

Community-Oriented Primary Care (COPC) in District Health Services of Gauteng, South Africa

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Abstract

Family Medicine is making great strides in Gauteng Province as new district-based Departments of Family Medicine/Primary Health Care are being set up to provide clinical leadership in the District Health Services (DHS) in this urban powerhouse in South Africa. The author has been centrally involved in this and tries to reconcile what appears a contradiction: that the dynamics in the DHS (and the future direction of the DFMs) appear to detract from community-orientation. This article explores the challenges of developing a COPC approach by Family Physicians in Gauteng District Health System (DHS). The Karks offer some practical approaches.

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Introduction

It is important for community orientation to emerge from an individual practice – and it often does, from an altruistic individual: COPC lives, and dies with him or her. One cannot ignore that, in a context like South Africa, (or any other country) where there is political commitment and a structured approach to population health and community orientation, the Family Physician must understand and relate to this. The Family Physician can complement such system changes, broaden the COPC-approach and model the future.

The South African context

Community orientation to primary care is very influenced by the context of social and health system. In South Africa health has been undergoing restructuring since 1994 like most aspects of South Africa. District health structures have struggled since 1997 to develop functional integration of fragmented primary care services. Representative local government was only really established in late 2001 in our path to democracy.

The National Health Act (61 of 2003) provides for a uniform health service in an attempt to overcome fragmentation. COPC appears central in the Act with the DHS principles of community participation, preventive-promotive health and a defined population approach. The Act does remove the competency of most health services from local government to provincial government whilst establishing local government in a strong advisory role in new district health councils. There is a creditable multi-sectoral approach with large investments in infrastructure –housing

etc, within Integrated Development Plans (IDPs) by local government.

An Audit of the Service

There are mixed views on improvements in health care. New clinics and community health centres (CHC) strive to provide a wider range of services. Health projects have tended inordinately towards 'electoral visibility' of bricks-and-mortar. However, services are still compartmentalised and operate as vertical programmes with variable clinical integration, poor clinical communication and serious problems with referrals. There is a chronic shortage of doctors and a reliance on primary health care nurses to see large numbers of patients. Patients often bypass the nurses to get to doctor and hospital. Health services still suffer from apartheid legacies. The DHS is characterised by the pressure of numbers and poor clinical capacity.¹

Managers are constantly under pressure from politicians and community to deliver. The DHS has limited participation by stakeholders. Management know the value of community orientation but often seem cautious about wide community involvement as it may 'create expectations'.

The state of community orientation

The model of the DHS is to combine curative and preventive services in a team-based approach. It supports elements of community-based rehabilitation with home-based care workers. Yet mention of COPC by doctors is mostly regarded by managers as an indulgence considering the patient queues. There

are serious record-keeping problems with little reliable demographic data. Follow-up addresses are impossible to use. Migrancy of the population is still very high in some parts of Gauteng with poor social organisation of communities in crowded townships. There are few models of COPC in urban South Africa of immediacy to Gauteng managers.

In South Africa we have a decentralised primary health care framework (the DHS) that is very suited to COPC because of the public health ethos in the DHS but we 'lack managerial capacity' and have 'a district and provincial staff excessively concerned with accountability to their administrative seniors'. This 'can lead to disregard for community concerns'.² Comments by Tollman and Pick that despite a motivated health leadership there are preoccupations with organisational structure amidst administrative inexperience appear true in Gauteng. Clinicians can be just as insular. All this makes it difficult to implement COPC in the DHS. Despite political commitment to principle there are practical difficulties and managerial limitations.

The question arises: What could the new specialist Family Physicians do as clinicians in the midst of all this to build a community-oriented primary care approach in the DHS? The Karks still offer lessons.

Background to COPC in South Africa

The COPC-approach arose from inequality in South Africa in the late 1930s. It was at a time when clinical activity was facility-bound with non-existent public health. It linked curative to preventive services. It involved

inter-sectoral collaboration that went well beyond selective primary health care approaches.^{3,4} It was innovative in its time by setting up health centres and multidisciplinary teams (including a 'medical aide'... 'extending the physician'). It was considered revolutionary 'social medicine' with its mix of epidemiological, social and psychological elements.^{5,6} They played quiet advocacy roles in varied ways both within the community and outside. Might sound like old hat now but ideas had major impact!

