The Primary Health Care Team:
What is it and who is best equipped to lead it?

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The South African health system is beginning the slow transition from a hospital based model to a service that is based on Primary Health Care (PHC).

This change will and must have an impact on the role of different categories of health workers and their appropriate place and function in a PHC system of health delivery. This article discusses the function of PHC and a number of contentious issues such as the composition and leadership of the PHC team. It is not intended to be a comprehensive discussion, but rather to raise some of the principles and implications of a PHC team. Time and experience in specific contexts will develop the finer detail of the different roles and functions of the members of the PHC team.

The District

Effective planning and management of the health service in South Africa has been impossible with the fragmentation caused by 14 health departments and the provision of separate preventative and curative services.

For effective and efficient delivery of a comprehensive PHC service, most progressive health workers are in favour of a district model for this service delivery. A district is a clearly defined administrative area, which commonly has a population of between 100 000 and 500 000, where some form of local authority takes over many of the responsibilities from central government departments, and where a general hospital for referral exists. It makes up a manageable unit which is still close enough to community level for problems and constraints to be acted upon.

In South Africa we still need to develop the political and administrative boundaries of appropriate districts. The discussion in this paper will be based on a district model.

The Principles appropriate to a PHC Team
1.Team functioning

It is essential that a PHC team function as a TEAM - not simply a mixed group of individual health workers who are called a team. How the team functions is as important as the people who make up the team. Unfortunately medical and nursing training does not prepare these categories of health workers to function well in a team. Doctors are a particular problem, because they usually assume that because they are the highest qualified in high tech medicine they rightly should head the PHC team. Their training has not prepared them to fully appreciate the important and essential skills other health workers bring to the PHC team.

There needs to be a team approach which affirms and acknowledges the important role each member of the team has in improving the health of the community.

2. Intersectoral Cooperation and Health in Development

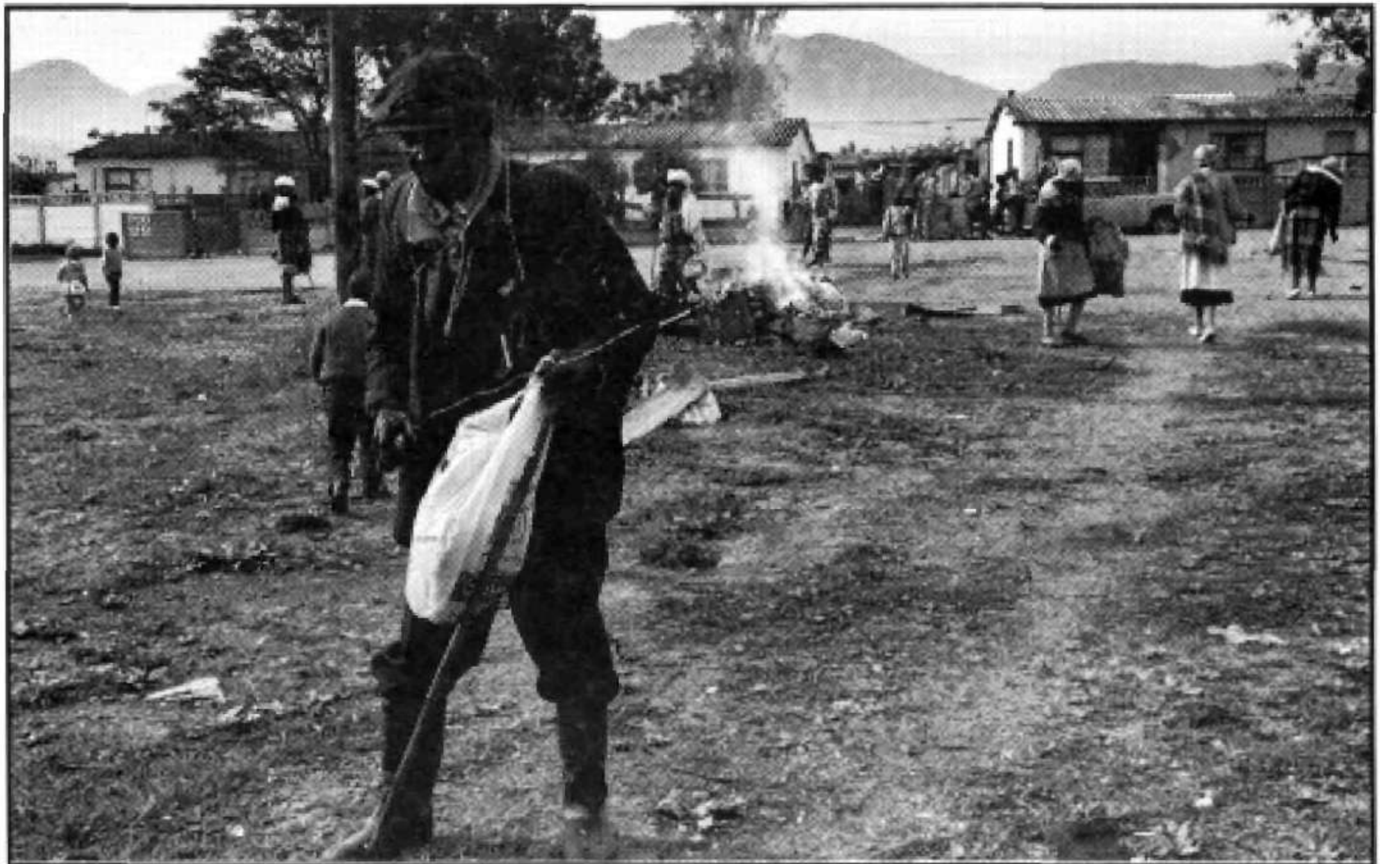
Health is intimately bound up with development. Socioeconomic improvements will directly affect the health of that community.

