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Emergency Situations Staff Members of Primary Healthcare Institutions

Richard Cooke*

Department of Nursing, University of the Witwatersrand, Parktown, Gauteng, South Africa

Abstract

These events frequently have an impact on the health system's capacity to effectively manage emergency risk and offer access to high-quality care because they interfere with a number of crucial aspects of the delivery of healthcare. This covers geographic facility accessibility, the availability of a skilled medical workforce, and the accessibility of money. It also covers problems with supply-chain management, such as insufficient resources, the infrastructure of medical facilities, and the availability of electricity and water. Government control, the existence of good leadership and organisational management are important as well but may be lacking in an emergency. In emergency situations, health staff may be particularly exposed. This may be due to a number of factors, such as the increased workload and psychological stress they experience.

Keywords: Emergency situations • Primary healthcare institutions • Emergency

Introduction

The health system being disrupted can potentially result in them going without pay for extended periods of time. In addition to lacking general disaster response competences including infection prevention and control, case management, surveillance and reporting, and risk communication, local health workers frequently lack training in risk assessments, emergency prevention, readiness, response, and recovery. Additionally, the hiring of health professionals by international humanitarian organisations that are able to provide competitive pay packages could make the staff shortages worse. Data on general practitioner visit costs were acquired from the NZHS. In addition to being done in 1996–1997, 2002–2003, and 2006–2007, this national survey has been on-going since 2011–12, with updates being made on a yearly basis. The NZHS has an intricate design that has evolved over the years [1,2].

There are comprehensive details for each wave. In a nutshell, face-to-face interviews take place in respondents' homes. The interviewer enters responses directly for the majority of questions. Health systems have been impacted equally by the COVID-19 epidemic. Essential health services were disrupted in nearly all (90%) of the nations the WHO examined, with LMICs reporting the most interruptions. There were substantial setbacks in the treatment of chronic illnesses and non-communicable diseases. 18 Over 50% of nations restrict outpatient care. Reduced service availability was caused by the cancellation of elective care and the diversion of clinical staff to pandemic response. 17 Disruptions were also caused by decreased demand for services; 76% of nations reported a decline in patient presentation for care17, and 45% of patients in need of services across 18 African countries delayed, missed, or were unable to receive medical care. 18 The most frequent justification for skipping doctor visits was fear of contracting COVID-19. 18 Similarly, concern over Ebola infection influenced [3].

Primary healthcare must be acknowledged as a crucial factor in all emergency management plans at the national, state, and local levels. Currently, national and international health security initiatives are mostly focused on central and national-level structures and institutions, where primary healthcare is either missing or underrepresented. Primary healthcare must be acknowledged at the national level and incorporated into national health emergency risk management policies, strategies, and programmes. Primary care must have clearly defined and acknowledged roles and tasks in emergency prevention, planning, and response that are incorporated into health-facility risk management plans and connected to secondary and tertiary care systems at the regional, district, and community levels [4].

Medical doctors, nurses, midwives, clinical officers or physician assistants, laboratory technicians, pharmacists, community health workers (CHWs), and other health professionals, as well as management and support employees, make up the health workforce. There is a correlation between the availability of health workers and the delivery of health services, even if the ideal quantity of various sorts of health workers varies from context to context. For essential primary health care services, the staffing levels below have been defined as the minimum required attaining and maintaining primary health care services of acceptable quality. Diversity and gender should be taken into account. Imbalances in staffing should be addressed by redeploying health workers to areas that experience critical gaps in relation to health needs, or by recruiting.

The focus of the primary health care (PHC) system's services was on disease consultations and drug prescriptions. The Alma-Ata Declaration, which viewed access to health care as a fundamental human right, altered its scope in 1978. The primary health care system is essential for achieving the statement's goals, according to Section V of the declaration. This proclamation causes the PHC's mandate to shift from providing patients with counselling regarding their symptoms to providing comprehensive community health care. The WHO examined this PHC goal of comprehensive health care in a report published in 2008, which focused on moving PHC services away from hospitals and specialised facilities and toward regular walk-in clinics. PHC is a whole-society approach to health that focuses on people's needs and preferences (as individuals, families, and communities) as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation, and palliative care and as close as practical to people's everyday environment. It aims to ensure the highest level of health and well-being and their equitable distribution [5].

Description

A people-centered approach in primary care should put an emphasis on making sure that people are involved in the planning, provision, and evaluation

***Address for Correspondence:** Richard Cooke, Department of Nursing, University of the Witwatersrand, Parktown, Gauteng, South Africa, E-mail: Richard.Cooke101@wits.ac.za*

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of healthcare services and provide them the tools they need to defend themselves and their communities, promote health, and head off emergencies. Investments in community-level interventions promote this cooperation and increase community resilience since local communities are a crucial resource in preventing and preparing for emergencies. Ensuring constant, proactive communication with the populace will help combat misinformation, which is typical in emergency situations. Additionally, considering and empowering communities as co-designers of service delivery and other solutions, such dealing with environmental and social challenges, could also help to prevent or minimise emergencies and is crucial for recovery. Front-line workers must be trained and encouraged to participate more actively in emergency risk assessment, planning, coordination, and action on the basis of clearly defined roles and responsibilities. This calls for the hiring and retention of sufficient numbers of health professionals at the local level, suitable and prompt compensation, as well as supportive policies and structures for a favourable work environment to protect employees during every stage of the disaster response.

Conclusion

Due to the abandonment of routine primary care services in favour of emergency case management and the aforementioned difficulties in providing care, quality of care and patient safety are frequently jeopardised during emergencies. Building trust in primary care and promoting greater utilisation are two benefits of offering high-quality primary care services that are safe, efficient, and patient-cantered. The continuity of quality before, during, and after emergencies should be addressed in national policies, strategies, and plans on quality. Water, sanitation, and hygiene as well as critical infection prevention and control are important building blocks for high-quality treatment. There are several treatments to increase quality (21), but in emergency situations, it may be useful to employ clinical standards or protocols, monitor quality through incident reporting, train and oversee the workforce, and inspect the institution.

Acknowledgement

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Conflict of Interest

None.

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