ORIGINAL ARTICLE

The Role of the Family Practitioner in Developing Primary Health Care Services in a District Health System

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Curriculum Vitae

Dr Neethia Naidoo qualified as a general practitioner from the University of Natal Medical School in Durban. He has been in general practice since 1972 and obtained the MFGP in 1978. He is vice chairman of the South African Academy of Family Practice/Primary Care and Task Group Director – Rural Health, for the Academy. He was the first President of the National Medical and Dental Association (NAMDA). He is presently chairman of the Dalton and Districts Child and Family Welfare Society and District Surgeon for the magisterial district of New Hanover. He is active in under- and post-graduate education in general practice. He is convenor of the New Hanover Primary Health Care and Development Programme.

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Currently Director of the Centre for Health and Social Studies (CHESS), since 1989. Lecturer in Community Health, Occupational Medicine, Health Policy, Health Systems Research and social welfare since 1980, at the Universities of Natal and Durban-Westville. Consultant to national and international organisations, foundations and institutions. Academic service commitments in the Department of Community Health (1979 - 90), both clinical and administrative. At the community level – the organising of a number of health and welfare programmes and surveys in various areas such as Phoenix, Chatsworth, Tongaat, KwaMashu, Inanda, Umlazi and Malagazi. Published many articles on health and social policy, health systems research and development in national and international journals.

Summary

An evolving assessment of the health needs of the poor in the Magisterial District of New Hanover underlines the inequalities in access to health care, the fragmentary nature of health service provision and the poor intersectoral co-operation between service providing sectors of the local economy.

The findings from the assessment also emphasise the need for urgent action to improve basic health care (incorporating curative, preventative and promotive services), health education and health facilities for the needy. The high incidence of essentially preventable illnesses among key at-risk groups such as young children, women and the elderly, and the lack of potable water and poor sanitation characterise the district.

To begin to address these problems an action-orientated "Primary Health Care and Development Programme (PHCDP)" is being implemented based on a "learning by doing" approach and stressing community involvement in health (CIH). It is the contention that a relevant and appropriately planned, funded and managed district health service or authority can improve the health of those most at risk. It is also apparent, from growing and widespread interest from many that the PHCDP holds promise for developing a model of district based PHC and related community development that could be widely replicated in other parts of the Natal Province and in South Africa.

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KEYWORDS:

Physicians, Family; Primary Health Care; Research; Organisation and Administration

The Purpose of the Paper

The purpose of this paper is to define an extended role for the family practitioner in promoting health and development in a District Health System. The processes for establishing priorities and developing an integrated community-based primary health care (PHC) service, are outlined. Some preliminary results of the New Hanover Primary Health Care and Development Programme (NHPHCDP) will be presented. The paper concludes with challenges facing the family practitioner in South Africa.

Background

The magisterial district of New Hanover, situated between Pietermaritzburg and Greytown in the Natal Midlands, is a well conserved farming district. Over eighty percent (80%) of the population of about 68,000 is black, the majority of whom live and work on the farms and in the peripheral Kwa Zulu areas. (Annexure 1)

The present health services are fragmented, with limited funds and auxillary services, is discriminatory and biased towards curative care.[1] The profile of health services in the New Hanover magisterial district

based on a situational analysis has identified a number of problems in the primary health care services.

The New Hanover Primary Health Care and Development Programme (NHPHCDP) was initiated to address the need for a co-ordinated and comprehensive primary health care service, and to develop a model for a district health system in which the role of the family practitioner is defined.

Can an appropriate service be developed out of a fragmented, unco-ordinated, poor system?

This is an action-oriented programme based on a "learning by doing" approach which stresses community involvement in health and which poses the following question: Can an appropriately planned and managed District Health System be developed out of a fragmented, unco-ordinated and poorly funded health service in a semi-rural district?

Towards Developing a District Health System (DHS)

The first phase in this process involved a community profile to establish a baseline, identify priorities, focus available health services and initiate community involvement. The next phase involved all the health and community workers in deepening their understanding of community involvement in health (CIH), primary health care (PHC) and in re-orientating health services to priority needs. This occurred through a series of workshops.

Subsequent phases aim to consolidate and rationalise existing health services and direct resources to priority needs.

