

**SECOND CARNEGIE INQUIRY INTO POVERTY
AND DEVELOPMENT IN SOUTHERN AFRICA**

**Do the primary health care nurses
in Gazankulu provide second class
cheap care to the poor?**

by

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PREFACE

Gazankulu is one of South Africa's so-called "black states". The Mhala district is an isolated island midway between Nelspruit and Tzaneen. It is typical bushveld with limited water and poor agricultural potential. 152,000 people live in Mhala's 57 villages which vary in size and infrastructure. Health services are underdeveloped and comprise one 260-bed hospital (Tintswalo), one health centre, ten clinics and a mobile clinic.

Why did Wits Medical School become involved here? It was by both design and fate. At Wits we had people interested in rural health and a benefactor (Anglo American Chairman's Fund) prepared to sponsor rural health work. The government has encouraged the various medical schools to become involved in rural health care and has designated schools to particular "homelands".

So we became involved in Gazankulu and the Health Services Development Unit (HSDU), a project of the Wits Department of Community Health, was established. The objectives of the Unit are the training of appropriate health service staff, the expansion and development of clinic services and the creation of a health service which is community supportive and responsive to local needs. To succeed we need the goodwill, support and respect of the community and the wholehearted backing of the existing health service.

This paper and the others of the HSDU are reflections, analyses, recommendations and ideas and are the product of our first two years' experience. Opinions expressed are based on the critical analysis of hard data on the one hand and on personal impressions on the other. Whatever the opinion, it has been acquired by first hand and sustained personal experience.

The papers cover three aspects of our experience:

1. The State of Health and Health Care in Mhala
 - a. Health and Health Care in Mhala : an overview.
 - b. The Nutritional Status of Children 1 - 5 years.
2. A Critique of Some Health Service Interventions in Mhala
 - a. Community Health Workers in Mhala : Perversion of a Progressive Concept?
 - b. How well do our Rural Clinics Function?
 - c. Reviewing the Health Centre Policy.
 - d. Mobile Clinics : What can and do they Achieve?
3. Health Service Interventions by the Wits HSDU
 - a. Do Primary Health Care Nurses in Gazankulu provide Second Class Cheap Care to the Poor?
 - b. Can good Tuberculosis Services be provided in the Face of Poverty?
 - c. School Health Services : Problems and Prospects.
 - d. Mass Immunisation Campaigns - The Tintswalo Experience.

The message is that:

- Health care in Mhala is inadequate.
- This care can be improved without preceding changes in the present economic and political systems.
- Such improvement is limited by social, economic and political constraints which are the root cause of such illness.
- It is worth working in "homeland" health services because of what can be achieved.

In acknowledging all who have worked in or with HSDU it must be remembered that health service development is a team effort. Many of the people of Mhala, the hospital staff, primarily Dave Stephenson as superintendent and the community health nurses, Dr Erica Sutter and the superintendents and staff of Gazankulu's other hospitals, the health department led by Dr Roos and, more recently, Dr Robert, and the Chief Minister of Gazankulu have all contributed to the establishment and development of the Unit. The Chairman's Fund of Anglo American and the University of the Witwatersrand have provided the infrastructure.

The action has come from Anita and Bob Backentose, Eric Buch, Rob Collins, Cedric de Beer, Clive Evian, Vic Gordeuk, Meryll Hammond, Thoko Maluleka, Shirley Maswanganyi, Sanilesive Mtetwa, Dipuo Mosoue, Robert Waugh and Merrick Zwarenstein.

DO THE PRIMARY HEALTH CARE NURSES IN GAZANKULU
PROVIDE SECOND CLASS CHEAP CARE TO THE POOR?

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INTRODUCTION

Primary Health Care Nurses (PHCNs) were introduced into Soweto after doctors had been withdrawn because of political violence during 1976. Those introducing the new service believed that PHCNs supported by doctors would provide a better service. Reports indicate that PHCNs have flourished in Soweto. (1,2,3). This success gave impetus to moves in the Nursing Council to recognise Primary Health Care nursing as a post-graduate qualification. This has succeeded, and the Nursing Council now gives a diploma in "Clinical Care Nursing Science, Health Assessment, Treatment and Care." (4)

Tintswalo hospital first began training PHCNs in July 1980. We are now training our third class and must face up to the question: Do PHCNs in Gazankulu provide a means for delivering second class cheap care to the poor?

