A COMPREHENSIVE PRIMARY HEALTH CARE SERVICE PACKAGE FOR SOUTH AFRICA

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CLINIC: FAST QUEUE / REPEATS

COMMUNITY HEALTH CENTRE 29

APPENDIX 1

THE COMPREHENSIVE PRIMARY HEALTH CARE SERVICE PACKAGE OVERVIEW

SUMMARY

The purpose of this Package is, in the perspective of equity, to define comprehensive PHC services which within a period of 5 years following implementation will be common to the whole country. This Package would help to quantify requirements in terms of staffing, infrastructure, equipment and financial resources. It is hoped that this quantification would then assist health managers negotiating an appropriate budget with their authorities.

Development of this Package was commissioned by the National Department of Health to the Centre for Health Policy at Wits University and the Centre for Health Systems Research and Development at the University of the Free State. The project was funded by the Health Systems Trust. The development of the Package built on the work of Needs/Norms from the Centre for Health Policy and on the initial Package developed by the Gauteng Health Department. The Package went through a process of consultation initially with managers and providers in Gauteng and the Free State, then with all directorates in the Department of Health. A series of consultation workshops were held in eight provinces. Comments from all these consultations have been integrated in the Package to form this document.

The Package is presented as follows: an introduction explaining the background to the Package, the Package itself with an explanation of the different levels of services presented, a list of services and their components with suggested prioritisation. Appendix 1 is a report from the provincial consultation process with its ensuing recommendations.

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INTRODUCTION

Primary health care is seen as the key element in the plan to transform the health services in South Africa. A comprehensive and integrated Package of essential PHC services made available to the entire population will provide a solid foundation for a single unified health system.

This document sets out comprehensive services that grew out of a synthesis of, and experiences from various national and provincial stakeholders. It marks the dawn of a Package that will contribute to greater social justice and promote equity by reducing the gap between those who have access to an appropriate level of care and those who do not.

The Package attempts to define services in terms of both level of care and an approach. It refers to the level of health service closets to communities and also highlight the set of activities performed at this point of first contact between health worker and individuals.

This introduction describes the background to the work, the way the Package was produced and its potential uses.

BACKGROUND

The vehicle for the delivery of the PHC service Package is the district health system (DHS). Clinics (fixed/mobiles) community health centres (CHCs) and district hospitals (where access to clinics and CHCs is limited) forms the platform for the delivery of this Package within a DHS. This comprehensive Package of PHC services is expected to be universally accessible and be gauranteed for every citizen of our country.

The Comprehensive PHC Package was defined following detailed consultation with national and provincial experts over a period of time.

At the request of the National Department of Health a comprehensive Package of services was developed by the centre for health policy (CHP) Wits University, and the Centre for Health Systems Research and Development (CHSRD) Free State University. This Package covers services rendered at Community level, Clinics (mobile/fixed) and CHC level.

The services defined are expected to be capable of tackling the leading causes of mortality and morbidity in the country using the most cost effective strategies. Furthermore this Package of services represents the services that should be rendered for PHC services to be regarded as fully comprehensive; but it is clear that not all districts will be able to immediately provide all these services. As a result of this, the services represent a 5 year goal, both in terms of service and type of organisation by which the NDoH expects that this comprehensive services will be delivered within each district. In that perspective, timing for phasing-in implementation has been suggested in the document, reflecting which services should be rendered now, which within 3 years and which within 5 years.

The Package, and the suggested timing for phasing-in, reflect the definition of the priority areas which need to be protected. This includes:

a) Child Health, and in particular infectious diseases

b) STDs and AIDs

c) TB

d) Reproductive Health: Ante-Natal, Family Planning and Maternity

e) Mental Health

f) Chronic Diseases (HP, Diabetes, Asthma)

g) Trauma and Injuries

h) Disabilities

POTENTIAL USES

- A tool to negotiate budgets for PHC
- A planning tool to move towards comprehensive services
- Planning for the integration of non-personal services
- A tool to monitor move towards Comprehensive PHC services
- A tool to assist health workers identifying the scope of services to be delivered
- A tool to assist communities on what they can expect

PROCESS OF DEVELOPMENT

WHY A PACKAGE DEFINED CENTRALLY?

As stated earlier, an important goal of the Package is to establish national norms and standards as a move towards greater equity in PHC service provision. Whilst the initiative to create such a Package was taken at a national level, the work to develop the initial version of the Package built on work carried out in some provinces. Comments and suggestions from the consultation with the provinces were integrated to create the Package. It is likely that if consultation with the provinces would have started with a blank slate, the process would have been much more lengthy at a time where there is a real urgency with defining the content of Primary Health Care.

