant in motivating the township youth to become doctors as noted in Katjinaani et al., (2024); Woodward et al., (2017); Mabuza & Ntuli, (2018); Zayabalaradjane et al., (2018). Some GPs also mentioned supporting community projects and alleviating unemployment by using local staff.

The GPs had less enthusiasm about their professional bodies. The HPCSA was viewed as complainant biased, vicious and unsupportive towards GPs whilst they pay expensive annual fees to it. The two bodies, SAMA and HPCSA were seen as useless, with the latter viewed as targeting real doctors instead of fake ones. These were unexpected findings as these were the bodies (HPCSA and SAMA) that were supposedly guides to GPs and supportive to the doctors (HPCSA, 2024; SAMA, 2024).

As a health strengthening effort, the GPs were amenable to attending regular meetings with their public sector counterparts. The GPs suggested mutually benefitting sessional work for them in public primary hospitals as these sessions were seen to be an upskilling exercise which would alleviate patient burden in hospitals. These sessional duties were not unknown as Moosa et al., (2016) mentioned their existence but were seemingly uncommon to these GPs. The GPs were also looking forward to a strong public-private partnership in the health sector as they viewed themselves as key stakeholders in strengthening health systems.

This study put into perspective how important the state funding is for tertiary education especially for students from underprivileged communities and especially for long degrees such as MBChB. Good role modelling by forebears is significant motivator as shown in this study, which could equally apply to other fields of studies to motivate our youth.

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The solo GPs saw the sprawling townships as suitable areas of work as there were background, cultural and language similarities which ultimately created good clinical outcomes and understanding of THPs. This is their strength as they have more connection with the communities they work in as compared to public sector doctors. It was interesting how the GPs viewed the public health sector as lacking in quality care with hostile personnel and poor communication. The public health sector might be reciprocating same statements about GPs and a quick solution is needed for breaking down these tribalistic barriers for effective public-private partnership before NHI is implemented. The NHI was seen by the GPs as a public health solution that still needs tailoring to suit their needs as potential team players in the universal cover.

These GPs saw themselves as victims who were exploited by non-paying patients and medical aids, victims of crime, bullied by HPCSA and unsupported by SAMA. All these could potentially impact health system strengthening and NHI negatively and prompt an exodus of GPs from townships. The HPCSA and SAMA lost popularity amongst the GPs and very few are affiliated with the latter and questions must be raised by these structures on how to support township GPs. The participants expressed more challenges than rewards in their line of duty, and the question is why they remain in these settings. Is it a matter of them being trapped by their debts, or having no alternatives but to remain in their established practices living in hope that things will change? What steps have they taken to address those challenges, if there are any. In terms of crime, only a few mentioned upgrading their security but no upstream solutions were mentioned in any of their problems.

5.1 Study Limitation

These study findings cannot be applied to other settings or contexts of GPs as only a small sample of 12 GPs was selected. Whilst being aware that this sample size may not be sufficient to fully understand the topic, it was the only option available for this study. The 18 GPs who were contacted for the study were not all willing to be interviewed citing their busy work schedules while some cancelled at last minute or simply were not comfortable with interviews. Other GPs were uninterested as they never responded to invitations for interviews and ultimately snowball sampling topped up the number of participants. These GPs were selected from a social media group of Cape Town's Black township GPs that the researcher also belongs to. These GPs belong to different IPAs and organised themselves as a group facing similar GP challenges. The absence of a GP register (Competition Commission, 2018, p. 40) and the lack

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of geographic and contact information on GPs led to convenience sampling being used to select GPs for this study as it enabled practically quick and easy access to available GPs (Scholtz, 2021). Whilst being aware that this sampling method would create substantial selection bias, Purposeful sampling was also used to gain in depth understanding of GPs thoughts, gain rich information from the small sample targeted within the context of scarce information available on township GPs, for a rigorous study (Campbell et al, 2020). The study is subject to selection bias as most GPs in the social media group were selected. The rich data provided and in-depth interviews with the participants was to enable transferability so readers can apply these findings to their own contexts. The GPs characteristics and descriptions mentioned, the transparency of the methodological process and other research aspects were all for promoting transferability. While this study will go some way in explaining the role GPs play in the DHS, it is in no way applicable to the whole GP population. The study is subject to selection bias as only GPs in the social media group were selected. As previously mentioned, researcher bias is also a factor as the researcher is a current black township GP who also belongs to the social media group and methods to minimise this bias were applied. The researcher was reflexive throughout the study using her diary, also assisted by her assistant who was tasked to check biases during the data collection, and by her supervisor who noted any other researcher biases during debriefing. Also, re-listening to the audio tapes of the in-depth interviews provided reflexivity. The collected data was thick and rich to maintain a rigorous study. Data triangulation would assist in overcoming the limitations and validate the findings by conducting a quantitative study on this topic.