Our experience thus far has led us to conclude that:

1. PHCNs are the most appropriate category of health worker for the task of delivering accessible high quality primary health care to rural villagers.
2. PHCNs can only fulfil their role effectively if:
 - a. There are enough PHCNs.
 - b. The best possible students get selected.
 - c. Training ensures that workers are skilled for their job.
 - d. Graduates are well supported.
 - e. Graduates have favourable work conditions.
3. We can only be partially successful because of the limitations of homeland health services.

This paper looks at the experiences that led us to these conclusions, but before we do this we should clarify what the role of the rural PHCN is.

WHAT IS THE CORRECT ROLE OF THE RURAL PHCN?

The first training programme at Tintswalo followed the urban model developed at Baragwanath Hospital. The urban PHCN is only trained to diagnose and care for the ill people that arrive at her clinic. If she has a problem, she asks the doctor next door for help. Her role is essentially curative. (point a. below)

The rural PHCN works under completely different circumstances. Her tasks are much broader and she is responsible for the primary health care of 10-15 000 people. She must be skilled in clinical care and in community health. As there is no doctor to help, she must also be able to provide emergency care. Our experience has led us to the following job description for a rural PHCN. She should:

- a. Diagnose and provide care for patients with common health problems and refer those problems beyond her competence.
- b. Provide chronic disease care.
- c. Provide emergency care.
- d. Ensure a safe pregnancy, labour, and delivery for mothers.
- e. Provide comprehensive child care.
- f. Inform patients and communities about health.
- g. Undertake health work in the community.
- h. Support community development in her area.
- i. Administer and manage her clinic.
- j. Function as the leader of the health care team at her clinic.
- k. Form a link between her community and the health service.

In the practice of her work the PHCN should show respect, caring, and warmth for her patients; and be self-reliant and hardworking. She should share her knowledge and skills with her co-workers and with her community. The PHCN should also strive to build her community's awareness of their health problems, and if possible assist in developing community-based efforts to overcome them. She will spend time in her clinic and in her community.

With this role in mind let us consider the experiences that have led us to the conclusions stated earlier.

ARE PHCNs THE MOST APPROPRIATE HEALTH WORKER FOR DELIVERING ACCESSIBLE HIGH QUALITY PRIMARY HEALTH CARE TO RURAL VILLAGERS?

It has been argued that anything less than care by a doctor constitutes second class care. (5) This logic was used in Cuba and as a result care by doctors is available to all her citizens. (6)

However, the circumstances in Cuba are very different to those in South Africa. The developments in Cuba were part of a broader political process. Their doctors were specifically schooled in the provision of primary health care and in the need to serve the community. (6) In South Africa the present training, attitudes, language and class background of most doctors make them ill suited and unwilling to work in a rural clinic. Although PHCNs may suffer from some of these drawbacks, they are far more likely to fit into both the clinic situation and the community.

For this reason they will certainly do better in community health care. From the clinical point of view, a PHCN is as competent as a doctor to diagnose and treat common illnesses. (7)

If the possibility emerges for the training of large numbers of rural people as doctors, and they can be specifically trained for rural work, this debate should be re-opened. At present adequately trained and supported PHCNs are more appropriate than doctors for staffing rural clinics.

ARE THERE ENOUGH PHCNs?

Based on two PHCNs per clinic, 4 per health centre, and 6 per hospital OPD; Gazankulu needs 155 PHCNs. Leave requirements raise this to 186. Do we have the posts available, and can we train this number?

Posts available

PHCNs are appointed against registered nurse posts. The situation at Tintswalo serves to demonstrate the shortage of posts available for PHCNs. Tintswalo has 68 registered nurse posts, and an immediate need for 40 PHCNs. We cannot increase the number of nurses doing PHCN tasks much beyond the current 16 without serious disruption of other nursing services.