HOW WAS THE PACKAGE DEVELOPED?

A HORIZONTAL APPROACH

The approach used for developing the Package was deliberately a service-based, rather than a program-based type of approach. It aimed at defining services per level of facility as a way to maximize the integration of services. However, in order to ensure that all the different components of services (ie. the range of personal and non-personal services, and the range from community based services to community health centres) were included, a vertical breakdown per type of condition was performed in parallel with the horizontal analysis. The two approaches were then merged to produce the Package.

AN INCLUSION RATHER THAN EXCLUSION APPROACH

Some argue that it would be easier to define services as "everything except ...". Whilst this approach has been used for hospital Packages to define which kind of procedures has to be performed by different levels of hospitals, the purpose of this PHC Package is to move towards the definition of comprehensive services. It is thus more operational to specify what is included at the different steps of the phasing-in process. This approach also allows to better quantify the resources implications.

CONSULTATION PROCESS

The Package grew out of work developed by the Centre for Health Policy (The "Need / Norms" project) and package developed by the Gauteng Health Department. The former relied heavily on consultations with experts whilst the latter developed out of a lengthy process of consultation with provincial and local authorities officials. From these two initiatives emerged a new version of the Comprehensive Primary Health Care Service Package. It was discussed further with experts, and a process of consultation on the ground was then set up in Gauteng and the Free State. Health services managers and front-line providers working in mobiles, clinics and community health centres were consulted. Urban, peri-urban and rural areas were covered and a mix of local authorities and province-run services were contacted. Comments from this consultation process led to a revised version of the Package which was then presented to the Department of Health. Each Directorate made comments and suggestions

which were incorporated in this final version of the Comprehensive Primary Health Care Service Package.

Subsequently consultation workshops were held in 8 provinces. Comments, suggestions and recommendations from these workshops were integrated in this final version of the Package. (Appendix 1 highlight issues raised during the process of consultation).

DESCRIPTION OF LEVEL OF SERVICES

COMMUNITY SERVICES

This section covers the whole catchment population and as such includes three different types of services:

- district management functions
- non-personal services
- personal services: home-based

DISTRICT MANAGEMENT FUNCTIONS

The district management will have a co-ordinnating function between the various levels of services. To list just a few:

- ensuring proper referral system from community, to clinic, to CHC, to district hospital and beyond.
- ensuring a smooth drug supply across the district
- ensuring and monitoring that activities take place outside of facilities: adequate organisation of outreach services by clinics, adequate systems of visits by CHCs, environmental health, and other relevant specialists to local clinics. Given the pressures on facilities from the immediate workload of presenting patients, there is a danger that these out-of-facility activities will be undermined. It is thus important that district management ensures proper planning and monitoring of such activities.

NON-PERSONAL SERVICES

These cover district-wide services: environmental health, health promotion, school health services and services to other institutions. Again smooth and equitable distribution of these services will need to be co-ordinated by district management, even if rendered from a more localised base.

PERSONAL SERVICES: HOME-BASED

Given the scarcity of resources for this type of services, it is essential in the pursuit of equity that such services be planned at a district management level from a picture of localized needs.

CLINICS AND MOBILE SERVICES

Services at clinics were defined, not by the size of the facility, but by the level of skills of the staff. As such they include, as part of the common Package, services which can be delivered by a professional nurse. Additional services could be delivered if regular visits by doctors or other specialists (psychiatric team, ophthalmologist, rehabilitation specialists, environmental health officers ...) are organised. This is of particular importance in rural areas where CHCs/hospitals may be non-existent or very distant.

Proposed organisation of clinics suggest three service points (children, adults, fast-queue/repeat), although local clinics may choose different types of organisation, better adapted to their situation.

COMMUNITY HEALTH CENTRES

The proposed organisation of CHCs is a target, and may not apply immediately to the current organisation of services. Some areas do not have CHCs yet, and for other some services would, in the short term,

be better rendered from existing hospitals (eg. deliveries, casualty, TOPs). However the proposed organisation suggests that a CHC be structured with three components:

- a clinic for the local catchment area
- a referral section with specialists
- a 24 hours unit with maternity and casualty

In addition to the services rendered at CHC level, the CHC referral section staff will also visit clinics to hold clinical sessions and training/audit/staff support sessions. Such visits would decrease the level of referrals and increase the quality of care at a local level. Where CHCs do not exist, local hospitals could take over that function.

