RE-ENGINEERING PRIMARY HEALTH CARE FOR SOUTH AFRICA
HUMAN RESOURCE IMPLICATIONS

PRESENTATION HWSETA

15 SEPTEMBER 2011

THE MAIN FOCUS OF THE PHC RE-ENGINEERING

- Strengthen the district health system (DHS) and do the basics better

- Place much greater emphasis on population based health and outcomes
  - a new strategy for community-based service
  - a team approach including community health workers (CHWs)

Why now again?

- PHC improves health outcomes
- SA has high investment in health with poor outcomes
- NHI needs strong district health system driving effective PHC
- Health system needs to re-find its focus
  - To be service and outcome oriented
  - To have a motivated, enthusiastic committed health workforce
  - To maximise all available resources
- The time is right and the necessary political will is strong

The re-engineered PHC strategy

Two fundamental differences to the current PHC approach:

1. The current DHS needs to be strengthened

- the basic systems need to be better implemented
- The DMT needs to be given the responsibility for with the consequent accountability for managing the district and being responsible for the health of the population.

2. Strengthen Interaction between the health services and the users of the health service.

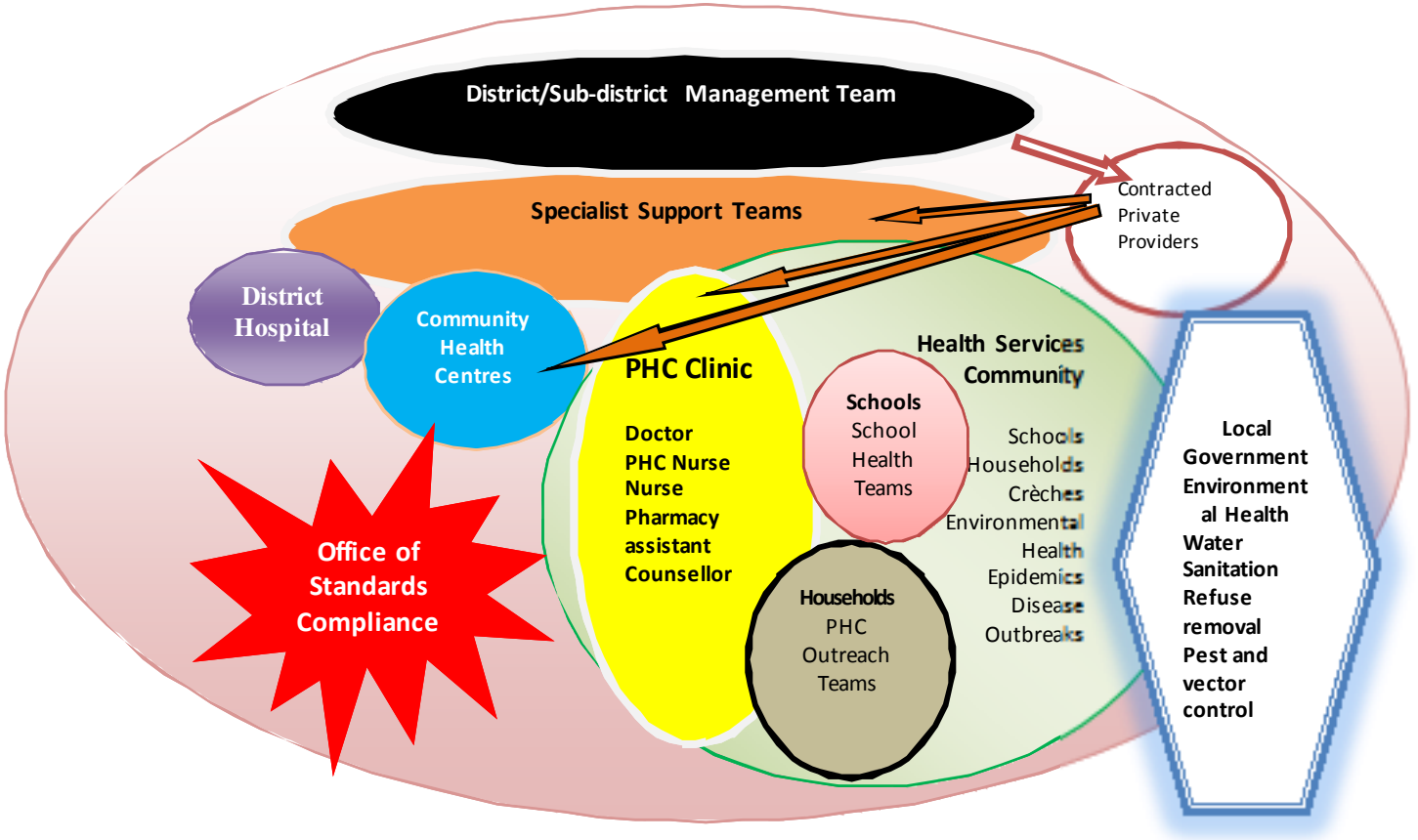
- the health services pro-actively reach out to families emphasis on health promotion and preventive activities;
- outreach into communities and homes of families with family census;
- early identification of individuals within families at high risk;
- greater interaction with communities to get their support for participation in maintaining and improving their own health; and
- a team approach to health care.