Training potential

There are 19 PHCNs in Gazankulu, and a further 9 are in training. Our maximum class size is 16, so it will take us 10 years to meet Gazankulu's current need. By then needs will have increased. Because the hospitals are short of registered nurses we cannot fill our classes. As a result our second class had only 11 Gazankulu students and our third class 9.

The limit on the number of nursing posts available for PHCNs and the number that we can train unfortunately leads us to conclude that we will not reach the needed number.

CAN THE BEST CANDIDATES BE SELECTED FOR TRAINING?

We are slowly ensuring that all nurses learn about the possibility of PHCN training. We have also developed an improved selection process, but this has not yet been tested.

We have spelt out the attributes that we are looking for and plan to hold training seminars for the staff that select our students. We are encouraging selection of nurses who want to live in rural villages, as many of our graduates have ended up in hospital out-patients departments. We accept non-matriculants because if we did not we would be excluding some of our best potential students.

When we have put all our selection plans into practice we will need to evaluate how successful we have been in getting the best candidates.

There is one further problem to address. We are trying to attract nurses who will work in the clinics, but work conditions and support systems are still very unsatisfactory and the image of the clinic nurse is very poor. These problems will be considered in detail later. For now, we can say that they limit the number of people who want to be trained as PHCNs.

DOES TRAINING ENSURE THAT PHCNs ARE SKILLED FOR THEIR JOB?

We have progressed from a stage of having too few trainers with too little experience to one where we can build for the future. In addition to training our current class, we are developing course materials and training PHCN graduates as future PHCN teachers.

Let us briefly review our experience in curriculum design, teaching methods, and evaluation of students.

Curriculum design

The initial course had three major curriculum design flaws.

The first course taught clinical care only. We have since broadened the curriculum to include a wide range of community subjects to match the work that our graduates will do.

Subjects were initially taught according to medical disciplines (surgery, medicine, etc.) for a month each. We now allocate times spent on subjects according to their importance, and integrate our teaching as much as possible. Students are taught by systems (e.g. respiratory, gastro-intestinal) rather than by disciplines, and the community and clinical aspects of a subject are integrated wherever possible.

The third shift is related to the need to develop our students' attitudes, thinking skills, and ability to relate to people. These essential attributes were overlooked in the first course.

As we have built our curriculum to match our workers' job description we have created a new problem - we are overloading our students; and are thus considering increasing the course to 15 or 18 months.

Teaching methods

We have shifted away from lectures in which students are passive listeners and will later try to recall information. Active learning methods such as role plays, small group discussions, and projects are now used extensively. We have found that these increase our students ability to understand, think, analyse, and solve problems; as well as their ability to recall.

From the first course our training has included extensive practical work. An average day has the students in class until tea-time, with outpatients from tea until lunch, and doing one of a variety of activities in the afternoon. These include reading, project work, seeing ward cases, and possibly further work in the out-patients department.

Evaluation of students

Our course is registered with the S.A. Nursing Council and is subject to their method of evaluation. Their exams test the students ability to write essays and to recall facts, neither of which are necessary PHCN attributes.

We prefer methods that test students ability to perform their job. These include problem solving exercises, open-book examinations, and practical tests of their ability to do clinical and community work. We hope that the planned decentralisation of examinations will allow us to adopt these methods of evaluation.

In conclusion: we believe that we have proved that PHCNs can be well trained. However, the training programme is very labour intensive and high standards are difficult to maintain. We still have to show that these efforts can be sustained without outside input. To this end we are training PHCN graduates as teachers of PHCNs but we still have to see if they are able to maintain the programme.

ARE PHCN SUPPORT SYSTEMS ADEQUATE?

The support system refers to those aspects of the health service that help a worker do their job well. An adequate support system for PHCNs will start with a commitment from the health services to development and support of this category of health worker.

It also includes supportive supervision; functioning communication, transport and referral systems; adequate drugs and supplies; an efficient record system; and continuing education.

