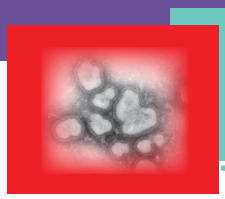

Pan American Health Organisation
Office of the Assistant Director
Health Systems and Services Area

Technical Document 5

THE PRIMARY HEALTH CARE STRATEGY AND THE RESPONSE TO THE INFLUENZA A (H1N1) PANDEMIC

This document provides technical information and recommendations on organizing first level of care services and communities in response to the Influenza A (H1N1) pandemic. It is intended for health care managers[1] in all countries in the Region of the Americas, which may or may not have probable or confirmed cases of infection. It will be revised as the situation evolves and additional information becomes available.

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The Primary Health Care (PHC) strategy calls for health problems to be approached in a comprehensive manner and their solutions to be based on integrated responses. The current influenza pandemic is not an exception to this strategy. This emergency does not justify a deflection or abandonment of the transformation of health systems and services into PHC-based health systems.

I-COMPREHENSIVE APPROACH

From the perspective of a comprehensive approach, the response to the pandemic cannot be exclusively confined to the health services negating the participation of communities, their organisations and other sectors. Participation of individuals and organizations should not be reduced to being simple receptors of information and public health measures.

Individuals, families, community organisations and other institutions present in the community, play a fundamental role in preventing influenza transmission, the promotion of personal and collective hygiene and cough etiquette, and in the early detection and care of affected persons. The organised community can be an ally of the health services, as well as active participants in the provision of ambulatory and home care in their communities.[2]

II- INTEGRATED APPROACH OF THE RESPONSE

The objective of the health services during an emergency is to provide care to the persons affected by the emergency, without diminishing provision of regular care required by persons not affected by it. On the other hand, the integrated approach demands planning, organisation and participation of all levels of the health services either private or public, in responding to the usual health needs and those generated by the emergency.

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1 ***Health care managers***: are all persons who manage a health care settings be it a locality (country, region/district, village) or a facility (hospital, ambulatory care centre). This includes the person in charge of the National Health Authority (e.g. Minister of Health) and all other persons in the health system who manage a health care setting and the health of its resident population and in so doing are responsible for decision-making.

2 For example, various sources identify the importance of the participation of district organisations in campaigns for the elimination and control of breeding sites for the dengue vector. http://www.cdc.gov/ncidod/dvbid/dengue/slideset/set1/viii/slide06.html , http://journal.paho.org/?a_ID=508

Fragmentation of health services is one of the fundamental problems of health systems in the Region. It constitutes an obstacle to the timely provision of effective and integrated care to individuals and communities. Additionally, inadequate, hospital-centred, organisation for the pandemic exacerbates fragmentation of health services to the detriment of the health of the population. A good national plan for health services response to emergency situations and disasters, should contemplate the rational, efficient, and integrated use of all the resources available to the national health services network.

A preliminary analysis of the current Influenza A (H1N1) pandemic, though incomplete, has shown that most of the countries' response plans have a noticeable tendency to focus exclusively on hospitals. The majority of these response plans specify actions at hospital level only although projections (CDC-FluSurge[3]) indicate that current installed capacity will not be enough to take care of the excessive demand that a pandemic could generate.

This type of response model loses sight of the added value of integrating first level of care health services and communities in response to a pandemic that will undoubtedly have an enormous social, economic and human impact.

III- ORGANIZATION OF THE FIRST LEVEL OF CARE FOR THE RESPONSE TO THE PANDEMIC

The first level of care is a vital component of the health services and must play a crucial role in the response to the pandemic. Health posts and centres, public or private clinics and health care facilities in general that provide ambulatory care services, can be the key in containing the heightened demand, disorder and chaos that may occur at hospital emergency departments. This is reinforced by the fact that most first level of care establishments are geographically closer to individuals and communities than hospitals.

The first level of care can be organised around three important tasks: public health, provision of personal care, and community and intersectoral organisation.

The First Level of Care and Public Health Activities

With an increased presence in the communities and interrelation with other institutions that share community presence (for example, local governments, schools, churches, work places, etc.), the first level of care can be the sentinels of the epidemiological surveillance system, and the focal point in public health activities to contain or respond to a pandemic or other sanitary emergencies. They can play a central role within the health services for follow-up activities in the community, which is especially useful when efficient coordination is maintained with other levels of care working in networks.