REFERRAL MECHANISMS

There is a danger that CHCs would be seen as a center of excellence and be overloaded with patients, as is evidenced now by the by-passing phenomenon of PHC patients attending OPDs in hospitals. Given the proposed structure of CHCs with its three components, the following suggestions were then made:

- *All patients attending the referral section will need a letter from the clinic*
- *Those patients presenting directly to the referral section without a letter will be sent to the clinic section of the CHC where the need for referral will be assessed.*
- *Referral down from CHC to clinic must be ac companied by a letter clarifying the diagnosis and next steps.*
- *Serious casualty cases will be referred directly from clinic to hospital without going through CHC.*
- *Smooth referral system from CHC to District hospital need to be set up.*

SUCH STRICT REFERRAL SYSTEM WILL HOWEVER REQUIRE THE FOLLOWING:

- *A concerted marketing campaign to describe the respective roles of the clinics and CHCs, and mention visits of specialists teams at clinics.*
- *A regular supply of drugs to clinics. Inadequacy of drug supply at clinic level has proven to be an important factor in the by-passing phenomenon.*

THE PACKAGE

The current Package is divided in three sections:

- Community services (non-personal services and community-based personal services)
- Clinics/mobiles
- Community Health Centres (CHC)

For each section, detailed components of services are listed, with a proposed timing for implementation. The overall aim is to reach delivery of comprehensive services across the country within 5 years.

As such the proposed organisation of services, in particular CHCs, as well as the list and components of services represent a five year target.

The following section provdes the description of level of services and explains the criteria used for allocation of services in one level or the other. It also makes a few suggestions concerning referral mechanisms.

The next section is the Comprehensive Primary Health Care Service Package itself with list of services and components of services. Sections on infrastructure and equipment have been left blank. These will be filled in follow up versions of this Package. In the same way management structure and support services have not been detailed, nor the information and monitoring systems.

Appendix 1 is a report from the consultation process in the provinces, which spells out the main issues raised, as well as some recommendations

THE DISTRICT BASED SERVICES

INPUTS	PROCESSES
INFRASTRUCTURE AND EQUIPMENT:	**COMPONENTS OF SERVICES:**
TYPE OF STAFF: • Professional Nurse • Enrolled Nurse or Assistant Nurse • Assistant health therapist • Psychologist • Medical Officer • Community (liaison) Development Officer • Other support staff: SASO, cleaner, clerk • Environmental health Officer • Health Promoters • Pharmacy Support staff • Oral Health professionals • Social workers	**District level services** • Marketing messages • Health promotion • School Health Services • Environmental/Occupational Health Services **Institutions** • Children • Tertiary Education Institutions • Prisons **Home Based care** • Special needs register • Terminally ill/palliative • Geriatrics • Disabled **School Health Services** **Promotive Health Services**
SPACE REQUIREMENTS:	

COMMUNITY SERVICES

1. DISTRICT-BASED INTERSECTORAL SERVICES

The District ensures the inter-sectoral collaboration between Health and Social welfare, Education, Water Affairs and Housing Departments and other related sectors.

COMPONENTS		TIME FRAME
1.1 Liaison with:	Youth Commission Community organisations NGOs about liaison of services	XX XX XX
1.2 Traditional healers:	co-ordination training: referral follow-up STDs, HIV, TB training other	XX XX O
1.3 Liaison with other health workers:	Environmental Health Private GPs and nurses Social workers Occupational Health services	XX XX XX XX
1.4 Surveys in community on: a) perception of quality and convenience of services coverage b) community participation		 O XX
1.5 Organization of disaster relief plans		XX
1.6 Outbreak and hazard investigation and response		XX
1.7 Organisation immunisation, other health days, Youth		XX
1.8 Organisation of DOT system for TB		XX
1.9 Contact tracing: typhoid ...		O
1.10 Defaulter tracing for:	immunisation TB Mental Health	XX XX XX

XX	Introduced and is in place by end of 2001
O	Introduced and is in place by end of 2002
OO	Introduced and is in place by end of 2005

NON-PERSONAL SERVICES

2. MARKETING MESSAGES

This section refers to marketing through use of media or posters ... It does not refer to education and training activities, which covered either in school health or in CHC Promotive activities.