PHC Package

- New primary health care package (NHI):
  - Community based services
  - Increased emphasis on promotive, preventive services at household level
  - Includes: oral, hearing, vision, rehabilitative
  - School health services
- Aligned with District Hospital package
- Effective referral system
- Appropriate emergency and planned patient transport

Figure 1 Proposed PHC model

DHS MODEL



PHC Re-engineering

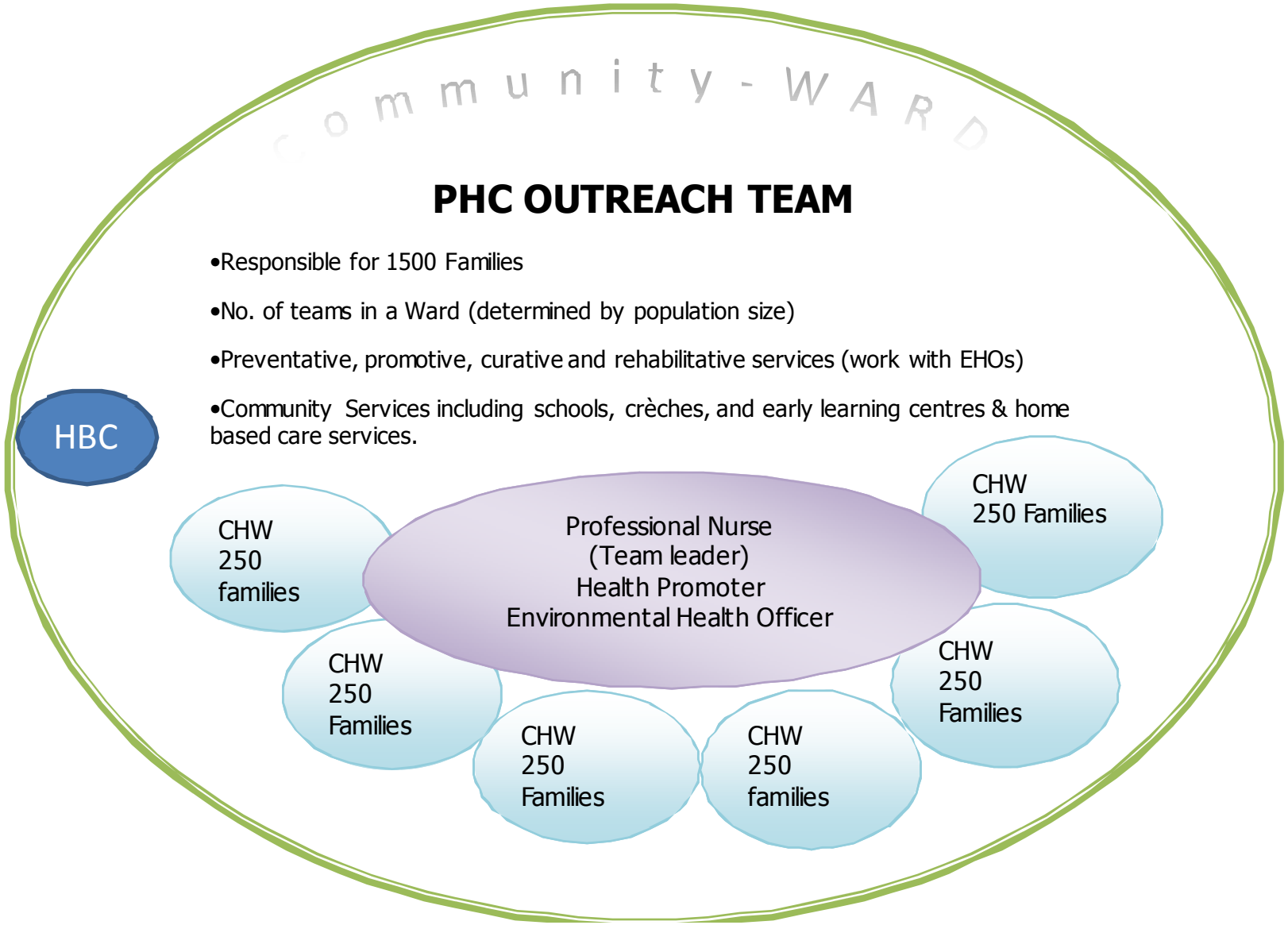
Three stream approach to PHC re-engineering adopted by Department of Health