In most situations, the provision of clean water and sanitation will have a greater impact on the health of a community than the presence of a highly trained doctor. Roads and agriculture are sectors that also have an intimate role in improving the health of a district. The PHC team must have representatives from these other sectors, or at least efficient and clear channels of communication to the other relevant sectors.

For this to happen, the PHC team needs to work on the overall development of their district and region. Self help projects, employment generating projects (that particularly empower women) are essential to the work of the PHC team if they hope to improve the overall health of the communities they serve.

3. Community Participation

A health worker committed to PHC will try to ensure full community participation and control in planning, evaluating and refining the delivery of PHC. At the same time no health worker who has worked in a community based health service or project will deny the difficulty of developing effective community participation. It takes a great deal of time, patience and persistence. The PHC team cannot allow itself to believe that it alone must decide and control everything.



The provision of clean water and sanitation will have a greater impact on the health of a community than the presence of a doctor.
Photo: Medico Health Project

4. Equity

This principle is essential in developing a PHC system that will be acceptable to the majority of South Africans. Apartheid has entrenched inequality in access to health care. The PHC team needs to continually evaluate their progress towards an equitable PHC service.

5. Accessibility

PHC emphasizes the role of clinics which are within easy walking distance for the majority of people in the district. Accessibility is also one of the reasons why the PHC team should include community health workers (CHWs) or community based rehabilitation workers (CRWs). Because they come from the community and speak the language and can be held accountable to the community - CHWs and CRWs personalize accessible health care.

6. Management

All members of the PHC team should be trained in management. It is not only for doctors or nurses. The development of work programmes, planning, goal setting and evaluation is important for all the PHC team. Within the PHC team there will need to be a sub team which is responsible for managing the district health services.

7. Composition of the PHC Team

The composition of the PHC team varies in different countries and regions and especially at local level. Sub-teams will focus on a particular aspect of health. The team must be multidisciplinary and will consist of the following categories of health workers:

1. Community Health Workers and community based rehabilitation workers.
2. Mid level health workers (PHC nurses or medical assistants)
3. Nurses
4. Midwives
5. Doctors
6. Health inspectors/environmental health workers.
7. Physiotherapists and occupational therapists (and or mid level assistants)
8. Pharmacist and pharmacist assistant
9. Development officer
10. Traditional healers/ homeopaths/ osteopaths/ acupuncturists
11. Auxiliary staff: dentists/ oral hygienists/ optometrists/ psychologists/ social workers/ podiatrists.
12. Administrative staff

Role and Function of Different PHC Workers in the Team

While different workers and sections will have responsibility for different aspects of health, no one sub team or section should become so engrossed in the service they deliver as to lose sight of how and where it fits into the common PHC goal of improving the health of the community. Rather than detail the function of each category of worker in the PHC team, I will raise a number of the more contentious issues relating to the composition and function of different workers.

1. Community Health Workers (CHWs) and community based rehabilitation workers (CRWs)

The big debate is how much of a curative role should the CHWs play in the PHC team? The community based accountable health worker deals with health education and promotive and preventive aspects of health. Often this role is under valued by other members of the team and is often the most difficult aspect of behaviour change.
Many CHW programmes equip CHWs with varying levels of curative skill including dispensing simple medicines. This curative role is often thrust upon them because of the desperate need of the community for curative care for minor illnesses. But does this result in poor health care for poor people, while the middle class are treated by higher level health workers? Some programmes argue that by giving the CHW a curative role, they become increasingly involved in that role (with the distinction of being a healer), while the essential preventive and promotive works slips further into the background.
However, many argue that an appropriate curative role (with respect to the felt needs of their community), strengthens their effectiveness and appropriateness with regard to preventative and promotive health.
Similar questions arise about the role and function of the community based rehabilitation worker.

2. The PHC Nurse and the Medical Auxiliary/Assistant

This category of health worker is the backbone of the PHC teams. They staff the clinic or health centre and see the majority of patients who come for curative care. The debate in South Africa now is whether this level of health worker is needed - but should we move away from the PHC nurse and rather train a specific category of medical auxiliary/assistant to fill this diagnostic and curative role?

