COMMUNITY HEALTH CENTRE

INPUTS

INFRASTRUCTURE AND EQUIPMENT:

include X-rays, lab, physiotherapy

SPACE REQUIREMENT:

TYPE OF STAFF:

- Generalist Nurse
- Generalist with special areas of training
- Specialized full-time:
  - Advanced midwives
  - Child health nurse
  - Psychiatric nurses
  - EHO
  - Dental therapist, oral hygienist and dental assistants
  - Nutritionist/Dietician
  - Pharmacy assistant
  - Social worker
  - Medical Officer
  - Rehabilitation assistant
  - Radiology assistant
  - Lab technicians
- Visiting Specialized staff, include. Dentist, genetic nurses
- Enrolled Nurse or Assistant Nurse
- Other support staff: cleaner, clerk ...
- Ambulance and transport staff
  Support 24 hours unit

PROCESSES

COMPONENTS OF SERVICE:

Clinic (for local population) + All referrals from clinics and mobiles

Referrals from hospital

Day time service:

- Pediatrics
- Reproductive Health (including:
  - Ante-Natal
  - TOP
- Adult Curative (including:
  - Chronic Disease care
  - Acute illness
- Mental Health
- Dental
- Service for people with Disabilities and genetic disorders
- Environmental Health
- Specialized services e.g. Ophthalmology, Dermatology

24 hours service:

- Emergency care
- Normal deliveries
- Minor operations

Management Out-reach services

- Management, Logistical and technical support

Support to clinics

- visit by specialized staff to clinic
- quality support and monitoring

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

1. PROTOCOL ANTENATAL CARE

PHCN/MOs at CHCs will see all first visits (TO BE FINALIZED), all first pregnancies throughout pregnancy (?) and all high risk pregnancies throughout the pregnancy unless referred to the hospital

COMPONENTS	TIME FRAME
1.1 Routine of observations according to schedules for ANC at each step of the Pregnancy (3-6 visits)	XX
1.2 Screening for risk factors and situations in the evolution of the pregnancy according to protocols	XX
1.3 Tetanus immunisation	XX
1.4 Screening for: • Syphilis • Hemoglobin, Blood group, RH • Nutrition/weight • Congenital/Hereditary disorders • Mental Health	 XX XX XX XX XX
1.5 Promote voluntary HIV testing (if counselling/support available)	XX
1.6 Booking – preparation for delivery if required	XX
1.7 Education and counselling to pregnant women and partner on: • Monitoring signs of problems (bleeding, Std, HIV...) • delivery • new-born and child care	 XX XX XX
1.8 Treat STDs	XX
1.9 Completion of patient-retained ANC card	XX

2. PROTOCOL TERMINATION OF PREGNANCY

Variable incremental introduction and service available within 3-5 years

Service for incomplete abortion at Community/District as complications around surgical procedure can be greater with need the complete surgical casualty staff - equipment of a hospital 24 hour Casualty Dept.

COMPONENTS	TIME FRAME
2.1 Details concerning legal rights of both users and staff secured	OO
2.2 Privacy during service + previous consultations	OO
2.3 Availability with/without partner consent	OO
2.4 Privacy in space for recovery after TOP	OO
2.5 Components of service: as per schedules and protocols • Medical termination under 9 weeks • Surgical termination under 12 weeks • In selected CHCs with 24 hours unit in-patient and good transport system, surgical termination under 16 weeks	 OO OO OO

COMPONENTS	TIME FRAME
2.6 Numbers of services to include: • 1 visit to confirm pregnancy • 1 visit for pre-TOP counseling, possibly more • 1 visit to perform the termination • 1 visit for post-TOP counselling and check-up, possibly more	 OO OO OO OO

3. PROTOCOL REPRODUCTIVE HEALTH - OTHER

COMPONENTS	TIME FRAME
3.1 Infertility: • Screening, advice and referral as per national guidelines • Limited initial investigations in specialized clinics	 O O
3.2 Cervical cancer screening: follow-up with MO for abnormal clinical Features, including colposcopy	XX
3.3 Breast abnormality (breast self-examination and professional assessment)	XX
3.4 Other gynecological complaints: abnormal bleeding	XX
3.5 Male and Female Sterilization under local anesthetic	XX
3.6 Genetic counseling	XX
3.7 Referral from clinics for other complaints	XX
3.8 Referral upwards to specialists	XX
3.9 Adolescent/Youth services: • FP • STD • Health Education & Counselling	 XX XX XX