(a) a ward based PHC outreach team for each electoral ward;

(b) strengthening school health services; and

(c) district based clinical specialist teams with an initial focus on improving maternal and child health.

WARD BASED PHC OUTREACH TEAMS



PHC OUTREACH TEAM SERVICES

Each PHC outreach team will offer an integrated health service to the households and individuals within its catchment area.

The core components of the integrated service are:

1. Promote health (child, adolescent and women's health)
2. Prevent ill health
3. Ante and post natal community based support and interventions that reduce maternal mortality
4. Provide information and education to communities and households on a range of health and related matters
5. Offer psychosocial support
6. Screen for early detection and intervention of health problems and illnesses
7. Provide follow-up and support to persons with health problems including adherence to treatment
8. Provide treatment for minor ailments
9. Basic first aid and emergency interventions

PROFESSIONAL NURSE ROLE IN PHC OUTREACH TEAM

TEAM

1. Assume responsibility as team leader
2. Allocate and assign tasks and supervise and manage team members
3. Develop capacity of CHWs to deliver PHC outreach services
4. Promote teamwork amongst PHC outreach team members
5. Train, mentor and coach PHC Team members
6. Manage performance of team members (set performance requirements, assess, evaluate, correct and improve performance)
7. Monitor and evaluate team performance

COMMUNITY

1. Facilitate entry into the community for the PHC outreach team.
2. Conduct a community assessment and compile a profile and diagnose the health needs of the community.
3. Initiate a community-based PHC outreach service to households, their inhabitants and to schools, crèches and day care centres in a designated geographic area.
4. Establish and maintain collaboration and liaison with local community and local service providers.
5. Assess health needs and priorities for the catchment population.
6. Map households, schools and crèches/day care centres in the geographic area serviced by the PHC outreach team.
7. Keep local community informed of health related matters and potential health threats

PROFESSIONAL NURSE ROLE IN PHC OUTREACH TEAM

SERVICES

- Plan, implement and evaluate health and wellness services to the catchment population
- Promotion, prevention, early detection, curative, rehabilitative and palliative service
- Develop a targeted plan to address the health needs of those that are vulnerable (children, women, elderly, disabled persons affected by TB, HIV, chronic diseases)
- Act as an advocate for improving health services
- Deliver the community component of PHC package of services

Role of Community Health Worker in the PHC Outreach Team Year 1 and 2

Household

1. Identifying and registration of households (Year 1 100% of households)
2. Conduct household assessments (35% of households in year 1)
3. Health promotion and prevention (Maternal and child health, HIV, TB (year 1) Chronic Diseases (year 2) will be an essential element of all home visits and other community based activities of the CHW. Specific functions include:
    1. Health promotion
    2. Provide health related information (immunisation, ante-natal and post natal care, HIV, TB and chronic diseases)
    3. Conduct simple screen for potential health problems
4. Perform basic first aid
5. Adherence support and counselling
6. Provide supportive counselling
7. Refer to and receive referrals from health other services