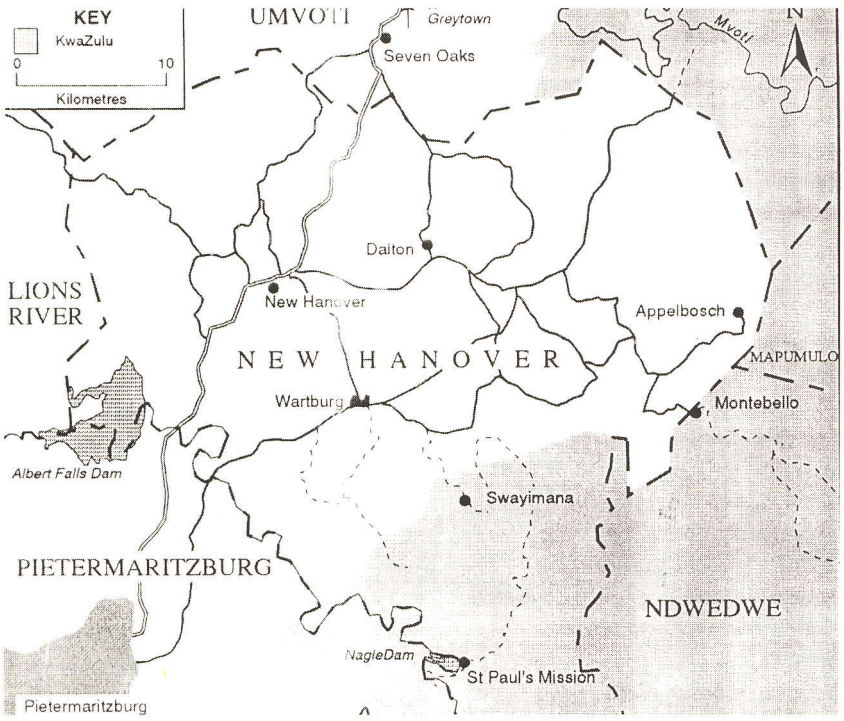
Community Profile of the New Hanover Magisterial District

A profile of the community was established by undertaking a community survey as a baseline for the district health service, and by analysing the records of children attending a general practice.

The community study of 180 households on the farms and 78 households in the black rural area in the district was undertaken by trained field workers using a pre-tested standardised questionnaire. Two hundred and fifty eight (258) houses were randomly selected in the magisterial district consisting of 1112 individuals. The study design was a cross sectional prevalence study.

Most of the reported deaths were preventable

A survey of a thousand (1000) children under six years attending a general practice for well baby care and minor ailments was undertaken by a trained nurse during a one year period.[2] The data was analysed using the EPIINFO programme.



Annexure 1: Location Map: New Hanover Magisterial District

Table 1. Community Profile of the New Hanover District

		Number	Percentage
1.(a) Sample population		1112	
(b) Total population		67922	1,6
2. Sex	Male	534	48%
	Female	578	52%
3. Ages in years	0-14	185	16,6%
	15-19	295	26,4%
	> 20	520	46,7%
	> 60	112	10%
4. Educational Level	None	184	15,5%
	< Std 3	266	24%
	Std 3-6	366	33%
	> Std 6	234	21%
	Standard 10	46	4,1%
	Post Matric	15	1,4%
5. Mean Household Size		6,0	
6. Residential Status	At home	970	87,2%
	Migrant*	118	10,6%
	Commutes weekly	24	2,2%
7. Employment	Unemployed**	88	7,9%
	Employed***	259	23,3%
Mothers/Children/Scholars/Pensioner		765	53,7%
8. Household Income****	R200	48	18,2%
	201-600	92	35,8%
	601-1000	48	18,7%
	> 1000	70	27,3%
9. Land tenure	Owned	59	23,0%
No rent/renting, Permission to occupy		199	77,0%
10. Electricity Supply	None	243	94,0%
11. Water Sources	River, springs, rain water, tanks	232	90,0%
12. Sanitation	Pit latrine	245	95,0%
	Open veld, septic tank etc	13	5,0%

* Migrant worker – working outside the district
** Unemployed but seeking employment
*** formal and informal
**** Total Number of Households = 258

Results

The health profile is typical of a third world profile both in South Africa[3,4,5] and internationally[6,7] as regards the demographic, socio economic and key health status indicators. (Table 1)

The majority of blacks need basic amenities. Sixty percent (60%) felt that hospitals and clinics were too far to walk to, the journey to a doctor or hospital usually occupies the whole day.