The COPC approach of Sidney and Emily Kark (Wits alumni) in the early 1940s in South Africa laid the basis for a far-sighted and comprehensive National Health Service (NHS) in the Gluckman Report of 1944. Their approach demonstrated practicality and the value of small experiments.

The NHS was unfortunately abandoned as institutionalised apartheid took root from 1948 and the Karks work withered away in the 1960's. This was despite further innovation with the Department of Social, Community and Family Medicine occupying centre stage in the new Natal Medical School in the 1950's with the three other major disciplines.⁶ The Karks' work on COPC contributed strongly to the Alma Ata Declaration in 1978 and the current body of international public health.⁴ Public health has grown considerably since but COPC is still about linking public health principles to the clinical primary care setting.^{6,7}

COPC today has not changed much in concept since the Karks. Although it withered in apartheid South Africa, COPC expanded to other countries. The COPC approach appears very urgent in places where the public health system and health planning is still poor.^{2,4,8,9} Proponents of COPC are often strong advocates for patients and communities.

Advocacy within the DHS

The challenge for family physicians in the DHS is to clarify their value framework in terms of transformation in South Africa, understand and articulate with public health and management prerogatives and then hone in on a few key practical COPC elements within the system. Leading District Family Physicians need to play an advocacy role for both the individual patient and community without necessarily undermining management and governance prerogatives.

There are some simple ways to develop this advocacy role between seeing patients. These could be by bolstering management commitment to community-orientation: joining community committee/board meetings of clinic, CHC and Hospital Board and supporting management in multi-sectoral collaboration and local government liaison. These few elements can strongly contribute to clinical health services. Family physicians can especially support the management team by leading clinical sub-district functional integration, bolstering a pro prevention-promotion budget, reducing the vertical programmatic slant and ensuring horizontal integration at the clinical interface. These can produce immediate benefits for patient and community and are a necessary project in our context. Family physicians in health districts need to create space and develop trust for later COPC-projects that may appear indulgent.

COPC works well in a rural context however in the urban setting in South Africa it is an elusive concept with its overlapping systems, dispersed locations of patients and complex range of issues defining community. Practical issues are the rate-limiting steps.

COPC gone wrong

It was quite interesting to read about Mervyn Susser and a team of three other doctors who were inspired by the Karks Pholela experiment. They worked at Alex (80 000 in 1 square mile!) in the early 1950s trying to replicate the Pholela project.⁵ They reported their progress to the Karks after a few months of trying. Susser recounts the discussion: 'Kark responded (to their report): "I don't see where you have a family and community practice. Perhaps it's a pretty good emergency service and policlinic, cycling your patient or family through all your special clinics...but how is that better than a decent hospital ambulatory service could do?" "That's unfair" Margaret Cormack retorted. "It's all very well for your training institute to run a family practice with all your resources; you can give each team its own family to care for. The demands of unfiltered township life, whoever comes, hundreds in a day relentlessly, are what we must face and we have no choice but to care for them all"'

Mervyn Susser recounts "On our way back we knew how we would create a family practice...we divided

the township into three areas. Each area was to have a team of doctors, nurses, midwives and assistants assigned to them. Over a weekend, a task force of friends and students helped us reorganise the many thousands of clinic records into three defined areas". Despite a considerable amount of concomitant supportive community-based work done by Helen Navids of Entokozweni success was equivocal and little appears changed at Alex Health Centre. I wonder whether the point was ever understood.

A practical COPC approach:

starting a small community practice In contrast the details in the Karks project show that they set about developing the Pholela Centre quite differently. They provided general services to a population of more than 30 000 *but* they had a specific epidemiological programme for an 'initial defined area' (IDA) (or small community practice) of only 130 families / 900 people in a mapped vicinity. This IDA is where they did a census, home visits, engaged in group discussion exploring nutrition, community disease profiles and explanations as well as periodic health examinations. One community health worker (CHW) was allocated to 25-30 homes in the small community practice.

They progressively and annually added new communities of similar size to this IDA or small community practice and compared the old with the new (as control). The total in the IDAs however went only as high as 8500 people ten years later (probably out of a population of little more than 30 000).^{9,10} There were demonstrable differences that were documented and these became compelling for policy changes as was seen in the Gluckman Report. There were queues but the Karks clearly managed these together with the epidemiological tasks in the IDA or small community practice without huge resources. One must confess the Karks were afforded considerable freedom of operation but they engaged the community very respectfully.⁹ Their approach was a useful one.