4. PROTOCOL CHRONIC DISEASES CARE

COMPONENTS	TIME FRAME
4.1 1st consultation (initial diagnosis) by more qualified clinical staff at CHC	XX
4.2 Regular clinical reviews (1-2/Year) to be conducted by more qualified clinical staff at CHC	XX
4.3 Range of services enlarged by the presence of MO (e.g. for multiple diagnosis)	XX
4.4 Interpretation of common laboratory and x-ray results	XX
4.5 More accurate screening for complications of diabetes, HP, Asthma, Epilepsy, Heart conditions	XX
4.6 Screening of mental health problems	XX
4.7 More specialised geriatric care, including foot care	XX
4.8 Palliative care consultation	XX

COMPONENTS	TIME FRAME
4.9 Telephone consultation service for patients calling the CHC: for information on routine controls, control of signs of risk and complications and taking of medications	XX

5. PROTOCOL TUBERCULOSIS

Protocol clinic +

COMPONENTS	TIME FRAME
5.1 TB diagnosis and treatment implemented by nurses at clinic level, including discharge.	XX
5.2 Complicated problems are treated, e.g. : • Sick patient • Diagnosis not made on sputum micro x 2 • Poor progress on treatment • Other complications	XX XX XX XX

6. PROTOCOL PEOPLE WITH HIV / AIDS

Protocol clinic +

COMPONENTS	TIME FRAME
6.1 Management of acute illness:e.g.: • Lower Respiratory Tract Infection, • Dehydration requiring intravenous therapy	 XX XX
6.2 Investigations not available at clinic	XX
6.3 Doctor consultation	XX
6.4 Short stay in some CHCs	XX
6.5 To refer to secondary level for: • Admission • secondary consultation and diagnostic	 XX XX
6.7 Organisation of home base care	OO

7. PROTOCOL OTHER CURATIVE

COMPONENTS	TIME FRAME
7.1 All referrals from Clinics and mobiles	XX
7.2 All referrals from Hospital	XX
7.3 Interpretation of common laboratory and X-ray results	XX

8. MENTAL HEALTH

COMPONENTS	TIME FRAME
8.1 Triage of patients needing to be seen by psychiatric nurse or more specialised staff	XX
8.2 Identification, assessment, management and referral of problems to community Resources/services	XX
8.3 Screening for common problems: trauma, abuse, depression, anxiety, substance Abuse	XX
8.4 Consultation with clinic or CHC nursing staff	XX
8.5 Assessment and management of referrals from clinic with support of multi-disciplinary assessment	XX
8.6 Initiate individual, group, family therapy	XX
8.7 Establishment of management plans for patients sent back to clinic	XX
8.8 Periodic review of cases followed at clinic level	XX
8.9 Brief term interventions with individuals or families not exceeding 10 sessions per Year	XX
8.10 Consultation with/ referral to other specialist services	XX
8.11 Linking with District for mental health promotion activities	XX

9. ORAL HEALTH

At least there should be a monthly outreach dental service

COMPONENTS	TIME FRAME
9.1 Examination	XX
9.2 Bitewing radiographs	XX
9.3 Cleaning of teeth	XX
9.4 Preventive measures including fissure sealants, etc.	XX
9.5 Basic curative services including emergency relief of pain and infection control	XX
9.6 Referrals to District Hospital or visiting dentists	XX
9.7 Promotive and Primary Preventive oral health services	XX

10. PROTOCOL REHABILITATION AND DISABILITY SERVICES

- Provide all services provided at clinic level plus
- Daily available service for patients attending the clinic + supervision of work of CBRW's in the communities surrounding the CHC
- Short waiting times - made easy through a booking system
- Services to be introduced from now, stepwise with staff appointment

COMPONENTS	TIME FRAME
10.1 Initial assessment of all cases referred by CHC, clinics and community workers	XX
10.2 Screening of "rehabilitation" needs and identification of disabilities at various service points (e.g. Child Health, Chronic Diseases Care) by clinical staff	XX
10.3 Referral to Rehabilitation technical staff for treatment and identification of assistive devices' needs, ordering/provision through public funds if socially justified	XX
10.4 Repair of devices	XX
10.5 Organizing supervision of Community Rehabilitation	XX
10.6 Assistants, carrying-out the supervision schedule	XX
10.7 Provision of basic rehabilitation services as prescribed	XX
10.8 Outreach services by resident rehabilitation workers	XX