Role of Community Health Worker in the PHC Outreach Team Year 1 and 2

Community
1. Update Resource Profile of Community 2. Assist with conducting Support Groups 3. Participate in specific health days in the community 4. Attend community meetings 5. Assist with School health 6. Support and promote health at crèches, ECD institutions and other institutions like old age homes 7. Spend time in facilities to update records and prepare reports

PHC RE-ENGINEERING
IMPLICATIONS FOR HEALTH PROFESSIONALS

Enabling regulatory environment for health workers to deliver PHC services:

- Scope of practice different categories of health workers
- Relevant education and training of new graduates
- Continuing professional development to maintain competence and update practitioners skills to meet service delivery advancements

ROLE OF PROFESSIONAL NURSE

- Facilitate comprehensive PHC service delivery
  - Comprehensive assessment, diagnosis, treatment and care
- Re-prescribe and prescribe treatment according to treatment protocols
- Manage Communicable and non-communicable (TB, HIV, Chronic diseases)
- Maternal and child health
- Manage quality of care
- Develop innovative approaches for improving health outcomes
- May be appointed as the PHC outreach team leader : lead and manage the work of the team and its members

NURSES MAY ASSESS, DIAGNOSE, PRESCRIBE TREATMENT, KEEP AND SUPPLY MEDICATION

In keeping with requirements for Delivery of PHC Section 56 of NURSING ACT 33 of 2005 provides for a nurse to assess, diagnose, prescribe treatment, keep and supply medication for prescribed illnesses.

- Regulations are required where the qualification and training and registration fee are prescribed
- The South African Nursing Council may issue a registration certificate to a person who complies with the prescribed requirements

What would CHWs do
Context: Quadruple Burden of Disease?

	MCWH	HIV & TB	Chronic NCD	Violence & Injury
Screening, assessment & referral	Pregnant women, newborn & infants, IMCI basic	Screen for HIV Testing, regular CD4, early HAART, TB symptoms	Screen for HT, diabetes, mental illness, complications of NCD	Screen for Substance abuse, abuse, high risk persons
Information & education	Pregnancy, Child birth, parenthood, nutrition	HIV, TB prevention, early intervention treatment	Chronic diseases prevention, early intervention treatment	Violence and injury prevention
Psychosocial support	Teenagers, parents of high risk babies and children	Integrated approach to treatment adherence support, patient and family education, link to community based and other resources		Victims of violence, trauma and injury
Basic home Rx and support	Post natal care, newborn babies ORT, worms, refer pneumonia		Elderly, defaulter tracing, treatment management for infirm, support palliative care	First aid, emergency care
Support community assessments,	Teenage pregnancies, immunization,	Food security	Diet, exercise	Pedestrian safety

Scope of CHW

- Conducting Community, household and individual health assessments and identify if there any potential or actual health seeks and facilitate the family or an individual to seek the appropriate health service;
- Promote the health of the households and the individuals within these households
- Refer persons for further assessment and testing after performing simple basic screening tests;
- Provide limited health interventions in a household (basic first aid, oral rehydration and any other basic intervention that she or he is trained to provide)
- CHWs will also provide psycho-social support and manage interventions such as treatment defaulter tracing and adherence support.

KEY DIFFERENCES BETWEEN CURRENT AND PROPOSED MODEL for CHW

- Currently there are no CHWs performing the role as outlined for the CHW in the context of the PHC outreach team
- There are persons working in communities providing home based care, DOTS, Adherence counselling, lay counselling, peer education, Tracing of defaulters

- New role of the category CHWs
  - Fulfill a role as a formal member of the PHC team;
  - will focus on prevention, promotion and support to communities and households; and
  - The will identify health needs of families and individuals within the family and link to health and other services
  - Report to the team leader and there work will be supervised by a designated PHC outreach team member

Home Based Care (HBC)

- HBC will continue to be community based service offered by NPOs
- HBC services will be offered as a comprehensive service including but not limited to terminally ill, aged, HIV, TB & Chronically ill persons
- Based on burden of disease on average require 20 505 home based carers
- The current HBC services rendered by NGOs and NPOs will continue to function after they are adjusted to meet the recommended population norm for home based care
- Overlap in services between health and social services requires intervention