6 Chapter 6: Conclusions and recommendations

From this study most GPs were motivated to study medicine through exposure to local doctors in their childhood and their parents also encouraged them to be doctors. This highlighted the significance of positive role modelling in young people to shape their future. After their medical degrees these GPs chose townships as their work area prompted by their language and cultural connection to these areas. They cited their love for township community and the desire to impact positively in community health as another reason for working in townships. The demand for private GPs and anticipated financial gain was mentioned as another pulling factor.

It emerged that the GPs understood their role to be that of quality primary service provision in the district health system. They saw their role as that of frontline clinicians who are township

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based with strong connection to their clients. They mentioned also linking individual patients to the broader health system and other public sector departments, together with also advocating for patients in the townships to be admitted in secondary hospitals and preventing mortality. As community-based GPs they felt this role would be more effective and clearer if better communication existed with the state at all government departments. These township GPs highlighted experiencing more problems and few rewards about their work. They felt unheard by the state and yearned direct consultation about their role. Also mentioned was willingness to support the health system in a public-private partnership. Their context reportedly subjected GPs to crime, and this they felt could be combatted by intersectoral collaboration with community, law enforcement and government. This collaboration was seen as also a crime prevention measure for the imminent NHI as they anticipated more patients and work hours to be brought to GPs. Crime was seen as a major challenge they were faced with in townships followed by financial constraints resulting from poorly paying medical aids and faltering business due to high township unemployment. Within the health system the solo GPs saw lack of collaboration with the public health sector personnel who failed at providing them with feedback about patients, which was contrary to the private health sector. The latter sector was seen as effective and efficient with quick access and short waiting times for their patients. However, they were rewarded by positive outcomes of their work as doctors.

They recommended that the state engage GPs more on various matters pertaining to their job description, their work context and NHI as lack of communication from the state was seen as non-existent. More support by government, SAMA and HPCSA was mentioned as a necessity in their solo GP work, and it was evident that they wanted engagements with these entities as they felt unheard and poorly understood.

The GPs are uniquely positioned to incorporate public health measures at community level daily in their work in the quest for improved community health. They are strategically placed to also address the social determinants of health whilst treating their patients. For example, these township GPs close encounters with THPs would provide valuable data on THPs, which would assist in preventing morbidity and mortality caused by the lack of collaboration between GPs and THPs. Furthermore, their contexts place them at a position where they can monitor population health trends and implement population health promotion at a primary level. A population centred private GP collaborating with public health professionals integrating GP work and community health would improve community health in underprivileged areas.

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Further research on this topic should be conducted on other GPs in different contexts to ensure validity of this study and triangulation using a quantitative study can validate these findings.

References

Abrahams, G., Thani, X.C. & Khan, S.B. (2022). South African public primary healthcare services and challenges. *Sabinet*,30(2).

Adams, W.C. (2015). Ch 19- Conducting semi-structured interviews. In J. Wholey, H. Hatry & K Newcomer(eds). *Handbook of practical program evaluation*. Jossey-Bass: 492-505

Aikins, Enoch Randy & McLachlan, DuToit. (2022). 'Africa is losing the battle against extreme poverty.' *ISS Africa.* Available at https://futures.issafrica.org/blog/2022/africa-losing-battle-against-extreme-poverty.html. Accessed September 2024.

Baird, B., Charles, A., Honeyman M., Maguire, D.& Das P. (2016*). Understanding pressures in general practice.* England, U.K.: The King's Fund

Bateman, C. (2014). CoN-lifeline for patients, noose for healthcare providers? *South African Medical Journal*, 104(9), 597-598

Bopape, M. A., Mothiba, T. M. & Malema, R.N. (2013). Indigenous practices of traditional health practitioners (THPs) methods by mothers of children admitted to the Polokwane/ Mankweng hospital complex, Limpopo Province, South Africa. *African Journal for Physical Health Education, Recreation and Dance*.