11. ENVIRONMENTAL HEALTH

COMPONENTS	TIME FRAME
11.1 Render environmental health promotion services	XX
11.2 Render environmental health training programs	XX
11.3 Monitor environmental health legislation enforcement	XX
11.4 Render food safety and food hygiene services, including meat and milk Control	XX
11.5 Render services in respect of public conveniences	XX
11.6 Render non-specialist impact/risk/hazard assessments and environmental evaluation	XX
11.7 Render non-specialist occupational hygiene/indoor environmental quality evaluation services/exposure assessment	XX
11.8 Render environmental health services in formal sector	XX
11.9 Render environmental health services at care centres	XX
11.10 Render services in respect of keeping animals, nuisances	XX
11.11 Render services in respect of collection and collation of environmental health data, and liaise with relevant care centres	XX
11.12 Render services in respect of outbreak investigations, communicable diseases investigation, as part of a team	XX
11.13 Render disaster management services in respect of environmental health	XX
11.14 Monitor health aspects of housing, water and sanitation	XX
11.15 Render environmental health planning, zoning, license applications	XX
11.16 Render vector control services	XX
11.17 Render pollution control services: inspection and monitoring	XX
11.18 Monitor waste management services: litter control, waste storage and Collection	XX

COMPONENTS	TIME FRAME
11.19 Render environmental health services in respect pauper burials	XX
11.20 Monitor food safety services	XX

12. PROTOCOL OCCUPATIONAL HEALTH

COMPONENTS	TIME FRAME
12.1 Render occupational health promotion services	XX
12.2 Sensitise workers to specific occupational health problems	XX
12.3 Primary risk assessment of occupational health exposure	XX
12.4 Facilitate formation of Occupational health/safety committees at Workplace	XX
12.5 Support data collection	XX

13. PROTOCOL CASUALTY

COMPONENTS	TIME FRAME
13.1 Care of trauma of limbs excluding fractures (temporary immobilization only)	XX
13.2 In CHC with X-rays facilities, treatment of minor fractures	XX
13.3 Preparation for urgent referral of serious trauma of trunk, limbs and head (including proper immobilisation, IV therapy and clearing of the airways) IF these cases brought in the CHC	XX
13.4 Management of poisoning cases	XX
13.5 Management of acute psychiatric cases and referral	XX
13.6 Care of medical conditions under proper management of MO (which would not call for anaesthetic procedures) or "high" care nursing) - and which the MO considers that the condition can be stabilised within 24 Hr	XX
13.7 Emergency treatment for stabilisation before referral	XX
13.8 Referral of all other cases to the appropriate referral hospital	XX

14. PROTOCOL MATERNITY

COMPONENTS	TIME FRAME
14.1 All steps of normal delivery services, from reception to discharge	XX
14.2 Ventouse and forceps available	XX
14.3 Decision on local service *versus* referral to hospital, according to Protocols	XX
14.3 Health education to mother on general + NB care issues + Immediate post-partum self-care	XX
14.5 BCG, oral polio given to NB before leaving maternity	XX

APPENDIX 1

REPORT ON PROVINCIAL CONSULTATION FOR THE PRIMARY HEALTH CARE SERVICES PACKAGE

CONSULTATION PROCESS

INTRODUCTION:

Following the development of the fourth draft of the Comprehensive Primary Health Care Services Package, which incorporated comments from the national DOH directorates, the Package was sent to all provinces (Heads of Departments, members of the District Facilitation Committee), to prepare for the consultation workshops. These workshops were held from the end of September 1997 in eight provinces. Mpumalanga postponed the consultation to the new year. The consultation was carried out by Ms. Assy Moraka from the National Department of Health, Dr Abdul Elgoni from the Health Systems Research Department from the University of the Free State and Emmanuelle Daviaud from the Center for Health Policy at Wits University.

The workshops aimed at reaching agreement on the scope and detailed content of the Package as well as identifying the main problems for implementation. By reflecting the different inputs of each province, this document constitute a comprehensive Package of services common to all provinces.

THE CONSULTATION PROCESS:

The consultation workshops were attended by provincial and some local authority staff, and in some provinces representatives of unions. In few provinces communities were represented.

The attendances varied from 50 to over 100 people. The distribution of the Package prior to the workshop was uneven, and often poor. This emphasized the importance of holding such workshops as the mailing of documents often did not reach beyond management.

The Package was generally well received: "It is a success and a triumph to have something to consult with" was the concluding remark in one of the provinces. Its use for planning purposes, setting priorities, helping to define the content of municipal services, and clarify the baskets of what communities can expect, as a base to involve communities better, were acknowledged. Whilst there was initially a certain unease at what was perceived as a top down approach from the National Department of Health, the process of consultation was appreciated. In all but one province, that reservation appeared to have been cleared by the end of the workshop.