The survey of children under six highlights the plight of the black children in the district. Most of the reported deaths were preventable. (Table 2)

Responses of the Family Practitioner to Addressing these Community Needs

The above findings supported the urgent need for an integrated, multisectoral and co-ordinated health service with a strong community involvement, to improve the standard of PHC in the district.

The family practitioner contacted a number of role players to share these findings. Encouragement and support was obtained for the development of a district health system based on primary health care principles. Table 3 shows some of the organisations and authorities consulted. The District Health System (DHS) Planning Workshop held at Tintswalo,[8] the World Health Organisation (WHO) literature on DHS[9] and the results of the nine consultative workshops held in various districts in South Africa[10]

Table 2 Profile of Children Under Six in a Family Practice. Number and Percentage(%).

1. Educational Status of Childminders	*Std. No.*	*Percentage(X)*
Up to Std 2	553	(55)
Std 3 - 6	188	260 (26)
Std 7 - 10	(19)	
*2. Immunisation Status**	*Inadequate**	*Adequate**
Blacks	246 (28)	656 (72)
Asian	32 (33)	64 (67)
*3. Nutritional Status***	439	(44)
4. Cause of Death	*Total No of Deaths(Y)*	
Diarrhoea and/or vomiting	89	(45)
Kwashiorkor	22	(11)
Still Births	21	(11)
Fever (Unknown Causes)	19	(10)
Chest Infections (Bronchitis/Pneumonia)	14	(7)
Prematurity	13	(7)
Unknown (?Influenza)	8	(4)
Measles	7	(3)
Others (Asthma, TB, Heart Disease, Tonsillitis & Drowning)	5	(2)

* Inadequate: Immunised more than a month out of the scheduled dates
* Adequate: Immunised within a month of the schedule dates
** Below the 3rd centile using to National Centre for Health Statistics Scale
(X) N = 1000
(Y) N = 198 deaths under 6 years for a 5 year period

were valuable in developing the programme and implementation structures.

The Centre for Health and Social Studies (CHESS) at the University of Natal and the Institute of Natural Resources (INR) at the Pietermaritzburg campus of the University provided the resources to develop aspects of the district health system model. A number of committee meetings, workshops and consultations with experts in the field of Health Planning and Organisational Development resulted in three workshops being held in the

GPs find a central place in this strategy for health

community viz "Community Involvement in Health" (CIH), "Primary Health Care" (PHC) and the "District Health Systems (DHS) Planning" workshop. The purpose of these workshops was to shape the DHS programme, identify the role of the health workers and deepen community involvement. The main aspects of these workshops are discussed below.

Community Involvement in Health (CIH)

The aim of the workshop was to understand CIH and apply its principles in the District of New Hanover. Fifty two people attended. They included community representatives, members, nurses, health care personnel, members from CHESS, INR, District Surgeon and

representatives from the local hospitals.

The presentation by the Ilimo Community Group, from Amaoti near Inanda, shared their experiences of coping in an impoverished informal community of 110 000 and demonstrated the different approaches to community involvement. A video on "Working with communities in South Africa " was shown to reinforce the issues involved.

It was recommended that the New Hanover PHC and Development Programme assess community needs, identify available resources, and plan and implement projects using the principles of CIH.[11]

Table 3. Role Players and Organisations Consulted

1. Dept of National Health, Natal	Regional Director Natal
2. NPA Health Services Branch - PMBurg	Director District Surgeon Services Director PHC Services Director Community Services Director Health Inspectorate, Health Education Director Nursing Services, Mobile Clinic Services, Family Planning, Youth Services
3. Municipality - PMBurg	Medical Officer of Health - PMBurg
4. Hospital Personnel	Appelsbosch and Montebello Medical Superintendents Community Health Worker Facilitators
5. SA Academy of Family Practice/Primary Care	New Hanover Branch of the Academy
6. Local General Practitioners	Four other Practitioners in the area
7. Farmers Associations	Chairman and members in the four regions
8. Environmental Conservation Organisation - (Echo)	Chairman of Midlands Branch
9. Community Organisations	Efaye, Umtulwa, Swayimane, Child Welfare, Local Committees, Local Civics
10. Institute of Natural - Resources University of Natal - PMBurg	Water and Sanitation Technology Transfer Project Steering Committee
11. Regional Joint Services Board	New Hanover Representative
12. Educators	School Management, Parent Committees
13. Allied Health Professions	Nutritional Education Service Manager, Dietician
14. Chess (Univ. of Natal)	Director
15. Development and Services Board PMBurg	Medical Director and Community Nurses