The first level of care centres and the primary care teams execute the functions of surveillance, mandatory notification and follow-up of important epidemiologic events and can even participate in the investigation and containment of outbreaks, as well as collecting biological samples to be sent to reference laboratories, etc.

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3 The initial projections made to calculate the behaviour of an influenza A pandemic, indicate that 15 - 35% of the population could become ill. Of that infected population, 53% could require ambulatory consultations and between 1.5% and 2% will require hospitalisation. The remaining 45% are projected to have a slight influenza or simple cold which could be managed at home following medical recommendations. (See: Zhang X, Meltzer MI, Wortley P. (2005) FluSurge 2.0: A Manual to Assist State and Local Public Health Officials and Hospital Administrators In Estimating the Impact of an Influenza Pandemic on Hospital Surge Capacity (Beta Test Version). Atlanta, GA, Centers for Disease Control and Prevention).

Additionally, through the particularity of its organisation and mission of promotion and prevention, the first level of care constitutes one of the most effective mechanisms for dissemination of public health information and coordination with other sectors in the response to health emergencies.

Provision of Direct Personal Care

In the provision of direct personal care during the pandemic, health services at the first level of care can provide support in at least two specific areas: patient triage and ambulatory management, and home-care for the confirmed cases that do not require hospitalisation.

Triage is the first step in the management of persons who go to the health services during a pandemic. It is a systematic process that allows the classification of patients based on their status and determination of the type of care that must be immediately received. With basic training, the medical and nursing personnel who provide services at the first level of care can carry out this process, based on the directions for triage articulated by the national health authorities and the technical recommendations the World Health Organisation.

It is recommended that the first level of care establishments identify and prepare a space or doctor's office for the provision of care for respiratory symptoms, or implement in the existing space the measures directed to reduce transmission of the Influenza A virus, and that they take other conducive measures for the protection of personnel, patients and their companions.[4]

The triage protocol, in addition to the basic recommended algorithm,[5] will need to specify for each country and region, the processes for patient referral, ambulatory home management and patient admission to referral hospitals, as well as recommendations for management and treatment in each situation.

The first three levels of the triage classification used in this emergency prescribe ambulatory management of patients who are deemed healthy and asymptomatic, or patients with slight respiratory symptoms that do not meet the criteria for a confirmed case of Influenza A, or patients who are suspected cases of Influenza A without complications but who require strict isolation at home. The majority of the patients infected by Influenza A (H1N1) have evolved with a mild to moderate form of the disease, as demonstrated thus far by the experiences in most countries.[6]

These patients in most cases will require basic care that includes recommendations on the use of analgesics/ antipyretics, oral rehydration, rest and, above all, remaining in isolation at home. To this, add infection control and respiratory etiquette measures (including recommendations for family members), and follow-up of the clinical course monitoring possible appearance of symptoms and alarm signals that could indicate deterioration or contagion in contacts.

Follow-up of clinical course will require organisation of surveillance mechanisms for the early identification of possible complications and to guarantee the referral of the patients who, due to worsening of their clinical status, require hospital care. With this in mind, it is recommended that "community care teams" be formed in the health centres and units of the first level of care that undertake this surveillance and care of a pre-determined population who share a geographic community. Typically, these teams are comprised of

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4 *See other recommendations detailed in Technical Document No. 2: General recommendations for clinical management of cases of influenza A (H1N1) infection, PAHO, HSS,* http://new.paho.org/hq/index.php?option=com_content&task=blogcategory&id=805&Itemid=569&lang=en.

5 Idem.

6 WHO. *Clinical management of human infection with new influenza A (H1N1) virus: initial guidance.* Geneva, 21 May 2009, http://www.who.int/csr/resources/publications/swineflu/clinical_management/en/index.html.

different combinations of health workers (professional, technical and voluntary) according to availability and the realities of each country or region. These teams have the potential to be of strategic value in ensuring home care of suspected, probable and/or confirmed cases, along with their possible contacts. The familial and community approach facilitates early identification of known risk factors in the members of each family (chronic diseases, pregnancy, immuno-suppression, among others), information of special interest which may determine the therapeutic conduct to follow in each case.

The community care teams can constitute the first point of contact with the ill population through visits to the homes of persons reported by the community organisations that participate in promotion and prevention activities, or through relatives who have called Hotlines or Call Centres to ask for advice or care. These teams also constitute the most suitable mechanism to coordinate actions serving as a connection between the patients, the communities and health care services of higher complexity (hospitals).

Isolated home care is essential in maintaining the availability of beds in the hospitals during a pandemic and will also contribute to the reduction of the risk of propagation. In this way, the first level of care services and their care teams, in association with the local community organisations, can be the first circle of containment to avoid overload and collapse of the hospital services.

Community Organisation

In many countries of the Americas and for many decades, community organisations have worked closely with the health services, fundamentally at the first level of care, with health promotion and community development activities. Health committees, health promotion organisations, community health workers (CHWs), etc., constitute local organisations in many communities of our region. In addition, in some countries non-governmental organisations (NGOs) act as important suppliers of first level of care and health promotion services, and community organisation.

All of these community organisations can construct social networks and be rapidly enabled to detect persons who require care from the health teams through daily visits or telephone calls to their neighbours, especially persons who live alone or are elderly, or others who lack family support. In addition, these organisations can be efficient in the distribution of health promotion materials, all this with the due knowledge of biosecurity measures and personal protection to avoid contagion.

In many countries and territories, services are being organised to orient the community to address any doubts and consultations via telephone lines or call centres, which must be in coordination with the health services. These centres can be staffed by qualified personnel (health service professionals, health sciences students, Red Cross volunteers, educators) and constitute a mechanism to reduce the number of people, many of them healthy, who would otherwise go to the health services and contribute to the congestion of same.

On the other hand, the participation of sectors such as education and other institutions whose missions have a strong community component can be crucial in expanding the range of the health services in the control of and response to the pandemic.

IV- MECHANISMS FOR COMMUNITY-HEALTH SERVICE COORDINATION

By its nature, the first level of care constitutes the ideal focal point for community and intersectoral efforts. However, the success of this strategy will depend on the development of plans for the integration of the health services, taking into account the characteristics of the model of care, and the mechanisms for coordination between institutions and the community.

The operational plan must anticipate mechanisms that include, but are not limited to, the existence of protocols for integrated care, referral and counter-referral mechanisms, communications systems, and an integrated information system that operates in the network of health care facilities independent of their level of complexity or institutional affiliation. It must also anticipate, the mechanisms for community and intersectoral integration and the necessary inter-institutional coordination at the level of state and private institutions

In order to facilitate the development of these mechanisms, the following actions are recommended:

- Call to action all community health organisations (Health Committees, health promotion organisations, NGOs, etc.) as well as state and private institutions.
- Organise the distribution of responsibilities of the primary care teams by locality and ensure that they are linked to health centres and a referral hospital.
- Take advantage of the presence of organisations in the community (health promoters, churches, educators and volunteers) and organise them to provide care and health promotion activities to neighbours.
- Establish coordination mechanisms between these organisations and the primary care teams and health centres with geographic-population responsibility.
- Organise call centres or telephone consultation lines, with clear guidelines and protocols to ensure that persons receiving calls will know how to direct the callers according to their needs, or, activate the home care team so that it responds appropriately in locating the patient and providing care.
- Assemble and quickly validate the first level primary care teams for enhanced epidemiological surveillance, case investigation and initial containment measures, public health actions, triage, appropriate diagnoses and case management.
- Guarantee coordination and communication of the primary care teams and first level of care facilities with other facilities in the care network, according to the characteristics defined in each territory.
- Establish, via development of institutional protocols and agreements, mechanisms of coordination and linkage between health centres, hospitals, ambulance services, etc.
- Additionally, it will be necessary to establish these mechanisms of coordination between the health services of the ministries/health secretaries, the social security institutions and the providers of private health services. This integration/coordination can be achieved by the establishment of Coordinating Groups, which exist in some countries of the region.

In summary, first level of care health services and community health organisations constitute a great force beyond the hospitals; their organisation and participation can enhance the capacity of the health services to provide an organised response. Approaching the response to the pandemic from a strategic focus centred on PHC and integrated health services, will not only give immediate results, but will contribute to the long term strengthening of the entire health services.