There was often a misunderstanding on the scope of the Package and its stage of development. A number of comments pointed to the need to have included in the Package sections on related support: from required management structures, to Health Information and monitoring systems, to other support services: pharmacy, X-Ray, Laboratory, transport, to equipment required. Once it was explained that these areas would be detailed when common agreement have been reached on a common scope of services the reason for the Package and Consultation was accepted.

MAIN ISSUES:

1. NEED OF STEPWISE APPROACH AROUND ORGANISATION OF SERVICES:

The Package is a document that represents targets, in terms of both content and organizational structure. Those will have to be met on an incremental basis, and of a different pace by various provinces and within provinces. Generally the infrastructure in terms of Community Health Centres (CHCs) is poor and a number of services allocated in the package to CHC level will remain with District

hospitals level for the foreseeable future. Downgrading local hospitals to the status of CHCs is likely to be politically sensitive. Thus, whilst a stepwise approach was recognized regarding services delivered, caution should also be drawn to the need of a stepwise approach regarding the proposed organization of services.

2. NEED TO LINK WITH DISTRICT HOSPITAL

All provinces mentioned the need to link the Package more clearly with the District hospital. Given the clearly stated framework of the Package within a District Health System, the non-inclusion of District hospital as part of the Package was seen as a missing part. With development of the work on the Package for District hospital the link between the two packages will have to be spelt out clearly.

3. CLINICS:

ORGANIZATIONAL APPROACH

The type of organization of clinics around service points was discussed both for its feasibility particularly in small clinics, but also for its desirability where the service point type of approach was opposed to the family practice model. The internal organization of the clinic, provided it is an integrated model, may not in fact need to be part of the Package.

The service point type of organization with a specific point for children raised the issue of the age break. Should it be 18 years, as per the definition of children in the Constitution, or 12 years to acknowledge some of the needs of teenagers, in particular regarding reproductive health, as more similar to those of adults. This again may be left to local discretion.

NEED FOR DEDICATED YOUTH SESSIONS

A very frequent demand during the workshops was that special times be allocated for youth sessions covering all needs of the youth; and that it be considered as an important priority regarding organization of services, even if only for the three years time target.

MATERNITY AND CASUALTY SERVICES IN RURAL AREAS

A common critic, when consulting in provinces with large rural areas, was that deliveries must be performed at clinic level and casualty services delivered there as well, given the distance to CHCs or local hospitals. We have modified the Package to include non-complicated deliveries at a clinic level, it is however unclear to what extent it is possible to expect professional nurses to provide casualty services beyond those already stated in the Package: stitching, bandages, and stabilization prior to referral. These points will have to be clarified.

4. ROLE OF CHC/HOSPITALS AS SUPPORT FOR CLINIC STAFF

A number of provinces mentioned the need to spell out the role of CHCs/hospitals to support clinic staff. It could be envisaged that part of the clinic visits by an Medical Officer or other specialists staff was used as audit sessions, or allocated times to discuss specific clinical issues. Such an arrangement would help improve quality of services.

5. COSTING AND FINANCIAL RESOURCES

Some provinces felt that the costing presented was in fact an under-estimate of the real costs, and feared that their budget would be cut accordingly. It is essential to use the piloting process as a way to reassess the validity of the costing presented.

A number of provinces mentioned that they would not have the resources to provide home-based care even in 5 years time. This type of service, they suggested, should be provided by families, support group, and NG0s.

In some areas, facilities are cost-centers. Such a move would enable better planning, more accurate costing and allow better monitoring of the reasons for selective implementation of the Package.

6. INTERSECTORAL APPROACH

All provinces commented on the health services bias of the Package and on the need to emphasize more an Intersectoral approach, in particular with environmental health and welfare services. The need was particularly acute in those provinces which have joint health and welfare services in the same Directo However, need for Intersectoral approach was emphasized vis a vis Water Affairs, Education Housing.

7. IMPORTANCE OF OCCUPATIONAL HEALTH

Whilst some provinces mentioned not having any occupational health officers. Other provinces emphasized the need to put more focus on occupati health. The area may need further investigatior

8. HUMAN RESOURCES

GENERALISTS VERSUS SPECIALISTS ISSUE

The staffing profile suggested for clinics and CHCs raised in a number of provinces, the debate on specialist versus generalists. The fact that the scope of services to be delivered at clinic level was determined by the level of skills of a professional nurse was questioned, in particular in those provinces which have large rural areas. A suggestion would be that specialists visit clinics at regular intervals, in particular for services with the highest level of demand. This in turn would decrease the number *of* referrals to higher levels. For instance it could be suggested that an MO visit each clinic on a weekly basis, an ophthalmologist and an oral hygienist on a monthly basis, a mental health specialist on a two-weekly basis, and an environmental health officer on a two-weekly basis. Such an approach may help deal with the concern that the generalists nurses required to staff clinics would have to be 'super-people' with extremely wide-ranging skills.