Primary Health Care (PHC)

The aim of the workshop was to gain a greater understanding of comprehensive PHC and to apply the PHC approach to developing a District Health System[12] in New Hanover. This workshop was attended by forty eight (48) participants. They included the previous participants to the CIH workshop, 15 community health workers, a few traditional practitioners, PHC nurses, facilitators from CHESS, INR and additional community representatives, including black traditional healers.

The PHC approach as outlined at Alma Ata and a slide presentation on the Jamkhed Comprehensive Health Care and Agricultural Project in India,[13] was presented by the workshop facilitators. An overview of the present health services in South Africa was also presented and solutions to the largely hospital-based curative services was discussed with emphasis on basic health services and the primary health care approach. The principles of the PHC approach included community involvement in health, utilisation of community health workers, intersectoral co-ordination with an emphasis on community development, health promotion and disease prevention, accessibility and use of appropriate technology.

The participants were divided into four groups. Each group considered

the relationship of the biological, social, cultural economical and political factors to the following four topics viz, malnutrition in infancy and childhood, alcohol and other substance abuse, sexually transmitted diseases and water related diseases.

... will be effective if it is based on community needs and involves the local community

The PHC approach to managing the above conditions was discussed with reference to community involvement, curative, preventive, promotive and rehabilitative care.

Each group identified important aspects of their findings and prepared it for a role play presentation at the plenary session. The rest of the group identified the important lessons from these presentations.

The presentations targeted black children, pregnant women, the elderly, those with sexually transmitted diseases and other infectious diseases such as TB and gastro-enteritis.

The groups identified the outline of a programme based on the principles of PHC and discussed the structures required to support the implementation of PHC within the District Health System (DHS) in New Hanover. An understanding therefore of the role of PHC in District Health Systems is of vital importance.

Primary Health care and District Health Systems

Primary health care attempts to bring health as close as possible to where people live and work and addresses the main problems in the community providing preventive, promotive, curative and rehabilitative services.

Primary health care as outlined in the Alma Ata Declaration[14] calls for three kinds of developments viz:

1. the availability of essential health care to individuals, families and population groups according to need.

2. the involvement of communities in planning, delivery and evaluation of such care and

3. an active role for other sectors in health activities.

Primary health care envisages team work by many health professionals, other professionals and individuals backed by appropriate referral and support systems from the local regional and central government departments. PHC therefore stresses the participation of people as citizens.

The district health system refers to a system of health delivery for a well defined population within a clearly delineated administrative and geographical boundary. It attempts to co-ordinate all the relevant health care activities in the area. It therefore consists of a large variety of inter-related elements that contributes to health in homes, schools, workplaces, communities and in related social and economic sectors. It includes self care and all health care personnel, organisations and facilities including clinics, health centres, services of family practitioners and includes the services of the community or district hospital and appropriate support services.

Family practitioners find a central place in this strategy for health. They achieve this by providing essential personal care, comprehensive care, ready access and continuity of care.[15]

The district health system will be effective if it is based on the assessment of community needs, if it

GPs need to combine their personal care skills with comprehensive health skills

involves the local community organisations, and community health workers. As a community-based doctor, the family practitioner has a vital role to play in addressing these needs.

Report on the District Health System Planning Workshop

The proposed structure was developed at the recent district health system planning workshop. It makes it possible for meaningful community involvement in planning and implementation and also for improving the co-ordiantion of government, private and traditional health care. Also, the key sectors are represented at their local level thus

facilitating intersectoral co-operation and the management of services across a broad front, at the district level. The structure makes it possible for health care to be delivered by the lowest organised unit of the system and as close to the people as possible. Embryonic local authorities are being empowered to jointly develop a strategic plan for PHC delivery in their areas eg Efaye and Swayimane villages.

The Contribution of Family Practice and the Challenges Facing Family Practitioners

The major contributions of family practice are personal, community-based, continuous and comprehensive care. It therefore holds great promise of being able to provide both effective and efficient primary care services to people from all cultures, races and social groups.