Brits H., Bezuidenhout J. & van der Merwe L.J. (2020). A framework to benchmark the quality of clinical assessment in a South African undergraduate medical programme. *South African Family Practice*, 62(1).

Competition Commission, South Africa (July 2018). *Health Market Inquiry*. *Provisional Findings and Recommendations Report*. South Africa.

Creswell, J.W. (1998). *Qualitative inquiry and research design: Choosing among five traditions.* Sage Publications, Inc.Creswell, J.W.& Miller, D.L. (2000). *Determining Validity in Qualitative Inquiry, Theory into Practice*, 39:3: 124-130

Creswell, J.W. (2014). *Research Design: Qualitative, Quantitative and Mixed Methods Approaches.* Thousand Oakes, CA: Sage.

Darzi, A.& Evans, T. (2016). The global shortage of health workers-an opportunity to transform care. *Lancet*,388(10060): 2576-2577.

Delobelle, P. (2013). Ch 9- The health system in South Africa. Historical perspectives and current challenges. In C.C. Wolhuter (eds). *South Africa in Focus*. United Kingdom: Nova Science

Gaqavu, M. M., & Mash, R. (2019). The perceptions of general practitioners on National Health Insurance in Chris Hani District, Eastern Cape, South Africa. *South African Family Practice,* 61(3):102-108

https://uwcscholar.uwc.ac.za/home

Govender, K., Girdwood, S., Letswalo, D.,Long, L.,Meyer-Rath, G.& Miot, J.(2021). Primary healthcare seeking behaviour of low-income patients across the public and private health sectors in South Africa. *BMC Public Health* 21, 1649(2021)

Health Professions Council of South Africa (HPCSA). Guidelines for good practice in the health care professions. Accessed October 2024. Available at https://www.hpcsa.co.za

Hongoro, C., Funani, I.N., Chitha, W. & Godlimpi, L. (2016). An assessment of private general practitioners contracting for public health services delivery in O.R. Tambo District, South Africa. *Journal of Public Health in Africa*, 6(2).

Johnson, J.L., Adkins, D.& Chauvin, S. (2020). A Review of the quality indicators of rigor in qualitative research. *American Journal of Pharmaceutical Education,*84(1):138-146.

Joseph, B.& Joseph, M. (2016). The health of the healthcare workers. *Indian journal of occupational and environmental medicine,* 20(2): 71-72.

Katjinaani, M., Tobi, K.U.& Christians, F. (2024). Factors influencing the selection of medicine as a course of study: a survey of undergraduate medical students at the University of Namibia. *Pan African Medical Journal-One Health,* 14(10).

Kirchherr, J.& Charles, J.C. (2018). Enhancing the sample diversity of snowball samples: Recommendations from a research project on anti-dam movements in Southeast Asia. *PLOS ONE*,13(8).

Lincoln, Y.S.& Guba, E.G. (1985). *Naturalistic Inquiry*. Newbury Park, CA: Sage Publications.

Mabuza, L.H.&Ntuli, B. (2018). What motivated students to choose a career in health sciences? A comparison of rural and urban- origin students in three South African universities. *Open Public Health Journal*, 11:44-53

Mash, R., Gaede, B., & Hugo, J. (2021). The Contribution of family physicians and primary care doctors to community-orientated primary care. *South African Family Practice*, 63(1) a5281

Mash, R.,Viljoen, W., Swartz, S., Abbas, M., Wagner, L., Steyn, H., Hendricks, G., Stapar, D., Wiliams, A., Adeniji, A., Schoevers, J. &Kapp, P.(2022). Retention of medical officers in the district health services of the Western Cape, South Africa: An exploratory descriptive qualitative study. *South African Family Practice*, 64(1)

Mathew, S.& Mash, R. (2019). Exploring the beliefs and attitudes of private general practitioners towards national health insurance in Cape Town, South Africa. *African Journal of Primary Health Care & Family Medicine*, 11(1)

Matseke, M.G. (2023). Taking stock of the healthcare workforce in the public health sector of South Africa during Covid-19: Implications for future pandemics. *Africa Journal of Public Sector Development and Governance*,1.