There appears to be some confusion about capacity of nurses to prescribe as required by scope of curative services to be delivered at cl level. and whether this is in accordance with nurses scope of practice. A paper clarifying issue may be required, coming from the Natic Department.

The national directorate covering Chronic Disea stated that professional nurses are able to diagn and manage priority chronic diseases now. This sition was however contested on a local level. So clarification is required on this point, as this co impact significantly on the level of referrals to CH local hospitals.

COMMUNITY HEALTH WORKERS (CHW)

Most provinces emphasized the needs to integrate CHWs as part of the formal staff establishment, indicating that it represents for them the only possibility to cover the scope of services indicated. In particular regarding out-reach services. There w very pressing demand for the national departm to review the case of CHWs.

SUB-AUXILIARY SPECIALISED OFFICERS (SASOS)

It was suggested that SAS0s should not be multi-specialised, since their limited level of training would produce an extremely superficial knowledge if spread across many areas. It was however suggested th they should be multi functional, to better respond the needs of the health services.

SUPPORT SERVICES; PHARMACY SERVICES:

With the increased importance of curative services at clinic level, and the suggested organization of fast-queue service point, there were strong demands for the inclusion of a pharmacist assistant at medium-size clinics. This was seen as a necessary condition for the proper running of the fast queue service. The code of practice of pharma assistants will need to be looked at.

More generally it was felt that support service pharmacy, X-ray, laboratory services, should l given clearer recognition in the Package.

9. FORENSIC WORK

The Package does not mention forensic work. Should this be left to District Surgeons or how should it be incorporated into the Package?

RECOMMENDATIONS

This section recaps the main points which will need to be clarified following the consultation with provinces.

1. Need of stepwise approach around organization of services in particular regarding CHCs/local Hospitals.

2. Need to link with District hospital Package to build a district Package

3. Clinics: organisational approach:
   Internal organization of clinic: service point, family practice or other should be left to discretion of local clinics.
   Need of dedicated youth sessions
   Maternity and casualty services in rural areas
   Package should include such services at clinic level, In particular for local areas. But level of casualty services need to be clarified.

4. CHC/District hospital/specialists to support clinic staff: clinical sessions and supervision/ training audit sessions

5. Costing and financial resources

   Costing and staff implications must be tested through the piloting process
   Decision must be made on the inclusion of home-based care in the Package given the scarcity of resources, but also given the likely demand through the AIDS epidemic.
   To suggest a move towards facilities as cost-centers.

6. Intersectoral approach to be emphasised more clearly

7. Occupational Health needs to be looked into given the disparities between provinces in this area.

8. Human resources:

   A paper should be sent from the National DOH clarifying the capacity of nurses to prescribe as required by the scope of curative services to be delivered at clinic level, and whether this is in accordance with the nurses scope of practice.

   Clarification is required on the capacity of professional nurses to currently diagnose and manage priority chronic diseases without referral to CHC/hospital level.

   Community Health Workers

   The national department should review the case of CHWs.

   Support services; Pharmacy services

   To clarify the possibility of having pharmacist assistant at medium-size clinics, seen as a necessary condition for the proper running of the fast-queue service. A paper should then be sent from the DOH clarifying code of practice of pharmacy assistants.
   Support services: pharmacy, X-ray, laboratory services, to be given clearer recognition in the Packaged.

9. Forensic work

   There is need to clarify how forensic services will be delivered. Should this be left to District Surgeons or how should it be incorporated into the Package?

10. Piloting

    A plan for piloting the Package and Its resources implications needs to be drawn up. Such piloting would enable providers to:
    - reach a more realistic consensus on prioritisation
    - assess which of these services. For which type of local authorities are implement-able, thereby contributing to the debate on municipal services
    - define more authoritatively the resources (staff, and financial) implications of the Package.

Decision must be made whether limited piloting should take place with a selection of sites, according
to pro-defined criteria or whether one pilot per province should be identified using the same pre-defined criteria in the selection of the pilot.

11. Task team

A task team with representatives of relevant directorates should be set up to ensure the ad equate follow-up on these recommendations, and the co-ordination of the piloting process