ARTICLE I

PRIMARY HEALTH CARE IN A PAEDIATRIC SETTING — THE BACKGROUND

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OPSOMMING

Die artikel beoog om as agtergrond te dien vir die artikel wat daarop volg en wat met bepaalde belangrike punte t.o.v. die verskaffing van primêre gesondheidsorg teen 'n pediatriese agtergrond gemoeid is. Dit sal primêre gesondheidsorg in sy geheel beskou — sy aard, wie dit moet verskaf en hoe dit organiseer moet word. In hierdie artikel word die pediatriese agtergrond nie afsonderlik bespreek nie, omdat die skrywers dit as belangrik beskou dat primêre gesondheidsorg deur gemeenskappe in die geheel ontwikkel moet word en nie as afsonderlike dele beskou of beoefen moet word nie. Die geïmmuniseerde baba, die swanger vrou, die beseerde werker en die hipertensiewe ouma is almal in die brandpunt van primêre gesondheidsorg.

WHAT IS PRIMARY HEALTH CARE?

At a recent conference[1], a definition was drawn up that is most appropriate to the South African situation:

"Primary health care is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation, and at a cost that the community and country can afford. It forms an integral part both of the country's health system of which it is the nucleus, and of the overall social and economic development of the community."

THE CONTENT OF PRIMARY HEALTH CARE

a) to be part of and involved with the community, and all its activities, in such a way as to become a focus for community development.
b) the provision of basic hygiene and housing, including e.g.:
   — safe water
   — safe excreta disposal
   — safe waste disposal
c) the provision of adequate nutrition particularly to pregnant women and children
d) the provision of basic preventive health care, e.g. immunization, health education, family planning, antenatal care, obstetric care, for low-risk pregnancies.
e) provision of care for the chronically sick, aged and handicapped,
f) act as a means of referring people needing more sophisticated care to the secondary level of care, and as a means of receiving cases back from these levels, and being responsible for the ongoing care.
g) to provide screening, preventive and curative care to crèches, schools and institutions.

WHO SHOULD PROVIDE PRIMARY HEALTH CARE

In looking at this question, there are two important factors to be considered. The first concerns professional boundaries. The term primary health care was first used in Britain to describe the general practitioner levels of care in the N.H.S. More recently, it has been applied to the situation in developing countries where first contact care cannot be provided exclusively by doctors. Conditions vary from country to country, but it is accepted that **who** provides is less important than that

measurably adequate and suitable care is provided. In this process, many traditional professional boundaries have necessarily become blurred.

The second factor concerns coverage. For primary care to have a measurable effect on the health of a people it must reach a very high percentage of all individuals. If, as often happens, resources are limited and a "trade-off" between sophistication and coverage is inevitable, coverage should take priority.

Very many categories of health worker may be involved with primary health care. Three main groups will be discussed here:

The Community Itself

Traditionally, health services have been externally imposed with little attempt to involve the people in their planning or provision. The result has been that the needs and convenience of organisers and staff have taken precedence over those of the people for whom the services are provided. As a result, communities often neither identified with, nor contributed to their local health service.

Ideally, primary care services should involve true representatives of the community in their initial planning and later running. The nature of such representatives varies from place to place, but for example, in cities and peri-urban areas, be tenants' or resident's associations, and local headmen and/or village committees in other areas. In places where communities have not organised themselves in this way, it is an urgent **health** priority that they should be encouraged to do so. An unorganised community cannot voice its needs and grievances coherently, and likewise, it cannot take effective community action to remedy problems. For example, in an area where indiscriminate garbage disposal is becoming a health hazard, it is only the community with a welldeveloped local organisation that will be in a position to do or get anything done about it.

The community acting as a whole should then be the prime agent for the provision of primary health care. It can make contributions in all the areas of activity mentioned above. Action may range from cleaning up the environment, to helping build or raise money for new health or education facilities, to forming parent groups for handicapped children, to organising day care for the pre-school children of working mothers, to forming buying co-operatives in order to keep food prices down, to electing members to be trained as lay health workers.

The community acting in this context can tackle and achieve things that the traditional health service cannot, and it is essential that it be brought in as a full member of the health team.