Medpages (n.d) IQVIA. Available at https://www.medpages.info

Moeta, M., Musie M.R., Seretlo, R.J., Ledimo, M., Rasweswe M.M., Makhavu, E. & Mulaudzi, P.M. (2023). Traditional health practitioners' training needs on biomedical knowledge and skills in a South African township. *African Journal of Primary Health Care & Family Medicine,* 15(1): 1-9

https://uwcscholar.uwc.ac.za/home

Moosa, S., Luiz, J., Carmichael, T., Peersman, W., & Derese, A. (2016). Insights of private general practitioners in group practice on the introduction of National Health Insurance in South Africa. *Africa Journal of Primary Health Care & Family Medicine*,8(1), 1-6.

Pauw, T.L. (2021). Catching Up with the Constitution: An Analysis of National Health Insurance in South Africa Post-Apartheid. *Development Southern Africa.*

Perrow, B.L. & Schneider, H. (2023). Mistrust in government and National Health Insurance: A qualitative study of solo private practitioners in Cape Town. *South African Family Practice.* 65(1): 5768

Pope, C., Ziebland, S.& Mays, N. (2000). Qualitative research in health care. Analysing qualitative data. *British Medical Journal*, 320(7227):114-116.

Richards, D.B.& Jacquet, G. A. (2012). Analysis of referral appropriateness in the Western Cape, South Africa, and implications for resource allocation. *African Journal of Emergency Medicine*, 2(2):53-58.

Robson, C., & McCartan, K. (2016). *Real World Research*, *4th ed.* Chichester, UK: John Wiley & Sons

Ross, E. (2008). Traditional healing in South Africa: Ethical implications for social work. *Social Work in Health Care.* 46(2):15-33

Setswe, G. (2010). 'Health in South African township communities' *AMREP World Health Day Conference 2010.* Monash University, 7th April 2010. Human Sciences Research Council South Africa, pp 1-14.

Solanki G.C., Wilkinson T., Daviaud E., Besada D., Tamandjou Tchuem C.R., Docrat S.& Cleary S.M. (2020). Managing the healthcare demand-supply gap during and after COVID-19: The need to review the approach to healthcare priority-setting in South Africa. *South African Medical Journal.*111(1):20-22.

Sutton, J.& Austin, Z.(2015). Qualitative Research: Data collection, analysis and management. *The Canadian journal of hospital pharmacy,* 68(3): 226-231

Wishnia, J., Strugnell. D., Smith, A. M.& Ranchod, S. (2019). The supply of and need for medical specialists in South Africa. Cape Town: Percept.

Woodward, A., Thomas, S.,Jalloh, M. B., Rees, J.& Leather, A.(2017). Reasons to pursue a career in medicine: a qualitative study in Sierra Leone. *Global Health research and policy* 2, 34.

Zayabalaradjane,Z., Abhishekh, B., Ponnusamy, M., Nanda, N., Dharanipragada, K.& Kumar,S.(2018).Factors influencing medical students in choosing medicine as a career. *Online Journal of Health and Allied Sciences,* 17(4):5

Zuma, T., Wight, D., Rochat, T & Moshabela, M. (2016). The role of traditional health practitioners in rural KwaZulu-Natal, South Africa: generic or mode specific? *BMC Complementary and Alternative Medicine,*16(1): 304

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APPENDCES

Appendix 1: Interview Guide

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2809 Fax: 27 21-959 2872

E-mail: soph-comm@uwc.ac.za

Topic

An exploration of how general practitioners, working in seven black townships in Cape Town, South Africa, perceive their role in strengthening the district health system

Research questions

How do GPs understand their roles as primary health care (PHC) providers within the district health system (DHS) in Cape Town's black townships? What are the realities of being a township GP? What contributions do these GPs provide to public health? What are the GPs thoughts on NHI? What recommendations do these GPs have regarding their role in strengthening of the country's health system?

Interview Guide

Background information

Could you please tell me your name and age? Where is your hometown?

When did you decide to be a doctor and what made you decide on this profession? How was your journey during your medical studies?

