Soul City – It's Real! Season 12 Message Brief (May 2013)

MESSAGE BRIEF (A): Re-engineering of Primary Health Care

SEASON TWELVE

The primary theme for SEASON 12 is the Re-engineering of Primary Health Care (PHC). This is an A Theme. There are also several B Themes in SEASON 12. Some of these are meant to be part of PHC, while others not necessarily.

This brief concerns only PHC. Due to the complicated nature of PHC, this brief includes several distinct parts with key messaging. This brief, however, does not include messaging around PHC meant to be directed at government or policy makers, which will be incorporated into a separate *advocacy brief*. This brief focuses on messaging around PHC meant to be directed at specific or general members of the public; and the various challenges, concerns, perceptions or responsibilities *they* have with respect to PHC.

Introduction and background

The *overall* creative brief for this season will include this brief on PHC messaging as well as those of the several other B Themes in Season 12. These are:

i) Infant and maternal health care (separate brief);
ii) To popularise the Thuthuzela Care Centres (separate brief);
iii) Contraception and fertility management (included in this brief); and most importantly
iv) The parameters and/or existing Soul City messaging around key social issues (separate brief).

The overall aims of Series 12 are:

1. **To support and raise awareness about the re-engineering of public health care;**
2. **To strengthen demand and uptake of primary health care services;**
3. **To facilitate greater community participation and monitoring of primary health care services;**
4. **To increase Public Awareness and demand for Thuthuzela Care Centres;**
5. **To increase uptake and consistent use of dual method family planning; is also included in CARMMA**
6. **To support the Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA);**
7. **To increase knowledge of pending obstetric, neonatal and infant emergencies among the general population in order to facilitate earlier presentation of such emergencies and facilitate a reduction in maternal mortality in South Africa;**
8. **To increase knowledge of all aspects of PMTCT and particularly to improve early attendance at ANC and follow-up of babies from the PMTCT programme at 6 weeks. Also included in CARMMA**

What is Primary Health Care?

At the outset it is an international philosophy that sees practical, scientifically sound, socially acceptable and affordable healthcare as a basic human right. As a clinical definition, PHC is regarded as the first point of contact that a person has with the healthcare system (hence the services of a local clinic or day hospital would be regarded as PHC). In a corporate sense, PHC is regarded as health care that people can afford or which is free. At its most basic level though, for the person in the street, PHC is about having access to a doctor or nurse and being assisted in the case of illness or disease.

The Alma Ata declaration, which is a seminal document providing not only a comprehensive definition of PHC but also clear guidelines on government's responsibilities with respect to this, defines primary health care as among others:

> *[E]ssential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development inthe spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.*

What is the Re-engineering of Primary Health Care?

This is a new approach towards the implementation and rollout of healthcare in South Africa that has been happening in various parts of the country since 2012. To date South Africa's health system has been clinic & hospital-centric and the idea of re-engineering PHC is about taking health out of the facility to the community. The emphasis is on prevention and health promotion, and marks a shift away from waiting until people are sick. It has two components (A) strengthening the district health system and (B) taking health to the community. It is being carried out through a three-pronged strategy: (1) Ward-based outreach teams comprising of a cadre of community health workers headed by a professional nurse, (2) Schools health teams and (3) improving child and maternal health by setting up District Clinical Specialist Teams (DCST). A fourth strategy involves the recruitment of private GPs to form part of the public health sector, but this is still in its infant stage.

MESSAGING AND MESSAGES

1. **Outreach teams and Community Care Givers**

Role and purpose:
The outreach team is the aspect of PHC that takes health to the community and household level. With a professional nurse as team leader, the rest of the team comprises of 3 staff nurses, and at least 6 community care givers (CCG). Each CCG is responsible for 250 households, or 60 households in the case of KZN. They are linked to a facility but are not based at a facility. The overall health intervention has three components [1] health education / talking / listening/ counselling [2] screening / early detection [3] keeping on treatment / rehabilitation. They make referrals to the facility, as well as to other agencies such as Home Affairs and SASSA. The staff nurses do screenings, home-based dressings; basic rehabilitative care; teaching and; health promotion. A CCG does household visits (up to 10 per day) and prepares reports, both written and verbal. They conduct household profiles with key information around elderly, infants and children, chronic medication, and social security users. There is more than one team per ward, since each team covers only 1500 households. The number of visits a CCG makes to one household depends on the disease burden of the household.