Traditional Health Professionals

Clinic nurses, public health nurses, physiotherapists, health inspectors, social workers, doctors, occupational therapists and clerks are all involved in primary health care. Where resources are abundant, a full team will be available. Very often it will be incomplete and, increasingly, health professionals in primary health care will need to be able to function in several capacities. The roles of such professionals are well known and will not be discussed further.

Traditional Health Professionals with several altered Roles

Blurring of traditional health professional boundaries was mentioned above. This has become essential in all developing countries of the world committed to full implementation of primary health care. In particular, the diagnostic and therapeutic role of the doctor has been taken over on a wide scale. Examples of workers specialising for this role are the clinical officers of Kenya, and the health assistants of Zimbabwe-Rhodesia. They have been found to fill this role very well indeed. In South Africa, state registered nurses have been trained for this task, and have become known as clinical nurses. Various training programmes have sprung up to meet a wide range of local needs. At present, little uniformity of training or work situation exists, and official recognition is absent. The situation regarding two separate categories of paediatric clinical nurses currently working in Cape Town will be discussed in the companion article.

Lay Health Workers

While it has become essential for nurses and other health workers to be trained to deliver care traditionally reserved for doctors in order to meet the over-riding objective of providing **coverage** in primary care, it has also become necessary to train and involve 'lay people' either on a paid or on a voluntary basis to act as the most peripheral of all health care agents. Natural leaders are recruited, motivated, and trained to serve a small cluster of families in their immediate residential area. These may be a group of labourers' families on a remote farm, or the residents of a block of flats in a city.

Lay health workers are armed with a simple knowledge of health, hygiene and domestic remedies for everyday minor complaints and, also, with a basic knowledge of the local health and welfare resources and how to put people in touch with them. They work under the supervision of the professional primary health care workers who are responsible for their training. They are also involved in the detection and referral of health problems among their group, and with helping with the continuing care of the chronically ill, aged and handicapped.

Used in this way, they become an extension of primary health care into the community so that it is possible for everyone in the population to be known to be contactable by a member of the primary health care team.

HOW SHOULD PRIMARY HEALTH CARE BE ORGANISED?

Of prime importance in organising primary health care is that it should be accessible to the people. It must be geographically accessible — as judged by travel time and cost; financially accessible — it must be affordable by everyone who needs it; culturally accessible — the mode of presentation must be acceptable to the people; functionally accessible — it must be available whenever it is needed.

Primary health care cannot be divided into watertight compartments such as that for children rather than adults, or that for cure rather than prevention. The ideal of the unified approach is laid down in the New Health Act. In what follows, a suggested 'ideal' organisation will be contrasted with the reality in urban and rural areas in the Cape Province.

URBAN AREAS

The Ideal

The provision of primary health care is based on a Community Health Centre, with staff and facilities to serve about 75 000 people. Ideally, a single health authority is involved, but it is possible to have several authorities working closely to provide a full range of promotive, preventive and curative services from one site.

Such community health centres should have facilities for the antenatal care and delivery of low-risk pregnancies, routine preventive work — both to patients and the environment, and simple curative work backed up by access to basic laboratory tests and X-rays. In addition, there should be facilities for surgery that can be performed on a day-patient basis, and the resuscitation of emergencies. Patients needing hospital admission or more sophisticated facilities are referred to the area hospital. While nursing and medical staff of such community health centres are generalist and not specialist, in the larger community health centres, the work load may well be large enough to permit certain workers to concentrate on particular groups, such as children or the elderly. It is in this setting that the entity of the paediatric primary care clinical nurse (see companion article) could best function.

The community health centre staff are ideally in touch with the community's representatives, usually through a liaison committee so that cross-fertilisation of ideas on health problems can occur. The centre staff are kept in touch with the community's own healthrelated endeavours.

Lay health workers serving the area are in close liaison with the staff at the centre, referring in problems found in the community and acting as outreach of the centre in helping with the home management, especially for chronic conditions.

A word about the area hospital is important because it is the first line of referral from the community health centres. Area hospitals are in contrast to regional and teaching hospitals which have facilities at the "super-specialist" level. They serve a number of community health centres, and a population of about 200 000. They should have facilities for investigation and hospital admission of routine cases, and have on the staff a general paediatrician, surgeon, obstetrician and general physician. Short-stay wards are an essential feature, particularly for children. Experience has shown that the majority of children requiring hospital admission, need to stay for 48 hours or less, during which time they very often need I.V. therapy and/or oxygen. Advanced paediatric clinical nurses are ideally trained to run such a ward, doing the bulk of the clinical work themselves under the general direction of a paediatric medical officer.