COMPONENTS		TIME FRAME
2.1 Marketing IEC messages and material on:		
	rights of the child	XX
	immunisation	XX
	breast-feeding	XX
	oral health	XX
	lifestyle	XX
	life skills	XX
	TB,	XX
	AIDS, STDs, condoms	XX
	mental health	XX
	nutrition including safe food preparation	XX
	women and child abuse	XX
	substance abuse	XX
	prevention of road accidents	XX
	prevention domestic accidents	XX
	environmental issues	XX
2.2 Marketing use of appropriate level of service clinic versus hospital for PHC		XX
2.3 Marketing need of Road to Health Chart		XX
2.4 Information in relevant places and media on services available, means of access and opening times		XX

3. PROTOCOL PROMOTIVE HEALTH SERVICES

COMPONENTS	TIME FRAME
3.1 Promotion healthy lifestyle	XX
3.2 Plan health promotion for the center and other clinics	XX
3.3 Implement health promotion activities with mass and traditional media	XX
3.4 Provide training and other support to the attached clinics Health promotion activities	XX
3.5 Ensure health promotion in schools, workplace, community groups	XX

4. ENVIRONMENTAL HEALTH

COMPONENTS	TIME FRAME
4.1 Prevention of violence and substance abuse	XX
4.2 Manage/co-ordinate environmental health for district	XX
4.3 Manage community interface for environmental services	XX
4.4 Environmental Impact assessment	XX
4.5 Chemical safety	XX
4.6 Ensure resource management: budget, resource, Infrastructure	XX
4.7 Manage information system	XX
4.8 Anticipate/Recognise/plan for environmental health Problems	XX
4.9 Ensure inter-sectoral collaboration	XX
4.10 Manage disposal of sharps	XX
4.11 Monitor implementation of environmental health and food safety regulations	XX

PERSONAL COMMUNITY BASED SERVICES

The District will liaise with and provide appropriate support e.g. health professionals, EDL and other materials the following institutions: Children (creche, centre for young offenders), Disabled, Geriatrics, Prisons, Hospices, Tertiary Institutions, Other (e.g. Shelters) These institutions, will refer to the nearest centre as appropriate

5. HOME-BASED CARE

	COMPONENTS	TIME FRAME
Special needs register: children and families: growth faltering needing Rehab	5.1 Organisation of home visits with support by social worker	O
	5.2 Selection of cases needing more health intervention, including emotional growth faltering	O
	5.3 Provision of aids for improving activity for daily living	O
	5.4 Support to families, including for Welfare Grants	O
	5.5 Enlisting support from Community groups for Individuals and families	O
Palliative care, people with AIDS (PWAs) and late stage care Terminal care	5.6 Visits by auxiliary nurse, Supported by professional Nurse	XX
	5.7 Home nursing care and training for care givers	O
	5.8 Enlist support (as above)	O
	5.9 Provide equipment	O

6. WORKPLACE

The District will liaise with the following institutions and provide appropriate support e.g. health professionals, EDL and other materials

	COMPONENTS	TIME FRAME
OCCUPATIONAL HEALTH	6.1 Render occupational health promotion services	OO
	6.2 Promotes development of child-care facilities and lactation areas	OO
	6.3 Sensitize workers to specific occupational health problems	OO
	6.4 Primary risk assessment of occupational health exposure	OO
	6.5 Facilitate formation of Occupational health / safety committees at workplace	OO
	6.6 Monitor child labor	OO
	6.7 Education of employers and workers	OO
	6.8 Support of people with substance abuse	OO
	6.9 Care of people with chronic diseases	OO
TB CARE	6.10 Support data collection	OO
	6.11 Provide Tuberculosis DOT	O
	6.12 Education of employers and workers	O
	6.13 Where occupational health service exists, diagnose, treat TB and trace contacts	O

7. SERVICES FOR SCHOOL AGE CHILDREN

Phasing - in of service:
Introduce now: 1 visit per year to grade 1 children, Priority 2: grades 1 and 7, Priority 3: grades 1, 4 and 7

COMPONENTS	TIME FRAME
7.1 development of child to child program re: hearing and visual deficiencies	XX
7.2 Screening:	
• eyes	XX
• ears	XX
• oral health care	XX
• immunization status	XX
• heart problems	XX
• genetic/congenital disorders	XX
• physical development	XX
• mental health & neurological problems	XX
• child abuse	XX
7.3 Mass deworming in endemic areas	XX

COMPONENTS	TIME FRAME
7.4 Health education and prevention • oral health • life skills, sexual health	 O O
7.5 Referral when needed	XX
7.6 Organization of youth oriented services and overall activities in the community (support groups) and schools	O

8. REHABILITATION SERVICES

The District should ensure the inter-sectoral collaboration between Health and Social welfare, Education, Water Affairs and Housing Departments and other related sectors.

COMPONENTS	TIME FRAME
8.1 Needs analysis regarding services	XX
8.2 Facilitating and supporting the development of self-help Groups	XX
8.3 Home visits for detection and follow up of people with Disabilities	XX
8.4 Networking with rehabilitation and disability forums, CBOs and NGOs.	XX
8.5 Planning and supporting research, training and sensitising programs for caregivers, volunteers, people with disabilities, etc.	XX