The specific skills and principles of family practice are as relevant in urban areas as it is in rural under-doctored areas where basic services are often inadequate.[16,17,18]

The long standing doctor-patient relationship has important implications in assessing health needs and implementing health related projects for the practice population.

An up-to-date knowledge of the patterns of health and disease in the practice population, or the district, will ensure that the health services target identified needs within the population being served.

The issues raised in the Alma Ata Declaration needs to be appraised and adapted to local needs in keeping with the prevailing socio-economic and political changes taking place in South Africa.

The challenge for family practitioners is to combine their present personal care skills with comprehensive health skills so that they could be important members of the health team.[19] Family Practitioners should provide leadership of a facilitating rather than a prescriptive kind.

The health services should be co-ordinated through community involvement in health to provide a comprehensive service. The PHC approach should be the basis for health provision. The challenge is to involve other sectors and relevant university departments and research institutions in health planning at the district level.

A long standing doctor-patient relationship has important implications for assessing health needs

The following are some of the achievements of using the PHC approach.

1. The infrastructure for the PHC and development programme is being developed in the New Hanover Magisterial District.
2. Valuable local resources and leadership potential have been identified.
3. A health centre facility is being developed to meet the community's needs.
4. Community involvement and participation has been achieved in improving health and fostering development.
5. A water and sanitation project at 10 farm schools has been implemented. Facilities at another twenty three schools in the district are also receiving attention.
6. A nutrition programme that targets at-risk children, is being undertaken.
7. A study on the social epidemiology of HIV infection and the development of HIV/Aids prevention in New Hanover has been completed. This is now linked to the programme. Two community health workers are to be employed on a full time basis by the Progressive Primary Health Care Network (PPHC) to provide Aids education and to link this with other developmental projects in the district.
8. PHC Women's groups are being developed in the district.
9. "Facts for Life" messages are being implemented in some schools and in women's groups in the district.
10. A costing study of General Practice services has been undertaken.
11. The initial steps for developing a

model to achieve a healthy district has been implemented.[12]

12. Training skills have been provided for eight local people who built about 100 Pungalutho toilets in the area (at homes, and schools).

Proposed Projects for the New Hanover District

The following are proposed projects to be implemented soon.

1. Community water and sanitation projects for Efaye, Swayimane and about twenty Kwa Zulu schools in the district.
2. Nutritional Status and eating patterns of children under 5 in the New Hanover area.
3. Factors influencing the participation of women in the PHC and development programme.
4. The benefits of a community PAP screening service in the New Hanover area.
5. Traditional birth attendants education and training programme.
6. Developing an Aids Preventive programme.

The Benefits of Implementing a PHC Programme for Family Practitioners

1. PHC and Development interventions at the community level will improve the quality of life for the defined community.
2. The process of research and evaluation will result in publications aimed at influencing national and regional policy.
3. The development of a comprehensive information system will make such data readily available not only to the health and development workers in community organisations involved, but also to the wider community, thus ensuring that it remains informed.
4. The economic viability of the District Health System will be investigated and practically tested, informing policy nationwide.

Conclusion

The Family Practitioner's commitment to the community is to have knowledge of the epidemiology of the community being served and to have the maximum influence on any health problem in the community. This entails identifying problems that go beyond the presenting problem and to approach those who lack care by case finding and health education. The community's own efforts to promote and safeguard their health will have to be supported and facilitated by taking into account the social, economic, environmental and political factors involved.

The community's own efforts to promote their health, needs to be supported

Underlying the concept of PHC is the idea that the main roots of poor health lie in the living conditions and the environment, and particularly, in poverty. A PHC service must provide not only curative care, but also incorporate preventive, promotive and rehabilitative interventions such as health education, proper nutrition, and basic sanitation. PHC is most effective when health and development projects, plans and procedures are owned by the people. Teaching people how to play a greater part in the improvement of their own health is not only a cost effective approach, but also one which begins to address social and psychological barriers to a happy and healthy society. A model of primary and curative health provision needs to be tested not only as to its effectiveness in human, resource and fiscal costs, but also for its practical, social and scientific acceptability. The New Hanover District Health initiative aims not only to answer to these requirements, but also to uplift the community which it serves.

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