Where else have you worked as a doctor?

What made you work in the township? How long have you been working as a private GP?

How long have you been working in this township?

What do you find most rewarding about being a township GP? What is most challenging in being a GP in a township area?

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What difference does your presence here make to the health of this community?

2) Questions on current role in the health system

Who do you work with in the health system?

How do you interact with the public health sector?

Probing questions

Where do you refer your patients? Do you send your patients to clinics or hospitals? What about traditional healers? Do you work with them?

Is there collaboration between you and other departments in the public sector? How does it work?

How do the local hospitals and clinics affect your work as a township GP?

How do you link with the local hospital in your line of work? And how does this affect your patients? Is it easier for you as a GP to work with the local clinics and hospitals? Please elaborate.

What are some of the systemic issues that you encounter with these health centres?

What recommendations do you have to strengthen health facilities?

3)Questions about the NHI

What do you know about the National Health Insurance plans?

Have you received any information from government or other bodies?

What opportunities and challenges will the NHI bring? What are your greatest concerns?

4)Questions on national government and regulatory bodies

How can the government and professional bodies like HPCSA, SAMA support and strengthen your work?

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APPENDIX 2: Participant Information Sheet

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2809 Fax: 27 21-959 2872

E-mail: soph-comm@uwc.ac.za

Project Title

An exploration of how general practitioners, working in seven black townships in Cape Town, South Africa, perceive their role in strengthening the district health system.

What is this study about?

This is a research project being conducted by Nozuko Mdlekeza at the University of the Western Cape. We are inviting you to participate in this research project because you are a private general practitioner (GP) in a black township. The purpose of this research project is to elicit from you as urban township-based GPs your experiences and perceptions of working in private practice within the township and to explore with you the contribution you understand you are making to the DHS in the country. With the exploration and description of the day-to-day reality of your physical environment and workplace, your links to other local health providers, and your relationship to your local patients and community members, it is hoped that this study will contribute understanding of your experiences and roles and assist in closing the gap in scarce information that currently exists about the GPs role within the country's district health system.

What will I be asked to do if I agree to participate?

You will be asked to give consent for a face-to-face interview at your workplace with the researcher and her assistant. The interview will be audio-recorded, and notes written down. This will be done in your private practice if conditions allow, at a time convenient to you.

The questions that you will be asked are about the role GPs play in the DHS. You will be asked to respond to questions from an interview guide. These questions will be to ascertain what you as a GP think you contribute to the health system. This interview will last for about an hour, and I will be recording this interview, with your permission of course, so as not to miss any of your comments. Even though my assistant and I will be writing down notes during the interview we cannot write fast enough to capture everything you will be saying hence the

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recording. Since you will be recorded, please speak up so you can be audible. The interview will not be recorded if you do not agree to be recorded. Recording of interview can be stopped at your request at any point. Please note a summary of the questions you will be asked below.
How do GPs understand their roles as primary health care (PHC) providers within the district health system (DHS) in Cape Town's black townships?
What are the realities of being a township GP?
What are your thoughts on NHI?
What contributions do GPs provide to public health?
What recommendations do these GPs have regarding their role in strengthening of the country's health system?

Do I have to be in this research, and may I stop participating at any time?
Your participation in this research is completely voluntary. This means you may choose or refuse to participate in this study. Should you choose to participate, there will be no direct benefits to you. There will be no negative consequences resulting from your refusal to participate in the study either. If you choose to participate you may withdraw at any time if you wish to do so, and you may refuse to answer some or all the questions if you don't feel comfortable with those questions.

Would my participation in this study be kept confidential?
The researchers undertake to protect your identity and the nature of your contribution. To ensure your anonymity, the interviews are anonymous and will not contain information that may personally identify you.(1) Your name will not be included on the collected data; (2) a code will be placed on collected data; (3) through the use of an identification key, the researcher will be able to link your interview to your identity; and (4) only the researcher will have access to the identification key.
To ensure your confidentiality, we will be using identification codes only on data forms and using password-protected computer files.
When we write a report or article about this research project, we will not use your name and location.
In accordance with legal requirements and/or professional standards, we will disclose to the appropriate authority information that comes to our attention concerning potential harm to you or others. In this event, we will inform you that we must break confidentiality to fulfil our legal responsibility to report to the designated authorities.