The debate is fueled by the fact that a number of medical assistants trained in other countries have returned to South Africa. Also much of the debate is a result of the territorial approach of the professions to the role of the nurse versus the doctor. Many PHC workers are unsure of the appropriateness of initiating a medical assistant training programme in South Africa, where we already have a large group of effective PHC nurses.

3. Doctors

What is the role of the doctor in the PHC team? She/he is highly skilled in high tech medicine and complicated diagnostic procedures and treatment. Their training is

What would the process be if the community wanted a say in the choice of PHC team leader? *Photo: Cedric Nunn*

very costly - both in time and money. Some would want to limit their role in the PHC team and rather use them to staff the hospitals. Others see them as integral to the team in a Community Health Centre or large clinic. Much of the debate also centres around the level of health care which is affordable and appropriate to South Africa.

Cuba went for a doctor centred PHC approach. They trained many doctors and developed ways to encourage/force them to work in the rural areas. This has resulted in very good health indicators. Others argue that doctors disempower the people and help to emphasize a curative diagnostic model. People are dependent on the professional doctor - rather than being empowered to do something about their own health.

In South Africa doctors are a very powerful lobby. The role of the doctor (both private and public service), is a key question that must be faced if we are to

develop an effective PHC team approach to health. Many doctors are in need or reorientation if they are to be effective in a PHC team.

4.Health inspectors/environmental health workers

In most areas health inspectors function as health police - trained to enforce rigid health regulations with respect to restaurants etc. Like doctors, they need reorientation and possibly retraining so as to become part of the PHC team responsible for environmental health in the community. They should become key personnel in the team as environmental factors are critical to improving the overall health of the community.

Some argue that this role should be deprofessionalised, and like some other countries we should train mid level or community based environmental health workers who might more effectively and efficiently address environmental problems.

5. Development officers

Health must be seen as an aspect of development. PHC emphasizes the importance of socioeconomic factors of ill health. Clinic based health care cannot address these issues. A district development officer as part of the PHC team will ensure that health is always drawn back to the broader developmental needs of the district and region.

6. Traditional healers

Their inclusion in the PHC team is still a matter of debate in South Africa and elsewhere. It must be acknowledged that 70% of black patients first visit a traditional healer before attending a clinic. There have been some innovative models where they are included in the health team, but their role and integration into the team remains unclear and opinions are divided.

The PHC team needs to develop a good working relationship with traditional healers in their district. There needs to be mutual respect for each other's role, and where possible traditional healers should be supported with ongoing health education. They should be encouraged and trained to diagnose and refer patients with diseases that will definitely benefit from western medical treatment (for example, dehydration, meningitis, T.B. etc) and discouraged from practices that will be harmful to the patient (for example, an enema for a child with gastro enteritis).

7. Administrative staff

This group is often relegated to the office and ignored as part of the PHC team. There are examples of innovative ways of including them in the team. What about using the driver of the mobile clinic as a part time development officer? While the PHC nurse is doing the clinic, she/he can be teaching people trench gardening or how to build pit latrines. Also she/he can be brought in to the team to give health education.

Clerks at the clinic or community health centre need to be included in the PHC team as well. They are the first contact with the sick patient - and often are the most unhelpful. By including them in the PHC team and training them to see how they can use their patient contact to further PHC, they will be much more motivated and encouraged to participate as a part of the team.

The hospital administrator/secretary in a district hospital is an essential member of the PHC team. They need to be encouraged and supported to see the important role the clinics and district services play in meeting people's health needs. A great deal of the money spent on health is used at the hospital, and therefore their involvement in planning and management of the PHC team is very important.

Environmental health is an important aspect of development.
Photo: Medico Health Project

Who Should Lead the PHC Team?

It is often assumed that the doctor will lead the team as they are "the most skilled". The prior question is: "most skilled in what"? If you want to develop a PHC team approach that is curative and hospital centred - then a doctor is probably the right person to lead the team. But if the goal is PHC committed to developmental and intersectoral work - doctors are likely to be inappropriate as the leader of the PHC team.

Similar concerns apply to nurses. Both these health professionals are trained with a curative emphasis and often includes a subliminal message that they alone know everything about health. There is a desperate need to reorientate health professionals as to their role in PHC.

The type of leader that is required is one that empowers and builds the other members of the team. They need special management training and facilitation skills.

What if the community wants a say as to the choice of the PHC team leader? How would this process happen? Would the community still be dominated by the ingrained view of health as the territory of the health professionals? As a system of community accountability of the health system is developed, the possibility of increasing the community's say in the management and leadership of the PHC team has to occur.

Conclusion

The PHC team is the key to an effective, accessible health service in South Africa. We still have a lot to learn with respect to hands on experience of the PHC team. As we develop this experience we will be able to better deal with the difficult questions of the role of the health professionals and who should lead the PHC Team. But with a team approach which does not allow professional health workers to dominate and oppress other health workers, emphasizes the development needs of the district and works with other sectors, we will be well on the way to implementing a PHC service which will really improve the health of all South Africans.

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