Drama:

They often deal with harrowing and tragic situations. In some cases, households can get attached to a CCG, or have a personal difference or grudge against them. There can also be an expectation the CCG must come with something for the household.
CCG's receive constant training and do practicals at facilities – hence rising tension around positioning and dominance in the facility. Facility managers and nurses may want to undermine to entrench authority; CCG's could be reckless and lack discernment; or nurses could abuse or misuse CCG's with workload.
Some great moments: finding people who have fallen off the grid and getting them back into the system; finding school-going children who are not at school; facilitating relief through social security
Specific suggestions to Soul City: (##) A CCG can make different types of referrals, e.g. to facility, dispensary, nurse, Home Affairs, SA Social Services Agency etc. The point is, to get the right service provider to service that household. (##) To show a household to be interviewed and the difference the CCG is making for them. (##) Following a CCG in her ward. (##) The CCG teams' interaction with other community workers and groups. (##) CCG's assisting people to manage their medication regime, tracing people who are not sticking to medication. (##) The safety and security of CCGs. (##) The individual caring response.

Locations and people involved:
- The community and broader suburb
- The household – those at home in the day
- The facility
- The CCG – generally young women under 40;
- Team leader – professional nurse; retired
- Staff nurses
- Facility manager
- Matron

Challenges and preferred areas of advocacy:
- Convincing members of the public to welcome and co-operate with CCGs in their homes;
- Ensuring that members of the public trust CCGs with personal information and health information;
- Facilitating greater trust amongst members of the public in the care, advice or referrals made by the CCG;
- Safety & Security: travelling within the ward; dogs, mental health issues; sexual assault; robbery; substance abuse;
- Empowering CCGs as frontline workers to negotiate complex intimate situations;

- Building capacity of existing health care workers and WBOTs to understand the role and objectives of the WBOT.

Messages: Outreach teams and community care givers

- Community Health workers are a new and better way government is providing healthcare to improve your health
- Community care givers are sworn to confidentiality
- Community care givers build on existing services and are part of the broader system
- Community care givers have received training

2. **Community Participation**

Role and purpose:
Community participation has always been seen as an integral part of health care, both in terms of vision in international conventions and, the South African government's genuine commitment to healthcare rollout to date. At a practical level of course, it makes sense. It is the key to providing appropriate services for a community's needs. In South Africa generally, our communities' needs are compounded by the heavy burden of disease overall. Notwithstanding a virtual global social norm where healthcare needs always surpass supply, the government has made great achievements. Most existing facilities have been upgraded while hundreds of new ones have been built over two decades, and in 2010 up to 122-million people were visiting primary healthcare facilities. At the time, this was predicted to increase by 3% annually. While many people are using PHC facilities, a fraction of these people volunteer in service of either work or governance at a facility. It is this fraction that Soul City needs to role model. Community participation encourages a sense of ownership; it involves participatory decision making in governance; it establishes responsibility of service and serving; it builds self esteem; it creates political awareness and in its more nobler ideals; it develops a relationship of trust and empathy between providers and the community; and fosters community cohesion. At governance level, people participate through clinic committees, hospital boards, health & welfare committees, ward committees and, district health councils. At political level, communities participate through social clusters in municipalities, regular Imbizos, and consultations leading to the District Health Plan.

Drama:

South Africa has great deficits in community cohesion on many levels. At the same time, an over emphasis on government accountability to deliver services and the deficiencies and corruption that accompany it, has shifted a public discourse away from their own responsibilities of serving, showing empathy, and ensuring community wellbeing. Government's failure to deliver for whatever reasons and/or when communities' expectations outstrip available resources is more often of public discussion and in many cases a cause of community conflict, mistrust, despondency and lack of involvement in public health facilities. Close to 60% of health facilities in South Africa have functioning committees in some way or the other. Nevertheless, in most instances they don't meet regularly; and are merely informed about facility plans or conditions. In a few instances, consultations happen that influence the planning; or where communities have actual powers in facility planning and functioning.

Community participation can often prove threatening to facility workers, particularly managers, and could cause more conflict if its emphasis is simply on monitoring and being a watchdog.

Before re-engineering, many thousands of community health workers, some of them volunteers and others employed by NGOs, were performing various health services in their communities. Some of them have now been drawn into the WBOTs, and others are still working through NGOs in specialised ways. The fact is, there many different kinds of community health workers who have or still are working at a community level.

Some victories:

- A committee in the Eastern Cape securing emergency transport for patients and more consistent supply of medication for the local clinic.
- In KZN, negotiations with a local chief for land to construct accommodation for nurses working at local facility.
- In the North West, committees are involved in assessing quality of care and attitudes of staff to patients.
- Committees establishing and being responsible for community garden projects.
- CCG's helping communities to establish disease support groups, mothers' support groups, and exercise groups.

Community consultations happen at ward and district level at Imbizos, seminars, public meetings or public dialogues.

Locations and people involved:
A clinic committee is meant to be composed of:

- Local municipal ward councillor
- Facility manager or sister in charge
- One person from community organisations in the locality (i.e. CBOs, NGOs, traditional healers etc.) and;
- Eight community members.