HUMAN RESOURCE REQUIREMENTS FOR DELIVERY OF PHC SERVICES

POPULATION BASED

THE PHC OUTREACH TEAM ROLES & FUNCTIONS	
WHO	**WHAT**
2 Professional Nurse (Facility based)	Support/Supervision of Community-based Services Clinical Support: Early Learning Centres (ELC), Crèches, Old Age homes, schools Comprehensive clinic based services IMCI basic Antenatal, Post natal care (normal pregnancies) Immunization Repeats stable chronic patients Treatment of minor ailments and some common illnesses (children and adults) using protocols including prescribing treatment Communicable diseases (HIV, TB, STDs)
1 Professional Nurse (Community based)	Support & supervise CHW services in the community School health services Community based programmes (e.g. antenatal, post natal care, immunization campaigns) Screening & support services to schools, ELC, Crèches, Old Age Homes
1 Enrolled Nurse (Facility based)	Clinic-Based Services Assist professional nurses with clinic based services
6 CHWs (Community based)	Screening, assessment & referral, Information & education, Psychosocial support, Basic home Rx, Support community campaigns, schools

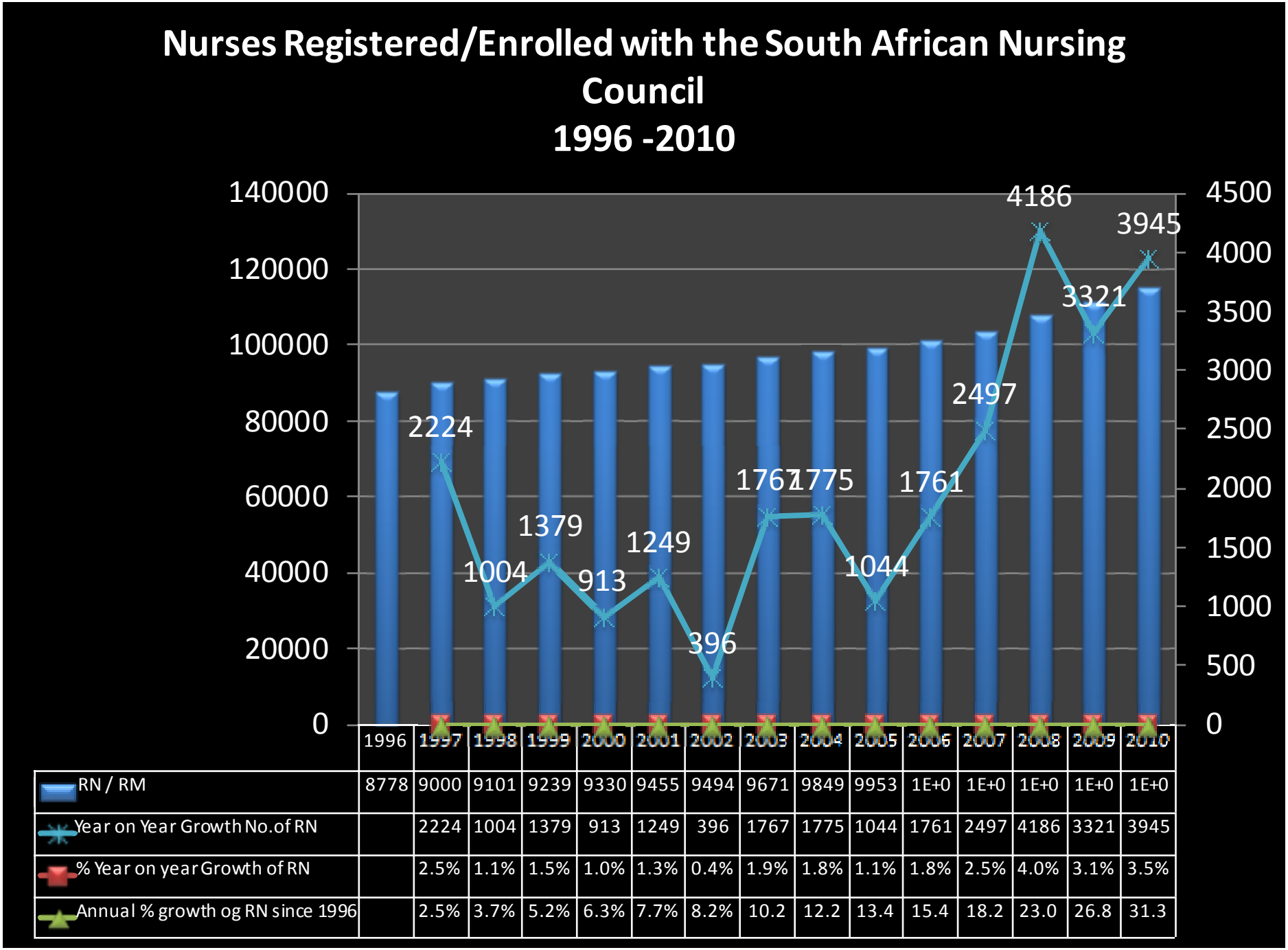
ROLE OF PHC CLINIC SUPPORT STAFF (PER PHC OUTREACH TEAM)	
Doctor (.1 FTE)	Complex cases, clinical governance
Primary Health Care Nurse (.3 FTE)	Complex cases, overall clinic management and supervision of support staff
Enrolled Nursing Auxiliary (.6 FTE)	Observations, tests support team members
Counsellor (1 FTE)	Main focus: pre and post diagnosis counselling; HIV/AIDS, TB, Chronic Diseases; treatment adherence support and counselling
Post Basic Pharmacy Assistant (1 FTE)	Dispense treatment, patient information