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We will do our outmost best to keep your identity and that of your practice confidential. I will always refer to you as participant and will always keep records of your participation locked away and destroy them after data has been collected. When I write a report about this research project your identity will receive maximum protection. However, the data may be seen by my supervisor and may be published in journal and elsewhere without disclosing your identity. I would like also to assure you that the rules of confidentiality extend to everyone participating in this research.

This research project involves making audiotapes of you to capture everything you will be saying. The audiotapes will be kept for five years in a safe location in UWC in a password protected computer where only the researcher and her supervisor can access them. They will be destroyed after five years.

What are the risks of this research?

There may be some risks from participating in this research study. All human interactions and talking about self or others carry some amount of risks. We will nevertheless minimise such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise during the process of your participation in this study. Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention.

The risks of the research are that it may expose your township, the health system and the district's incompetency which may inadvertently subject you to stigma of being called an informant. It is for these reasons that both your identity and your practice will not be revealed. There is also a risk that this interview may evoke uncomfortable negative feelings of anger or despair to which I will advise you seek counselling from a psychologist and will facilitate a referral.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the researcher learn more about the DHS and the role of GPs in marginalised urban areas. We hope that, in the future, other people might benefit from this study through improved understanding of the role of township GPs in strengthening the DHS and thereby improving public health.

The benefits of the research are that it will inform the health department of the limiting and the motivating factors of GPs in supporting the DHS. These factors can then be addressed by the national government to introduce new policies and create an environment conducive for strengthening health systems.

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Do I have to be in this research, and may I stop participating at any time?
Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

In terms of the requirements of the Protection of Personal Information Act (Act 4 of 2013), personal information will be collected and processed:

What type of personal information will be collected?
Name, age, gender, work location

Who at UWC is responsible for collecting and storing my personal information?
The researcher who is a registered student at UWC and the UWC's supervisor will have access to your personal details and the codes used to anonymise your personal information

Who will have access to my personal information outside of UWC?
No one will have access to your personal information outside of UWC.

How long will my personal information be stored?
For five years in a safe location in a password protected computer

How will my personal information be processed?
Your name will be linked to a code that will be known only to the researcher and supervisor.

What if I have questions?
This research is being conducted by Nozuko Mdlekeza and School of Public Health at the University of the Western Cape. If you have any questions about the research study itself, please contact me at 13 Suikerbossie Close DuNoon, Milnerton, cell number 0761715227, email 3817149@myuwc.ac.za.

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Prof Uta Lehmann
Head of Department: School of Public Health
University of the Western Cape
Private Bag X17
Bellville 7535
ulehmann@uwc.ac.za

Prof Anthea Rhoda
Dean: Faculty of Community and Health Sciences

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University of the Western Cape
Private Bag X17
Bellville 7535
chs-deansoffice@uwc.ac.za

University of the Western Cape
Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-959 2809, Fax: 27 21-959 2872
E-mail: soph-comm@uwc.ac.za

Biomedical Research Ethics Committee
Research Development
Tel: 021 959 4111
e-mail: research-ethics@uwc.ac.za

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APPENDIX 3: Consent Form

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2809 Fax: 27 21-959 2872

E-mail: soph-comm@uwc.ac.za

Title of Research Project: An exploration of how general practitioners, working in seven Black townships in Cape Town, South Africa, perceive their role in strengthening the district health system.

The study has been described to me in a language that I understand. My questions about the study have been answered. I understand what my participation will involve, and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits. This research involves making audiotapes of you to capture everything you say. These tapes will be accessed by the researcher and her UWC supervisor and kept for five years in a safe location in a password protected computer. Your name will be coded and nobody outside UWC will access the tapes which will be destroyed after five years.

Please tick one of the boxes below.

☐ I agree to be audiotaped during my participation in this study.

☐ I do not agree to be audiotaped during my participation in this study

In terms of the requirements of the Protection of Personal Information Act (Act 4 of 2013), personal information will be collected and processed:

☐ I hereby give consent for my personal information to be collected, stored, processed and shared as described in the information sheet.

☐ I do not give consent for my personal information to be collected, stored, processed and shared as described in the information sheet.

Participant's name……...

Participant's signature…….

Date……

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