Committee meeting space
Community meeting space

Challenges and preferred areas of advocacy:

- Facilitate community monitoring of healthcare facilities.
- Encourage establishment and greater functioning of clinic committees and hospital boards.
- Translating community participation into better health outcomes.
- Different ways in which people can be involved.
- Role modelling how communities/committees can be part of shaping interventions through creative engagements with the various teams emerging from re-engineering. Sharing data, analysing data, regular reporting.
- Challenges: confidentiality; premature release of data; misrepresentation of data; over-expectations of community; lack of role clarification vis-a-vis the running of the clinic; the added burden and/or conflict community participation places on facility workers.
- Gender and power issues

Messages: Community Participation:

- As community we are owners/partners of health facilities and services and have a right and responsibility to:
    - Participate and help where we can at our health facility
    - Ensure health workers safety
    - Hold services accountable
- Clinic committees can improve the quality of health services for the community
- Clinic committees should give feedback to the community and outreach teams
- Community clinic committee have a role to monitor the quality improvement plan at the clinic by using:
    - The Batho Pele principles
    - The six quality improvement pillars
    - The patient rights charter

- Care should be taken when electing people to be members of community committees. They need to have a mandate and be accountable to their constituencies. Everyone on the community committees have equal status.
- The community has a role as stakeholders to come up with ideas on how to improve quality of health care

3. **The improvement of care in PHC**

Role and purpose:
The National Health Insurance (NHI) requires that the whole health system improves in order for it to work. Six quality improvement areas have been identified as a baseline for improvement in the health system, *from a patient perspective*. They are: long waiting times, nursing attitudes, values of staff, safety and security, infection prevention and drug availability. The goal is to make the system more responsive to patients in at least six areas. So in other words, from a patient perspective – what do you want when visiting a health facility, and the answers:

- Less waiting time at the facility;
- A nice attitude;
- A clean area;
- A safe area;
- Good equipment;
- And my chronic medication.

Drama:

Long waiting times can be (A) patient caused or (B) caused by health workers (supply-caused): o A: patients come at the same time (e.g. rural areas where transport is erratic and better when it is pooled); people don't want to come throughout the day; they come long before appointments, but are stuck there. o B: Not good queuing systems and flow; can stagger working times, e.g. clerks vs clinicians; everybody or many personnel taking tea/lunch at the same time, what about staggering that?; The dispensary closing at lunch and people waiting an hour for restart; Nurses or doctors who don't want to see patients in the afternoon, then placing everyone in the morning.
Drug shortages at national – when a supplier can't supply – happens rarely. For the most part it's poor stock management at either facility level or depot. The clinic manager is ultimately responsible for placing orders. An electronic monitoring system has been installed at national level where all provincial depots can be monitored for stock availability. Health-E has a project to have monitors check on drugs at facilities.
Many facilities have a complaints or suggestion boxes, but many of these have fallen out of favour or practice. A suggestion is for clinic committees (as opposed to facility managers) to have supervision over these to facilitate trust that patients' views are being examined and not discarded. Communities should understand this system.
Facility Improvement Teams (FIT) has been established at district level in some areas. They conduct regular visits and audits of facilities.

Locations and people involved:
The facility
All workers in the facility
Clinic committee members
Facility improvement team members
Clinical specialists

Challenges and preferred areas of advocacy:

- The facilities audit reveals some of the trying conditions that many nurses have to work under and communities need to empathise and explore ways of helping too.
- What the six improvement areas are and the quality of care indicators
- People need to know what they have a right to: the right to be treated with care and respect; the right to appropriate treatment (drug availability); the right to complain.
- The right to demand acceptable service but also the responsibility to support the facility, e.g. volunteering.

Messages: The improvement of care in PHC

- Patients have a right to be treated with care and respect
- Specific messages for youth (positive and caring attitudes):
  - Young people are entitled to access reproductive services at clinics
  - School health services and mobile points may allow young people to access some services in more youth-friendly environments instead of at the clinic.
- If you are concerned about the care you are receiving, you have the right to ask for more information from facility manager
- Develop a transport plan if you are pregnant
- Help Set up maternity waiting homes to ensure safety and security of pregnant women
- Communities can help keep facilities clean and help maintain them.

4. Health promotion vs medical models

Role and purpose:
The emphasis of PHC is on prevention and health promotion, and marks a shift away from waiting until people are sick. Via re-engineering, CCGs are working with families to make them healthy, and this then improves the community. It is about empowering people about their own health, and not just having them expect pills or treatment. Health service users need to be educated about their responsibilities, which is that they need to take responsibility for health at an individual level, a family level and community level

Drama:

People are still standing in line for pills they don't necessarily need, or expecting treatment from a CCG.
CCG's facilitate the formation of support groups (diabetes, stroke survivors, cancer, etc).
In KZN, CCG's facilitated formation of walking groups or exercise groups; they established a netball team as diversion to address teenage pregnancies;

Locations and people involved:

Challenges and preferred areas of advocacy:

- Shifting away from emphasis on treatment and curative options, i.e. assessment and giving treatment;
- Looking after health instead of just treating it.
- Popularise ways of being more healthy
- Challenges: lack of choice and autonomy in cultivating better health choices and behaviours.