The Reality

For the affluent, primary care is provided by private general practitioners, with referral to private specialists. Local authorities have over many years established a network of preventive clinics and environmental health services within large urban communities.

Complementary, decentralised curative services for the last 10 years, in the form of the Day Hospitals in the metropolitan areas of the Cape Province. However, it is unusual to find Day Hospitals physically and functionally meshed in with the local authority services. An exception is at Heideveld in Cape Town. The City Council Clinic and Day Hospital are located next door to each other, and this has led to concerted efforts at interservice co-operation. Coupled with a recently begun lay worker programme, it seems that the ideal of a fully integrated community health centre may soon be realised. Unfortunately, nowhere is it yet the practice for crèche and schools' health to be fully and officially in the hands of a community health centre. It is the planner's intention that all new services will be developed along these lines.

Advanced paediatric clinical nurses have worked very effectively in the Day Hospitals in dealing with the majority of common conditions of children with a minimum of medical supervision. It seems likely that the newer paediatric primary care clinical nurses with a simple training may also be able to function very well in the existing Day Hospitals setting.

Peripheral health workers are a recent and so far, scanty development, in the Cape Metropolitan areas at least. The St. John Ambulance Brigade has, with the help of the Urban Foundation, started a programme of recruitment and training of 'health auxiliaries' to act as lay health workers in close co-operation with established 'official' health services.

RURAL AREAS

The Ideal

Community Health Centres based in small country towns are seen as the basis of primary health care services in rural areas too. In contrast to the urban situation, many people living at a distance on farms for example, will have poor access to the CHC. This difficult problem may be overcome in two main ways. Firstly, by the widespread use of lay health workers with good training and some means of communication to the community health centre. Secondly by the use of satellite and mobile clinics on a regular roster visiting remote areas. The staff of such peripheral clinics clearly need to be trained to be able to deal with the majority of the preventive and curative needs of poorer rural communities especially of mothers and children. In these remote settlements, the paediatric primary care clinical nurse functions very well. It is important to emphasise that where mobile clinics may visit a community only weekly, or less, lay health workers in that community provided the continuity of care and help in emergencies that cannot be provided by mobile or satellite services. Their usefulness in health promotion in depressed rural communities can hardly be overstated.

Referrals to area hospitals occur in the same way as in urban areas. The area hospital should have a similar function and staffing as the urban counterpart.

The Reality

For the affluent, with easy access to transport, the situation is little different to that in urban areas. The position of those of lower socio-economic status is not nearly as good as their urban counterparts. It has been only in this decade that State funding has enabled local authorities in the Cape Province to develop a system of preventive services in the rural areas. Fixed clinics, satellite clinics, and a complex network of mobile clinics are provided, and within the limitations of finance and staff, these provide an excellent **preventive** service. Unfortunately, the availability of curative care is much less favourable. Although there are 'x' hospitals in small towns in the Cape province, 'n' have outpatient facilities. In their absence, the part-time district surgeon is the usual source of curative care for the rural poor. It hardly needs pointing out that access to this service is difficult for those in even slightly remote areas, where for the mother of an acutely unwell child, the difficulties in gaining medical help may be formidable.

The recently announced plans to open community health centres in a number of small country towns are most encouraging. With the well-known difficulties in attracting doctors to country towns, it seems certain that the bulk of the clinical work in these centres will be borne by clinical nurses. It will also be most important to add a curative function to the existing local authority mobile and satellite preventive clinics, where it is clearly impractical to deploy or separate the preventive **and** curative staff. This could be most easily achieved by giving existing clinic staff a short clinical training, by a slight increase in the range of medications, and by increasing the staff density somewhat to compensate for the slower rate of work that a complete service would involve.

At present, very few, if any, lay health workers have been recruited and trained in rural areas. This is clearly an urgent priority.

An attempt has been made to place primary care, its nature, providers and organisation into perspective. It hopefully provides a background against which the specific issues discussed in the following article can be viewed.

REFERENCE:
Primary Health Care: A Joint Report by the Director General of the World Health Organization and the Executive Director of the United Nations Children's Fund, Geneva 1978.: