The Role of Community Paediatrics in South Africa

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SUMMARY

Community paediatrics in South Africa is concerned with helping to identify the factors that retard realization of the full developmental potential of the nation's children. It is also concerned with the removal of such blocking factors. Paediatricians familiar with the orientation and methods of community medicine are suited to this task, which involves: (i) co-operation with all health, education and welfare organizations concerned with child care; (ii) taking part in the education of all child care professionals; (iii) taking part in the planning and organization of child care services; and (iv) being concerned with clinical care, particularly at primary care and rehabilitative levels.


South African paediatrics has in the past been dominated by curative medicine practised largely in hospitals and consulting rooms. The overwhelming tide of disease has forced itself forward, demanding the paediatrician's attention and diverting it from the prevention of disease and the active promotion of child health. Disease has similarly taken the lion's share of administrative and financial resources.

In the past few years this has begun to change and it is the purpose of this article to examine the shift in emphasis and to suggest that paediatricians with similarly altered responsibilities will be needed. It will also explore some of the avenues along which such paediatricians might approach the challenges offered.

A mainspring of change has been the recent worldwide trend, described by authors such as Morley, King and Bryant, to assess health needs of whole communities and to plan services to meet these in a way that is financially, socially and culturally appropriate. The development of the Day Hospitals Organization in the Cape Peninsula was proposed by Ford et al., years ago as a result of this kind of approach. So also was the financing of semirural and rural local authorities by the State Department of Health to develop a system of polyclinics aimed at serving the whole population.

Polyclinics such as these, staffed by registered nurses with a minimum of medical supervision, provide maternal and child welfare services along with tuberculosis, venereal disease and, importantly, family planning services. The number of local authorities operating these services has risen steadily over the last 5 years. These clinics are seen as the skeleton of a network of local health centres which, if fully developed within the provisions and spirit of the recent Health Act, could become an impressive health service. The Act encourages collaboration of all health authorities to provide a fully comprehensive service.

In 1975, children made up 68% of all attendances at all types of Cape Town City Council clinics. The same situation holds for other services run by local authorities. Paediatric guidance for staff in these clinics is at present conspicuously lacking.

A further aspect of the changing scene has been the greater emphasis in recent years on the needs of children who are handicapped or chronically ill and those who face social and emotional deprivation. The community services to meet these needs have remained relatively underdeveloped.

This underdevelopment is exemplified by the situation in Athlone, a suburb of Cape Town, where 73% of severely mentally retarded children of school-going age who live at home, receive no form of training whatsoever. Residential care for the mentally handicapped is still mainly provided in 'traditional' institutions which hinder socialization of inmates and are expensive to run. Difficulties also exist with the early detection of handicap in child welfare clinics run by local authorities. Large numbers of children, hard-pressed staff and a distinct lack of paediatric guidance are among the problems encountered, and paediatricians clearly have important responsibilities here.

THE COMMUNITY PAEDIATRICIAN

To solve these many problems the concept of the community paediatrician as one who will operate in all strata of the community to promote child health in its broadest sense has emerged. The recent founding of two Chairs of Child Health whose incumbents will operate in these areas is some indication of the interest already shown in this field.

It is important to place community paediatrics in perspective as a large and vital component of community medicine. The health of children is closely interrelated with that of the whole community, and any functional division is arbitrary. Nevertheless, there are many problems peculiar to children that require a paediatric orientation for their solution. In particular it requires child health to be viewed in terms of optimal physical, emotional and intellectual development.

DEFINITION

Community paediatrics may be defined as that aspect of community medicine concerned with the health of children. That is to say, it is concerned with the
evaluation of the health of all children in the community, with the establishing of priorities among their health needs, and with action, either direct or through other agencies, to meet these needs. Community obstetrics and psychiatry are, similarly, branches of the parent discipline, community medicine. Free and complete co-operation between practitioners of these disciplines is essential to the effective promotion of the health of the community.

Comprehensive medicine is concerned with the assessment and management of individual patients in terms of primary, secondary and tertiary levels of disease prevention, as well as with the relationship to health of family, domestic, cultural and socio-economic aspects of life. Comprehensive pediatrics is no more than the application of these methods to problems which particularly concern children. Every good pediatrician practises comprehensively for individuals but seldom has the time or opportunity to practise community pediatrics.

In the UK it has been recommended in several recent publications that in each geographical area at least one pediatrician be appointed who has the time and opportunity to develop the preventive and social aspects of child health which had previously tended to be neglected. The community pediatrician is seen by Davis and Bamford as a doctor with clinical ability and social understanding. In a leading article, Lancet described him as one who specializes in epidemiology and the delivery of health care and in making a contribution to social policy at every level. In South Africa the emphasis will inevitably be very different, but the underlying principle the same.

The training of a community pediatrician should include a specialist training in general pediatrics, with particular emphasis on developmental pediatrics, the chronically ill child and primary care. In addition, he should have experience in the wider field of community medicine.

FUNCTIONS OF THE COMMUNITY PAEDIATRICIAN

So far the community pediatrician has been placed in context, but what will he do to meet this challenge? His functions are divided into 5 categories: (i) the determination of child health needs and their priority; (ii) co-operation with health, educational and welfare organizations; (iii) teaching; (iv) planning and delivery of services; and (v) clinical care.

**Determination of Child Health Needs and their Priority**

For this process information is needed. The community pediatrician will collate existing data and, where necessary, collect new information in studies that should be neither costly nor complex. The final measure of child health is seen in terms of optimal physical, emotional and intellectual development of all children. Information will need to be as much concerned with the social and economic aspects of communities, their population structure and the available medical and social services as with disease, disability and death patterns. Of particular concern must be the investigation of factors associated with under-utilization of existing preventive health services, especially in rural areas. Collaboration with social scientists, economists, educators and statisticians will be essential for the gathering of this type of information. Epidemiological studies of childhood diseases causing serious morbidity in the community will be a major part of the pediatrician's functions.

In most rural and peri-urban areas the picture will be familiar and the priorities obvious. The background is one of communities of low socio-economic status occupying a poor physical environment and of families whose social and emotional functioning is far from ideal. Poor maternal nutrition is common, leading to a high prevalence of babies of low birth weight, with its developmental disadvantages. Malnutrition and frequent debilitating illness in early childhood contribute further to retardation of growth and intellectual development of the young child. Further, medical and social services are inadequate and/or inappropriate to the needs of the community. Among the many undesirable results of this type of situation is the prolonged hospitalization of children suffering from advanced but preventable disease.

In the better developed communities the needs are most urgent in the areas of handicap and chronic illness, and increasingly with the 'new morbidity'. Behaviour disorders, adolescent problems, drug abuse, smoking, venereal disease, and unwanted pregnancy are some of the areas covered by this term. Here priorities are less obvious and much study is required to provide a rational basis for developing services.

Regionalization of responsibility within the health services would make provision of comprehensive information possible, and is thus desirable; so, too, is the need for all university departments concerned with community health to co-operate in formulating broad research objectives. Duplication and misdirection of scarce research resources may in this way be minimized, and such cooperation would be an essential part of the community pediatrician's role.

**Co-operation with Health, Educational and Welfare Organizations**

Many organizations deliver health, educational and welfare services to children. Their common aim is the promotion of the optimal development of children in their care. It is the community pediatrician's responsibility to work with such bodies and to give and receive advice on child health from such organizations, which include such bodies as local authorities, the State Health Department, provincial hospitals, schools, medical services and charitable organizations. He will provide them with the information he has gathered in a readily usable form and present it against the background of the established priorities. He will try to influence the way in which child health services are delivered and to work closely with all welfare organizations concerned with the care of children.
Teaching

Inclusion of the comprehensive approach to child health is essential in the curricula of medical students, midwives, health visitors, social workers and even school teachers. Such child care professionals need to be made aware of the environmental, social, economic and cultural factors which block or advance child health. The child health picture of their community needs to be drawn and priorities should be suggested. They should also be made aware of the health and social services that bear particularly on these needs. These include, for example, family planning, antenatal care, environmental sanitation, housing and health education, as well as medical and welfare services for deprived and handicapped children.

A variety of approaches to the delivery of health services has been adopted in developing countries. The importance and position of child care within such services should be discussed and, if possible, demonstrated. Teaching situations might include many settings in which child care takes place, including district hospitals, local authority clinics, day hospitals, GP surgeries and institutions, as well as homes and schools for the handicapped.

Teaching may well be where the community paediatrician makes his greatest and most lasting impact.

Planning and Delivery of Services

The community paediatrician should be in a firm position to assist health administrators in the planning and development of appropriate health services for children, suitably integrated into those for the whole community.

In the rural and peri-urban areas, for example, it is likely that there will be a need for the type of primary care service that is evolving in most developing countries with limited resources. These consist of small, low-cost buildings, locally recruited staff with relatively short training, the whole often financed by local communities. It has been found that these peripheral units, correctly run and planned to be within walking distance of most patients, can provide excellent preventive and first-contact medical care when combined with an effective referral system.

It is possible that, in line with trends in many countries, a model unit along the lines discussed above might be set up and run by a university department of comprehensive and community medicine as a demonstration of what can be done with limited resources and to provide an ideal teaching situation for all levels of health workers. The community paediatrician would be deeply involved in the running of such a unit, since it would inevitably be concerned with children.

Clinical Care

Possibly the greatest clinical challenge to the community paediatrician will be in practising modern paediatric medicine in unsophisticated settings, with only the simplest of technical aids, adapted for use in this situation. Teaching of and collaboration with every kind of health worker engaged in this form of child care is central to his clinical role. Paediatric nurse associates and primary care nurses, as described by Heese et al., working with the community paediatrician, are seen as a vital part of the paediatric health team. Planned integration of this team into the comprehensive health services that are to develop for all ages and groups is vital to its success.

The hospital care of children with acute infectious diseases falls naturally to the community paediatrician, in view of his close contact with preventive and follow-up services in the community.

The community paediatrician would be greatly concerned with the diagnosis and management of handicapped and chronically ill children at home, in hospitals, or in institutions. Involvement with planning and development of services for such children would likewise be his concern.

CONCLUSIONS

1. A nation's future development is closely linked to the health of its children.
2. The ultimate aim of all child care is the promotion of optimal physical, emotional and intellectual development.
3. There is a need to approach the health needs (development blocking factors) of all children, and not only of those who need medical care.
4. Paediatricians with the orientation and experience of the methods of community medicine are suited to this task.
5. Such a community paediatrician will promote child development by working to identify the important factors blocking development (health needs) of all children in the community. He will then act to remove such blocks (i) by co-operation with all health, educational and welfare organizations; (ii) by taking part in the planning and organization of child care services; (iii) by taking part in the education of all child care professionals; and (iv) by being particularly concerned with the clinical care of children at the primary care and rehabilitative levels.
6. Co-operation with other university departments and organizations concerned with community health is essential if dissipation of costly efforts in all fields of endeavour is to be avoided.

REFERENCES