<u>Messages: Health promotion vs medical models</u>

- Eat a variety of foods daily
- Limit salt in your food (remember salt is hidden in processed food)
- Exercise 30 minutes three times a week this doesn't have to be at a gym – walking is good exercise
- (all alcohol messages)
- (child health messages)

5. Contraception

Role and purpose:
Contraceptive, maternal, child, and women's health services coupled with STI/HIV prevention and management are integral components of sexual and reproductive health. Promoting women's sexual reproductive health and rights as well as improving access to contraceptive methods is the gateway to achieving most of the eight Millennium Development Goals (MDGs) set by WHO for all developing countries in order to alleviate poverty. Modern contraceptive uptake still remains a major challenge in South Africa where the National CYPR remains unacceptably low at 31% since 2008. A study conducted by FHI360 on family planning and HIV integration in five African countries from 2007-2009 found an unmet family planning need of 46% among HCT (HIV Counselling & Testing) clients in South Africa. South Africa is also characterised by an extremely high prevalence of HIV, with an estimated 30.2% HIV prevalence amongst pregnant women. Maternal, peri-natal and under-5 mortality remains unacceptably high, with maternal mortality showing an increase over the past few years.

Drama:

Women living in poor socioeconomic conditions and women in rural areas still tend to have less knowledge of contraception and less access to contraceptive services, and these factors are associated with lower contraceptive use.
Partner, family and community expectations around fertility. This includes, for example, pressures on teenagers and young women to prove their love through demonstrating their fertility by childbearing; negotiations concerning condom and contraceptive use between partners, and societal and familial expectations for women to have children.
Many people do not have a sufficient understanding about the fertile period and when pregnancy is most likely to occur. This influences their choices about contraceptive use and risk, and can result in unwanted, or unplanned, pregnancy. There are important missed opportunities for information provision and education on reproduction that could be provided to women in a variety of health and educational settings.
Although almost all women in South Africa know about contraception, most have a limited knowledge of the range of contraceptive methods available. This hampers their ability to make informed choices about methods most suitable for them, as individuals. It may also impact negatively on their uptake of a particular contraceptive method.
Primary health care providers play a critical part in influencing women's uptake of contraceptive services. There is evidence to show that young women in particular may be discouraged from using contraceptives by disapproving providers. Providers also influence which forms of contraceptives women may use, with evidence that method choice is frequently limited in the public sector by the opinions and practices of primary health care nurses.
Many women attending contraceptive services do not obtain sufficient information and counselling on the expected side effects of injectable contraceptive methods. Side effects are reported to be the most common reason for discontinued use of contraception. This indicates the need for better counselling of women on the expected common side effects of the methods they choose to use, especially when they first start to use a particular contraceptive method.

Locations and people involved:

1. Girls and young women aged 12–24: to reduce teenage pregnancy (12-19 year olds) and unplanned pregnancies (20-24 years); avert new HIV infections.
2. Women age 25–49: prevention and planning of pregnancy – child spacing, contraception; HIV prevention and PMTCT.
3. Men as partners promote shared responsibility in the prevention of unplanned pregnancies and the planning for health pregnancies; HIV and STI prevention.
4. Communities: raise awareness and demand for families, support networks, and community

Deleted:

members
5. Health care workers to promote the knowledge, attitude and skills to provide quality sexual and reproductive health services.

Challenges and preferred areas of advocacy:

- Raise community awareness of contraceptive options and the need for pregnancy planning.
- Increase demand and uptake of contraceptive and sexual and reproductive health services among sexually active women between the ages of 15–49 years.
- Ensure that the commodity supply chain is ready to meet demand
- Ensure health care providers are trained to promote and provide all contraceptive methods within the framework of quality service delivery.
- Strengthen multi-sectoral leadership and collaboration in relation to contraception

Messages: Contraception

- Contraception and fertility management: My right, my choice, our future.
- Make informed decisions to prevent unintended pregnancy by using various contraceptive methods consistently and correctly
- Prevent STI and HIV infection or re-infection by using a condom correctly every time you have sex and for dual protection (against HIV, STIs and unwanted pregnancy).
- It is important that couples plan pregnancies together but it is a women's choice around her body
- Understanding one's rights; the legislation and services provided for Termination of Pregnancy (TOP) and early detection of pregnancy in this regard. It's your right to choose TOP in the first trimester of pregnancy