PHC OUTREACH TEAM RATIOS

Ratio of CHW/PHC Outreach Team/Clinic to Households/Population		
	Households (Average)	Population (Average)
1 CHW	250	1000
1 PHC Team	1500	6000
PHC outreach teams required for current uninsured population		
Number PHC Outreach Teams in South Africa		6907

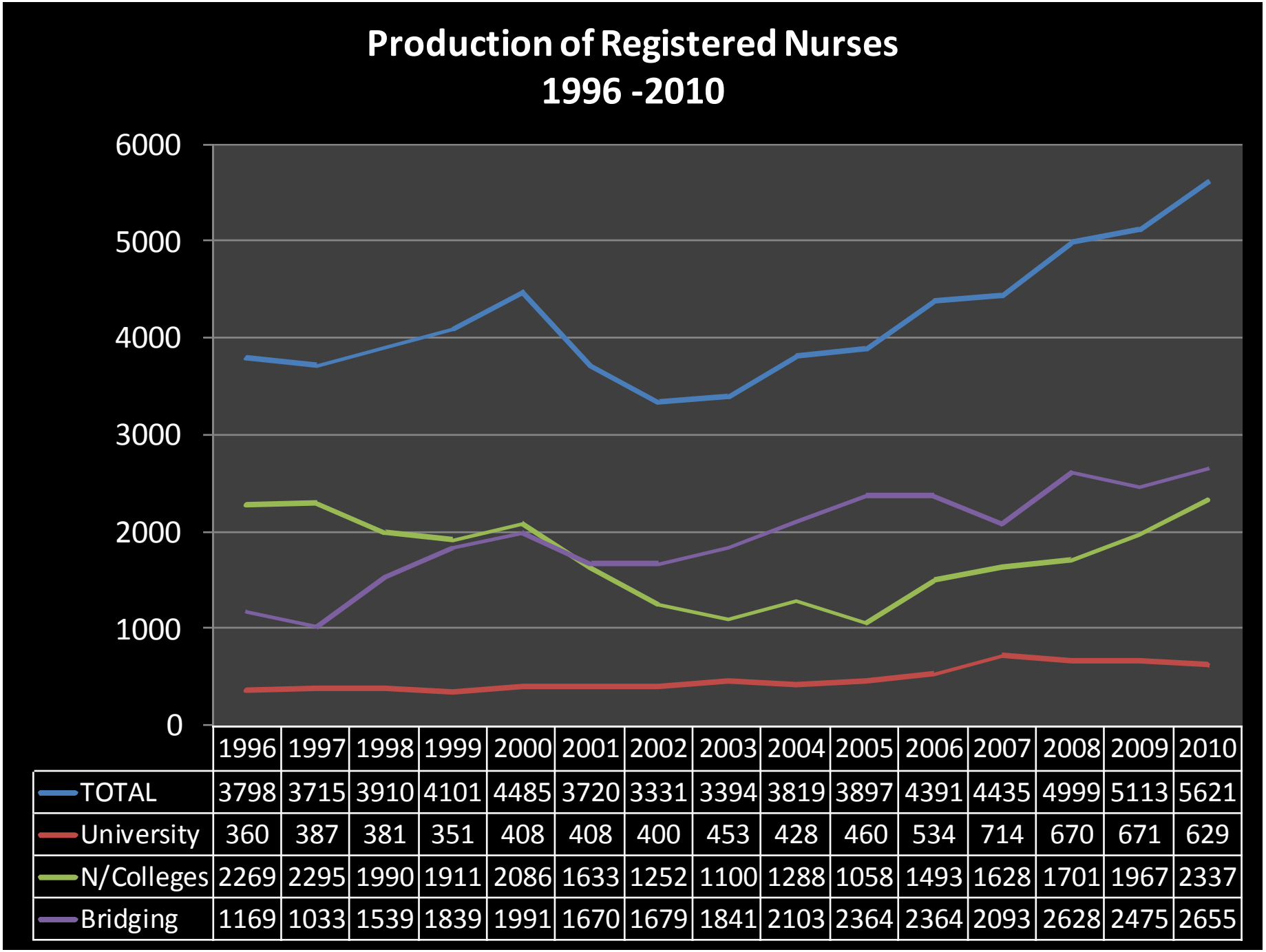
Human Resource Requirements PHC Outreach Teams and Clinics for Uninsured Population (Excluding CHC & District Hospitals)		
Category Health Worker	No. Required Enrolled Nurse Model	No. Required Staff Nurse Model
Professional Nurse	16 731	6,377
Staff Nurse	N/A	14 640
Enrolled Nurse	4 286	N/A
Enrolled Nursing Assistants	2 975	2 975
Doctors	259	259
PHC Nurses	2 322	2 322
Counsellors	4 323	4 323
Pharmacist Assistants	6 334	6 334
Clerks	5 482	5 482
Community Health Worker	32 891	32 891
Home Based Carer	20 710	20 710