Practical COPC Tools

There are practical tools that have developed further, since the Karks, that could be considered in building such a small community practice.

Community participation is vital^{8,10}

The exercise of selecting a small section of the community needs to be subject to consultation with the team and the broad community. Prioritisation and detailed assessment of selected health problems needs to occur with community participation. There must be local co-operation and community responsibility. It requires an understanding of behavioural sciences as the community is 'not only people and places but bricks and mortar, power structures, historical traditions, social values and customs and a myriad of unquantifiable and often indefinable but essential features'.¹⁰ One needs to be adept: the Karks involved members of a 'prominent family' in their project and had meetings with chiefs.^{8,9} The right knowledge, skills and attitudes are required.¹¹

A profile of this community.⁸

These can be developed using secondary data (like notification statistics) and/or ones own primary data- eg waiting room surveys or focus groups.⁷ These could both qualitative and quantitative. Objective health data such as demographic information on population, births, deaths and hospital discharge data are just as important as qualitative data for explanation, idea generation and planning e.g. understanding of local concepts of health and disease.¹² One could also use health and nutrition surveys, detailed maps with annual population, household census social structure, work, diet, housing (water, sanitation), and migrations. These are all still important in South Africa.⁹ 'Village' planning with the development of the historical context or even a windshield survey i.e. driving around can be useful.⁴ One can tap into existent health information systems around morbidity data and utilisation of health services and develop the skills of epidemiology and quality improvement together with the development of clinical guidelines.^{9,12}

Integration between the clinical and the community

There needs to be integration between the clinical and the community. The Karks employed family files (as a combination of patient clinic records with home-based field records). Records for each family were regularly summarised.⁹

Combine treatment with prevention

COPC should combine treatment with prevention using health education and health promotion around nutrition, family health, personal hygiene and general health. This includes supporting vegetable gardens & school meals. Environmental, educational and agricultural factors need to be considered. The Karks also had a comprehensive approach to the IDA or small community practice with immunisation programmes, home visits, outbreak investigations and early case action.⁹ The Karks health centres as well as sub-centres were used for community education.¹¹ They measured several things including movements of the population and the influences of environmental factors. Their controls were the add-ons done annually.³

The health team is vital.⁷

The Initiative for Sub-District Support (ISDS) lessons from Bergville with Participatory Action Learning emphasise the value of Community Health Workers (CHWs). 13131313131313 The Karks had weekly team conferences with the whole health centre staff.⁹

Evaluation

The cyclical nature of COPC includes evaluation.¹⁴ This allows qualitative and quantitative feedback from the programme to improve the integrity of the community orientation and epidemiological strength of the health care.

Limitations to COPC Tools

The increasing complexity of these tools can also become a limitation. There is often poor method with resulting dubious outcomes. Clinicians suffer from a lack of resources, skills, evaluation methods, quantitative data analysis techniques and management skills. Community participation can become narrowly-driven by practitioners with poor long-term sustainability of local community organisations. Forcing the issue on clinicians is also problematic. COPC driven from above can antagonise clinicians whereas a more emergent approach with experimentation within a supportive climate may be more successful.¹⁴ The limitations of provider mixes and limited links with other providers can become a problem. It is easy to be overwhelmed by the

complexity and it is often the well-trained team that works best.^{15,16}

A COPC partnership with Public Health Practitioners in the DHS

These limitations raise questions about the practicality of Family Physicians succeeding alone in the epidemiological approach of COPC. There is need for a considerable amount of training but COPC is no substitute for motivating including public health practitioners as part of the district clinical team.⁵ One needs to explore the many permutations to COPC and the costs.^{15,16}

Way forward

Family Physicians are being welcomed by managers: as advocates for patient and community within the restructuring of the DHS. They are willing to allow these Family Physicians to focus at a sub-district level to demonstrate impact. The space is available for practical COPC measures balanced with broad service needs. Practical steps will help clinicians progressively build team-based COPC. Building small community practices offers a model. A partnership with public health practitioners will certainly be very important.

Declaration of Conflict of Interests

None

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