We made the mistake of not ensuring that these support systems were developed before we started training. As a result we have been faced with a continuing uphill battle.

We have managed to solve some of the problems, but many still remain. Let us look at each aspect of the support system in turn.

Health service commitment to PHCNs

No such commitment was initially made, but a recent policy statement by the Gazankulu Health Policy Council has overcome this problem.

Supportive supervision

PHCNs, like other clinic nurses, require extensive supportive supervision. We are aiming at the kind of supervision where the supervisor tries to help and encourage the worker in their job, rather than simply look for faults. We are not there yet.

At present, visits to clinics are all too infrequent. We hope that doctors and specialist nurses will visit the clinics more regularly.

Communication, Transport, and Referral Systems

The PHCN must be able to communicate rapidly with her base hospital for advice in emergencies, or to call for an ambulance. This and other aspects of the referral system ensure that the PHCN is not forced to practice beyond her limits. Good communication is also needed for administrative support and for continuing education. Good transport services are needed for emergencies, for referral of patients to hospital, to ensure supplies, for supervisory visits, and to enable the PHCN to do community work.

We face many problems in these areas. Communication was previously based on a very inadequate telephone service, but has been improved by the introduction of radio communication. Referral systems are improving, but few PHCNs get enough help in emergencies or feedback on their cases. Transport remains a problem as hospitals have too few vehicles.

Drugs and supplies

We started out without equipment or drug lists, or guidelines for patient care. These are presently being developed.

We expect significant problems in an area of supplies which we have not yet tackled. This is the development of adequate supply, maintenance and repair systems for the clinics.

Records

Essential information should be recorded at every consultation. Our PHCNs are taught to do this. However, no such records are kept at the clinic. We are therefore faced with the task of developing a new record system.

Continuing education

We fail in our responsibility for continuing education because of our workload. In the future we hope to run regular continuing education courses and produce a newsletter, but wonder if we have the resources to do so.

DO PHCNs HAVE ADEQUATE WORKING CONDITIONS?

Good working conditions improve workers' job satisfaction, and hence their work. PHCNs are faced with the same poor work conditions as clinic sisters. These include inadequate accommodation, isolation, overwork, and no overtime pay. Poor support systems increase frustration and leave PHCNs without the encouragement they need.

There is an increase in concern about the working conditions of clinic sisters. They will soon get some overtime pay and plans are afoot to improve their accommodation.

It is crucial that we improve PHCN work conditions. If we do not, then the potential is low for them to work well and to remain at the clinics.

CONCLUSION

This paper set out to evaluate whether the use of Primary Health Care nurses in clinics in Gazankulu provided a means for delivering second class cheap care to the poor.

We come to the following conclusions:

- PHCNs are the most appropriate category of worker for the job they are expected to perform. They have the ability to provide improved medical care and can help to build a health system that is on tap to the community, rather than on top of them.
- Our experience shows that a PHCN programme in a homeland can make reasonable progress up to a point, but after that there are factors that hinder satisfactory development of a PHCN programme. These are that:
 - We are unable to train sufficient PHCNs to staff clinics adequately.
 - The workload that insufficient PHCNs puts on those who are trained prevents them from providing satisfactory care and places severe constraints on the time they can spend working in the community.
 - We cannot claim to have established adequate mechanisms for selecting candidates, for training, or for support systems.

- There is a danger that the pressure and hierarchical structures under which PHCNs work, will erode the caring approach developed during their training.
- We are not yet sure that living and working conditions for PHCNs will improve. Even if they do, nurses may not be attracted to the training course and the prospect of service in an isolated clinic with a poor support system.

Finally, it is clear that the introduction of one new category of health worker will not change either the society or the health service. PHCNs may improve the quality of care to those who get to the clinics. However, they will not overcome such problems as the shortage of services, or the inaccessibility of health care resulting from cost of treatment and distance from the clinics. Their constraints will also not allow them to provide adequate community health care.

It need hardly be said that PHCNs will make no impact on the extent of poverty; the basic cause of most ill health in rural South Africa, including Gazankulu.

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