Nurses Registered/Enrolled with the South African Nursing Council
1996 -2010

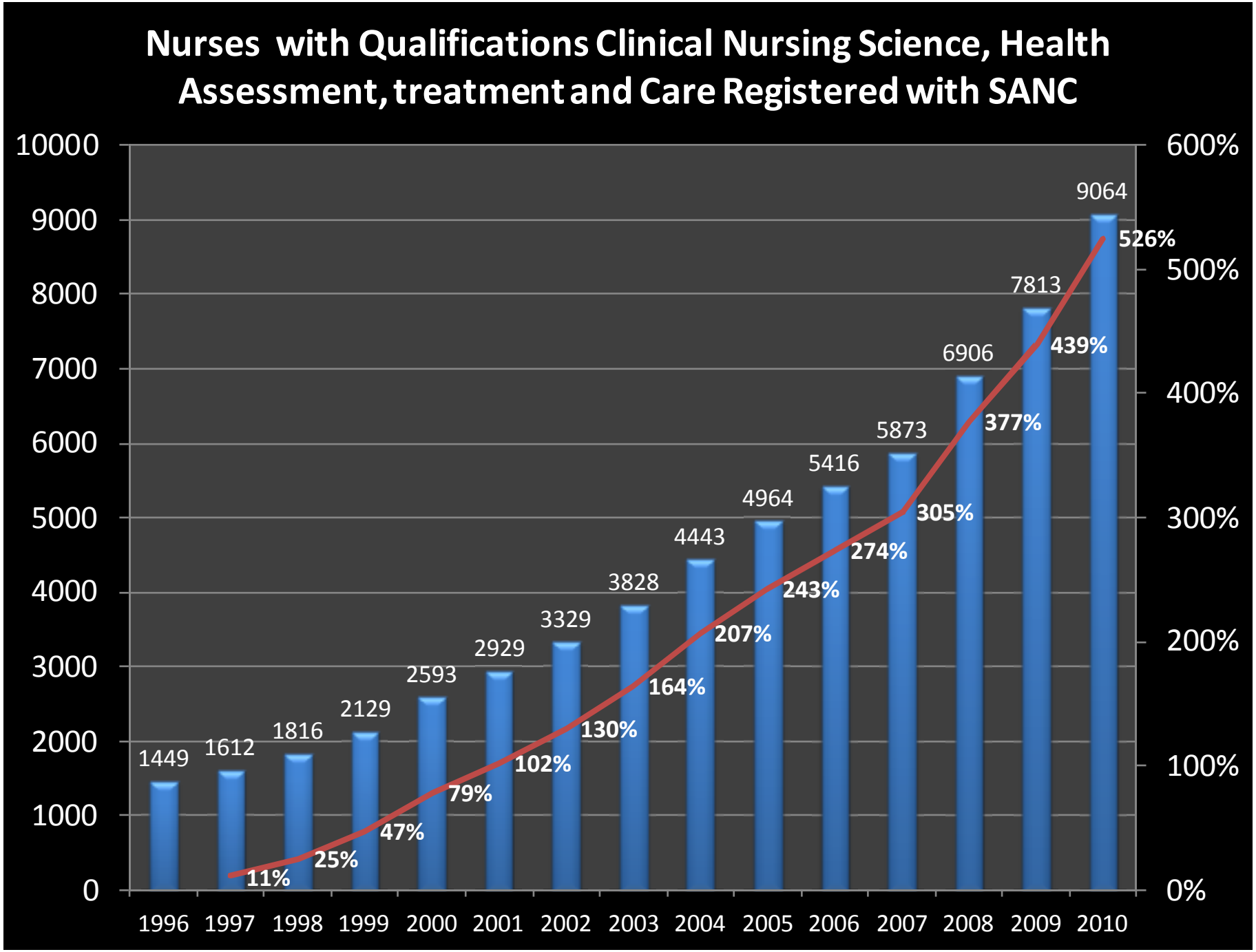


	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
RN / RM	8778	9000	9101	9239	9330	9455	9494	9671	9849	9953	1E+0	1E+0	1E+0	1E+0	1E+0
Year on Year Growth No.of RN		2224	1004	1379	913	1249	396	1767	1775	1044	1761	2497	4186	3321	3945
% Year on year Growth of RN		2.5%	1.1%	1.5%	1.0%	1.3%	0.4%	1.9%	1.8%	1.1%	1.8%	2.5%	4.0%	3.1%	3.5%
Annual % growth og RN since 1996		2.5%	3.7%	5.2%	6.3%	7.7%	8.2%	10.2	12.2	13.4	15.4	18.2	23.0	26.8	31.3

Production of Registered Nurses
1996 -2010



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
TOTAL	3798	3715	3910	4101	4485	3720	3331	3394	3819	3897	4391	4435	4999	5113	5621
University	360	387	381	351	408	408	400	453	428	460	534	714	670	671	629
N/Colleges	2269	2295	1990	1911	2086	1633	1252	1100	1288	1058	1493	1628	1701	1967	2337
Bridging	1169	1033	1539	1839	1991	1670	1679	1841	2103	2364	2364	2093	2628	2475	2655


Nurses with Qualifications Clinical Nursing Science, Health Assessment, treatment and Care Registered with SANC
10000
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
600%
500%
400%
300%
200%
100%
0%
1449
1612
1816
2129
2593
2929
3329
3828
4443
4964
5416
5873
6906
7813
9064
11%
25%
47%
79%
102%
130%
164%
207%
243%
274%
305%
377%
439%
526%
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010

HOW HWSETA Can Support Implementation of PHC Re-engineering

Address the skill gap amongst existing cadres of health workers specific skills required for delivery of PHC services
(IMCI, Nurses prescribing, Ante and post Natal care)

Supporting the training of new health professionals through learnerships

(CHWs, Post basic Pharmacists, Counsellors, Staff Nurses)

Facilitate the re-alignment of qualifications that are already registered on the NQF to the service delivery requirements

(Ancillary health care and CHW Qualifications)

Develop models for work-based vocational training programmes for certain categories of health workers

(CHWs, Counsellors)